DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

12/18/2015

Kevin E. Moore, Administrator
Division of Health Care Access and Accountability
Department of Health Services
1 West Wilson Street
P.O. Box 390
Madison, WI 53701-0309

Dear Mr. Moore:

We are pleased to inform you that Wisconsin's section 1115 Medicaid demonstration project, entitled SeniorCare (Project No. 11-W -00149/5) has been approved for a 3-year extension, from January 1, 2016 through December 31, 2018, in accordance with section 1115(a) of the Social Security Act (the Act).

The demonstration will continue to provide a comprehensive prescription drug benefit to Wisconsin residents who are age 65 and older with income at or below 200 percent of the Federal poverty level (FPL) and who are not otherwise receiving full Medicaid benefits. The program includes several innovative program features, including 1) a simple application and enrollment process, 2) an open formulary and broad network of providers, and 3) affordable cost-sharing for participants. Beginning January 1, 2013, Medication Therapy Management (MTM) services were also being offered as an optional service to enrollees.

Our approval of the SeniorCare section 1115(a) demonstration project (including the Federal matching authority provided thereunder) is contingent upon the state's agreement to the enclosed Special Terms and Conditions (STCs) and associated list of expenditure authorities. The STCs set forth in detail the nature, character, and the extent of anticipated Federal involvement in the demonstration project. The STCs are effective January 1, 2016, unless otherwise specified. All the requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the enclosed expenditure authority list shall apply to the demonstration. The STCs are incorporated in their entirety into this approval letter and supersede all previous STCs.

Written notification of the state's acceptance of this award, including the STCs and expenditure authorities, must be received within 30 days of the date of this letter.

Your project officer is Ms. Christine Hinds. She is available to answer any questions concerning this demonstration project. Ms. Hind's contact information is as follows:

Centers for Medicare & Medicaid Services

Center for Medicaid & CHIP Services
7500 Security Boulevard
Mailstop S2-14-26
Baltimore, MD 21244-1850
Telephone: (410) 786-4578

E-mail: christine.hinds@cms.hhs.gov. Official communications regarding program matters should be sent simultaneously to Ms. Hinds and Ms. Ruth Hughes, Associate Regional Administrator, in our Chicago Regional Office.

Ms. Hughes's contact information is as follows:

Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, IL 6060 1-5519

If you have questions regarding this correspondence, please contact Alissa M. DeBoy, Acting Director, Disabled and Elderly Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-7089.

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

Sincerely,

/s/

Vikki Wachino
Deputy Administrator

Enclosures
cc: Ms. Ruth Hughes, ARA, Region V

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00149/5

TITLE: Wisconsin SeniorCare Section 1115 Demonstration

AWARDEE: Wisconsin Department of Health Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the State's title XIX plan. The expenditure authority period of this demonstration is from the effective date identified in the demonstration approval letter through December 31, 2018.

Expenditure authorities listed below promote the objectives of title XIX in the following ways:

- Expenditure authorities 1 through 8 increase the efficiency and quality of care through initiatives to transform service delivery networks.
- Expenditure authorities 2 through 6 improve health outcomes for low-income individuals.
- Expenditure authorities 2, 3, and 6 increase access to, stabilize, and strengthen, providers and provider networks available to serve low-income populations in the state.
- Expenditure authorities 2 through 6 increase coverage of low-income individuals in the state.

Demonstration-Eligible Population ("SeniorCare Population") Expenditures for prescription drug costs and medication therapy management (MTM) services for individuals age 65 or over with income at or below 200 percent of the Federal poverty level (FPL) who are enrolled in the demonstration and who are not receiving full Medicaid benefits under a group covered under the State plan.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the demonstration population beginning January 1, 2016, through December 31, 2018.

Title XIX Requirements Not Applicable to the Demonstration-Eligible Population:

1. **Notice and Appeals** — **Section 1902(a)(3), 42 CFR 431.211, 42 CFR 431.213, 42 CFR 431.206, and 42 CFR 431.220**

To the extent necessary to enable the State to not provide the 10-day required notification prior to termination of eligibility in cases where the demonstration enrollee has clearly notified the Department either orally or in writing that he or she no longer wishes to receive services. Also, to the extent necessary to enable the State to not provide the right to a hearing to demonstration

enrollees with respect to denials of claims for benefit payments during any period in which funding for benefit payments under the program has been completely expended.

2. **Eligibility Standards and Methodologies** **Section 1902(a)(10)(A) and Section 1902(a)(17)**

To the extent necessary to enable the State to expand eligibility for coverage of pharmaceuticals and MTM services to demonstration enrollees with incomes at or below 200 percent of the FPL and to apply different financial eligibility standards and methodologies to the demonstration-eligible population than would be applied to other Medicaid recipients. Eligibility will be re-determined and income will be reassessed for demonstration enrollees once every 12 months.

3. **Amount, Duration, and Scope** **Section 1902(a)(10)(B)**

To the extent necessary to enable the State to offer a different benefit package to the demonstration-eligible population that varies in amount, duration, and scope from the benefits offered under the State plan.

4. **Benefits** **Section 1902(a)(10)**

To the extent necessary to allow the State, during any period in which funding for benefit payments under the program is completely expended, to not pay pharmacies or pharmacists for prescription drugs sold to program participants or for MTM services. Further, to allow that pharmacies and pharmacists will not be required to sell drugs to demonstration enrollees at the program payment rate nor perform MTM for demonstration enrollees at the program rate; that demonstration enrollees will not be entitled to obtain prescription drugs for the copayment amounts or at the program payment rate nor will they be entitled to obtain MTM services at the program rate; that the State will not collect rebates from manufacturers for prescription drugs purchased by demonstration enrollees; and that the State is required to continue to accept applications and determine eligibility for the program, and must indicate to applicants that the eligibility of demonstration enrollees to purchase prescription drugs and MTM services under the requirements of the program is conditioned on the availability of funding.

5**. Cost Sharing** **Section 1902(a)(14)**

To the extent necessary to enable the State to impose an annual enrollment fee of $30; establish that demonstration enrollees with income above 160% of the Federal Poverty Level (FPL) and at or below 200% FPL would pay the first $500 of prescription drug costs and MTM services prior to receiving the benefit of MTM services and obtaining prescription drugs at the copayment levels; and establish copayment amounts that are above the limits in current Medicaid statutes for the demonstration- population.

6. **Ex Parte Eligibility Redetermination and Applicant's Choice of Category** — **Section 1902(a)(19), 42 CFR 435.902, 42 CFR 435.916, and 42 CFR 435.404**

To allow the State to require that a separate demonstration application be filed by an applicant who is not eligible for regular Medicaid prior to being determined eligible for the demonstration program; and to require demonstration applicants to file separate Medicaid applications if they are interested in receiving benefits under any Medicaid eligibility group covered in the State plan.

7. **Retroactive Eligibility** — **Section 1902(a)(34) and 42 CFR 435.914**

To the extent necessary to enable the State to not provide coverage for the demonstration-eligible population for any or all of 3 months prior to the date of application. Demonstration enrollees may participate in the program on the first day of the first month following the month in which all eligibility criteria are met.

8. **Income Eligibility Verification** — **Section 1902(a)(46), 42 CFR 435.920, and 42 CFR 435.940 through 435.965**

To the extent necessary to enable the State to use all other State and Federal data exchanges under section 1137 except the Internal Revenue Service's data exchange for income verification for the demonstration-eligible population.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00149/5

TITLE: Wisconsin SeniorCare Section 1115 Demonstration

AWARDEE: Wisconsin Department of Health Services

DEMONSTRATION PERIOD: January 1, 2016 through December 31, 2018

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Wisconsin's SeniorCare section 1115(a) Medicaid demonstration extension (hereinafter referred to as "demonstration") to enable the Wisconsin Department of Health Services ("State") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted an expenditure authority authorizing federal matching of certain demonstration costs not otherwise matchable, which is separately enumerated. The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the State's obligations to the Centers for Medicare & Medicaid Services (CMS) during the life of the demonstration. These STCs are effective January 1, 2016, unless otherwise specified. This demonstration is approved through December 31, 2018.

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
X. Monitoring Budget Neutrality for the Demonstration
XI. Evaluation Plan and Design
XII. Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A Summary Chart of the Comprehensive Prescription Drug Benefit and Cost Sharing for SeniorCare Individuals

II. PROGRAM DESCRIPTION AND OBJECTIVES

On July 1, 2002, Wisconsin received approval for the SeniorCare Program, which offered a comprehensive prescription drug benefit to Wisconsin residents 65 and older with income at or below 200 percent of the Federal Poverty Level (FPL). The SeniorCare Program was approved by the Centers of Medicare & Medicaid Services (CMS) as a Section 1115 demonstration for a period of five years. After the initial approval period, Congress enacted legislation to allow Wisconsin to continue the program through December 31, 2009. The State subsequently requested an extension and CMS extended the waiver to December 31, 2015

On June 30, 2015 the State of Wisconsin submitted a request to extend its SeniorCare demonstration, which offers a comprehensive prescription drug benefit to Wisconsin residents who are age 65 and older with income at or below 200 percent of the FPL and are not otherwise receiving full Medicaid benefits. The program includes several innovative program features, including 1) a simple application and enrollment process, 2) an open formulary and broad network of providers, and 3) affordable cost-sharing for participants.

Wisconsin has established a SeniorCare Advisory Committee, which advises the State on matters pertaining to the SeniorCare program. The SeniorCare Advisory Committee includes AARP and the Wisconsin Coalition of Aging Groups.

Individuals with prescription drug coverage under other health insurance plans may enroll in SeniorCare. SeniorCare will coordinate benefit coverage with all other health insurance coverage, including Medicare Part D covered drugs when submitted by the pharmacy as a Part D prescription drug claim.

Demonstration Goals:

- Keeping Wisconsin seniors healthy by continuing to provide a necessary primary health care benefit;
- Reducing the rate of increase in the use of non-pharmacy related services provided to this population including hospital, nursing facility and other non-pharmacy related medical services;
- Helping control overall costs for the aged Medicaid population by preventing seniors from becoming eligible for Medicaid due to deteriorating health and spending down to Medicaid eligibility levels.

Demonstration Purpose:

Extending pharmacy care benefits to the aged population will result in a reduction to the rate of increase in the use of non-pharmacy related services provided to the aged population, and control overall costs for this population by preventing the aged from spending down to Medicaid full benefit eligibility levels.

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 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), must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy directive, 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. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the State 30 days in advance of the expected approval date of the amended STCs to allow the State to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The State must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal Financial Participation (FFP) for expenditures made under this demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

b. If mandated, changes in the Federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the 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 appropriate State Plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility (such as the expansion of eligibility beyond 200 percent of FPL, and /or changes to non-financial eligibility criteria) enrollment, benefit and cost sharing changes not reflected in Attachment A, evaluation design, sources of non-Federal share of funding, budget neutrality, 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 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. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

a. *Public Notice.* The State does not need to comply with the state public notice and comment process outlined in 42 CFR §431.408 until such time that CMS issues policy guidance to the contrary. However CMS encourages the State to do so in the event it seeks to amend the demonstration that modifies benefits, cost sharing, eligibility, or delivery system changes. CMS will post and accept public comments on all amendments.

b. *Tribal Consultation.* The State must provide documentation of the state's compliance with the tribal consultation requirements outlined in STC 15. Such documentation shall include a summary of the tribal comments and identification of proposal adjustments made to the amendment request due to the tribal input;

Demonstration Amendment Summary and Objectives. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; including what the State intends to demonstrate via this amendment as well as the impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes.

c. *Waiver and Expenditure Authorities*. The State must provide a list of waivers and expenditure authorities that are being requested or terminated, along with the reason, need and the citation along with the programmatic description of the waivers and expenditure authorities that are being requested for the amendment;

d. *Budget neutrality data analysis worksheet*. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget

neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under Sections 1115 (a), 1115(e) or 1115(f) must submit an extension request 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 STC 9.

a. *Compliance with Transparency Requirements 42 CFR Section 431.412*:

As part of the demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in STC 15, as well as include the following supporting documentation:

i. Historical Narrative Summary of the demonstration Project: The State must provide a narrative 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 as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. 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.

iii. Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Financial Data: The State must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

v. Evaluation Report: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vi. Documentation of Public Notice 42 CFR Section 431.408: The State must provide documentation of the state's compliance with public notice process as specified in 42 CFR Section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

vii. Quality: The requirement at 431.412(c)(2)(iv) does not apply to this demonstration.

b. Temporary Extension of Demonstration.

Upon application from the State or CMS determination that a temporary extension of the demonstration is necessary, CMS will temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. **Demonstration Transition and 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 six (6) 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 website 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 received, the State's response to the comment, and how the State incorporated the received comment into a revised phase-out plan.

b. *Transition and 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.

c. *Transition and 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.

d. *Phase-out Procedures*: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213, to the extent they are applicable. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221 as may be applicable. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230, as may be applicable. In addition, the State must conduct administrative renewals for all affected beneficiaries, as may be applicable, in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

e. *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 included services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out.** Notwithstanding the situation described in STC 19, if the State elects to suspend, terminate, or not renew this demonstration as described in STC 9, during the last 6 months of the demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State Plan must not be enrolled unless the demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the demonstration will not be renewed.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate 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.

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

13. **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.

14. **Adequacy of Infrastructure**. The State must 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.

15. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State. 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, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the state's approved State Plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 7, are proposed by the State.

a. *Consultation with Federally Recognized Tribes on New Demonstration Proposals Applications and Renewals of Existing Demonstrations.* 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 C.F.R. §431.408(b)(2)).

b. *Seeking Advice and Guidance from Indian Health Programs Demonstration Proposals, Renewals and Amendments.* 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 in accordance with the process in the state's approved Medicaid state plan prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.

c. 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.

16. **Federal Financial Participation (FFP)**. Federal funds are not available for expenditures for this demonstration until the effective date identified in the demonstration approval letter or a later date if so identified elsewhere in these STCs or in the list of waiver or expenditure authorities.

17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS)**. Section 1903(r) of the Act requires that all states with Medicaid programs have approved mechanized claims processing and information retrieval systems that are compatible with claims processing and information retrieval systems used in the administration of Title XVIII of the Act. Those compatibility requirements include: 1) a uniform identification coding system for providers, other payees, and beneficiaries under Titles XVIII and XIX; 2) provisions for liaison

between states and carriers and intermediaries with agreements under Title XVIII to facilitate timely exchange of appropriate data; 3) provisions for exchange of data between the states and the Secretary with respect to persons sanctioned under Titles XVIII or XIX; and 4) incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary. Additionally, effective for claims filed on or after January 1, 1999, a state's mechanized claims processing and information retrieval system will provide electronic transmission of claims data in the format specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) including detailed individual enrollee encounter data and other information that the Secretary may find necessary. The claims data format for MSIS electronic transmission is specified in the State Medicaid Manual, Part 2, Section 2700 as may be updated by the Secretary from time to time. CMS released a letter to State Medicaid Directors on August 23, 2013, that discusses upcoming changes to MSIS, which will be known as Transformed MSIS or T-MSIS. CMS is implementing T-MSIS with states on a rolling basis, with the goal of having all states submitting data monthly by July 1, 2014. For more information, please refer to the letter, which is available online at http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html. DHS will submit SeniorCare data through the T-MSIS feed with all other WI Medicaid data based on the timeline agreed upon between DHS and CMS T-MSIS leads.

18. **Payer of Last Resort**. The Medicaid program is the payer of last resort except as expressly provided by the Medicaid statute; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program will pay for the care of an individual eligible for Medicaid. Accordingly, the State must have adequate systems and safeguards in place to provide for coordination of benefits under the demonstration.

19. **Notice Due to Unavailability of State Funding**. In the event that state funding for the demonstration is unavailable for any period of time, resulting in suspension of the benefits under the demonstration, the State must provide advance notice in writing to CMS, demonstration enrollees, and any other parties directly affected by the suspension of benefits at least 30 days prior to terminating services to demonstration enrollees. The State must also provide written notice to CMS, demonstration enrollees, and any other affected parties within ten business days of reinstating benefits.

20. **Promoting Medicaid and Medicare Low-income Subsidy Eligibility**. The State, or its designated representative, must inform all demonstration applicants of their options for the Part D low-income subsidy, as well as full Medicaid benefits prior to enrolling in the demonstration. Information on such programs must be given to demonstration applicants who are applying for SeniorCare benefits.

IV. ELIGIBILITY

The SeniorCare program is available to Wisconsin aged individuals defined as individuals age 65 or older with income that does not exceed 200 percent of the FPL and who are not eligible for full Medicaid benefits.

An applicant must meet the following eligibility requirements in order to enroll in this demonstration as a member of the Demonstration-Eligible Population ("SeniorCare Population"):

a. Must be at least 65 years of age;

b. Must not receive full Medicaid benefits under the State Plan (low-income Medicare beneficiaries such as Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Individual (QI-1), or Qualified Disabled Working Individuals (QDWI) may qualify for SeniorCare);

c. Must have annual income that does not exceed 200 percent of the FPL, based upon the average prospective gross income without any deductions or disregards, other than those applicable in the case of self-employment income, with verification required. Self-employment income will be calculated by deducting estimated business expenses, losses, and depreciation from gross self-employment income;

d. Must provide verification, including documentation, of U.S. citizenship and Social Security Number (or proof of application for a SSN) in accordance with Section 1903(x) of the Social Security Act or the alternative citizenship documentation verification process if the State chooses to include in their State Plan as stipulated in Section 1902(a) and authorized through the Children's Health Insurance Program Reauthorization Act (CHIPRA) – P.L. 111-3;

e. Must be a Wisconsin resident; and

f. Must pay a $30 annual enrollment fee.

The chart below summarizes the sources of income that will be considered under the Demonstration:

Annual Expected Income Considered for Enrollment	**Annual Income Deductions**
Gross Social Security	NA
Gross Wages	NA
Interest, Dividends and Capital Gains	NA
Net Self-Employment Income	Business costs, business losses, depreciation of business assets and other deductions allowed by the Internal Revenue Service
Retirement Income	NA
Other Income	NA

21. **Retroactive Eligibility**. Enrollees who qualify for SeniorCare will not be provided retroactive coverage. The effective date of prescription drug coverage under the demonstration is the first day of the month following the month in which all eligibility criteria are met.

22. **Continuous Eligibility**. Enrollees who are eligible remain eligible during the 12 month certification period, regardless of income changes, unless they:

a. Begin receiving full Medicaid coverage;

b. No longer reside in the State of Wisconsin;

c. Become incarcerated or are institutionalized in an Institution for Mental Disease (IMD); or

d. Are no longer living.

23. **Application Processing and Enrollment Procedures**. The State may require applicants for this demonstration to adhere to the following application and enrollment procedures:

a. Applications: Applicants are required to complete an application. The State must verify the full legal name, date of birth, Social Security number, and citizenship status of all applicants; ensure that applicants receive a full explanation of program rights and responsibilities; and obtain an applicant/member attestation to the accuracy of the information provided.

b. Enrollment Fee: All applicants are required to pay a $30 enrollment fee at the initial enrollment and at each annual enrollment for the program. In addition, individuals who choose to reapply if their income changes are required to pay a new $30 enrollment fee. The enrollment fee will be returned if the applicant is not eligible to enroll in the demonstration.

24. **Redetermination of Eligibility**. Redetermination of eligibility for SeniorCare must occur at least once every 12 months, which is done through the State's central processing center. An enrollee may request a redetermination of eligibility for the demonstration due to a change in family size (e.g., death, divorce, birth, marriage, adoption) at any time, and the State must perform such redeterminations upon request. Each redetermination must include a confirmation that the enrollee is not receiving coverage under any Medicaid eligibility group covered in the Medicaid state plan prior to re-enrollment into the demonstration.

25. **Disenrollment**. Enrollees in the demonstration may be disenrolled if they:

a. Begin receiving full Medicaid coverage;

b. No longer reside in the State of Wisconsin;

c. Become incarcerated or are institutionalized in an IMD; or

d. Are no longer living.

V. BENEFITS

26. **Comprehensive Prescription Drug Benefit**. Upon implementation, the demonstration participants will receive a comprehensive prescription drug benefit, which is comparable to the

State's coverage of prescription drugs as currently provided under the Wisconsin Medicaid State Plan and at the Medicaid payment rate. Members are also eligible to receive Medication Therapy Management (MTM) services as an optional service. Under the MTM benefit, traditional pharmaceutical services called Intervention-based Services will be provided (including therapeutic interchange, adherence counseling, dosage adjustments, education on proper medication administration and potential addition or deletion of medications). Comprehensive Medication Review Assessments will also be included to provide more in depth analysis by a pharmacist of the member's health status, formulation of a treatment plan, documentation and communication with primary care providers, referrals to other health care providers, and coordination and integration of medication management services with the broader health care system.

VI. COST SHARING

27. **Cost Sharing**. Upon implementation, the SeniorCare participants are required to pay the following:

a. Enrollment Fee: All applicants are required to pay an annual $30 enrollment fee prior to the initial enrollment and at each annual enrollment for the program. In addition, individuals who choose to reapply if their income changes are required to pay a new $30 enrollment fee. The enrollment fee will be returned if the applicant is not eligible to enroll in the demonstration.

b. Co-Payments for Services: All enrollees are required to pay co-payments of $5 for generic drugs and $15 for brand name drugs. There is no copayment for MTM services.

c. Deductible: Enrollees with income above 160 percent of the FPL, and at or below 200 percent of the FPL are responsible for the first $500 of prescription drug costs and MTM costs while in the deductible period each year and may pay up to Medicaid rates.

VII. DELIVERY SYSTEMS

28. **Medicaid Pharmacy Providers**. The State will utilize the current pharmacy provider network that provides prescription drugs to the existing Medicaid program to provide prescription drugs and MTM services to members of the SeniorCare demonstration.

VIII. GENERAL REPORTING REQUIREMENTS

29. **General Financial Requirements**. The State must comply with all general financial requirements including reporting requirements related to monitoring budget neutrality, set forth in Section IX of these STCs.

30**. Reporting Requirements Related to Budget Neutrality**. The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section X of these STCs, including the submission of corrected budget neutrality data upon request.

31. **Monitoring Calls**. CMS will schedule conference calls with the State as needed. 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, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the State is considering submitting. CMS shall provide updates 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.

32. **Quarterly Progress Reports**. The State must submit progress reports in accordance with the guidelines in Attachment B 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:

a. An updated budget neutrality monitoring spreadsheet;

b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, grievances, quality of care, access, financial performance that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

c. Action plans for addressing any policy, administrative, or budget issues identified;

d. Quarterly enrollment reports for demonstration eligibles and other statistical reports listed in Attachment B; and

e. Quarterly updates on covered services and cost sharing. The State needs to confirm actual covered services and co-payments required as described in Attachment B for the demonstration in each quarterly progress report.

33**. Demonstration 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 (if relevant), benefit and cost sharing changes, policy and administrative difficulties in the operation of the demonstration, and systems and reporting issues. The State must submit the draft annual report no later than 90 days after the close of the demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

34. **Final Report**. Within 120 days following the end of the demonstration, the State must submit a draft final report to CMS for comments. The State must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 90 days after receipt of CMS' comments. A final report must only be submitted to CMS upon sunsetting of the WI SeniorCare demonstration project. This provision does not apply if the demonstration waiver is renewed for future years.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

35. **Quarterly Expenditure Reports**. The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided through this demonstration under Section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide Title XIX FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X.

36. **Reporting Expenditures under the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures (**Use of Waiver Forms)**. In order to track expenditures under this demonstration, the State must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual (SMM). All demonstration expenditures claimed under the authority of Title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00149/5) assigned by CMS (including the project number extension, which indicates the demonstration year (DY) in which services were rendered or for which payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary line 10B, in lieu of lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 37.

b. **Reporting by Demonstration Year by Date of Service**. In each quarter, the State must submit separate Forms CMS-64.9 Waiver and/or 64.9P Waiver reporting expenditures (including prior period adjustments), using demonstration name "SeniorCare." Wisconsin must also separately report (break out) "Aged Medicaid expenditures" from all other Title XIX expenditures and report them separately on the CMS 64.9 Waiver and/or 64.9P Waiver form or consistent with a method approved by CMS per the Corrective Action Plan (CAP) noted in subparagraph 36 g.

c. **Cost Settlements.** For monitoring purposes, cost settlements related to expenditures subject to the budget neutrality expenditure limit may be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for Summary Sheet line 10B, in lieu of lines 9 or 10C. For any other cost settlements not so associated, the adjustments must be reported on lines 9 or 10C, as instructed in the SMM.

d. **Premium and Cost sharing Adjustments**. Enrollment fees and other applicable cost sharing contributions from enrollees that are collected by the State under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64 Narrative, with subtotals by DY. In the calculation of expenditures

subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

e. **Manufacturer Rebates**. The State has the capacity to use its MMIS system to stratify manufacturer's rebate revenue that should be assigned to net demonstration expenditures. The State will generate a demonstration-specific rebate report to support the methodology used to assign rebates to the demonstration. The State will report rebate revenue on the CMS 64-9. This revenue will be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid. Budget neutrality will reflect the net cost of prescription drugs.

f. The State will restate its SeniorCare only demonstration expenditures on the CMS 64.9 by reporting expenditures by calendar year (January through December) instead of demonstration year (September through August). The State will continue to report SeniorCare expenditures on a calendar year basis going forward on the CMS 64.9.

g. The State shall continue to follow the March 1, 2013 CMS approved reporting using the state's Decision Support System or data warehouse enabling the State to report the Medicaid aged population consistent with STC 37 for the purpose of measuring budget neutrality.

37. **Expenditures Subject to the Budget Agreement**. For the purpose of this section, the term "expenditures subject to the budget neutrality limit" will include the following:

a. All medical assistance expenditures (including those authorized in the Medicaid State Plan, through Section 1915(c) waivers, and through 1115 waivers and expenditures authorized) made on behalf of the Medicaid aged population as determined by the calculation of the agreed upon budget neutrality limit; and,

b. All expenditures (net administrative costs) associated with the SeniorCare population.

38. **Administrative Costs**. Administrative costs will not be included in the budget neutrality expenditure limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All such administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using waiver name "SeniorCare."

39. **Claiming Period**. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

40. **Standard Medicaid Funding Process**. The standard Medicaid funding process must be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable/ Federal share) subject to the budget neutrality agreement must be separately reported by quarter for each FFY on the form CMS-37.12 for both the Medical Assistance program and administrative costs. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

41. **Extent of FFP for the demonstration**. The CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section IX:

a. Administrative costs, including those associated with the administration of the demonstration; and

b. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act for aged individuals, with dates of service during the operation of the demonstration.

42. **Sources of Non-Federal Share**. The State certifies that the matching 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 match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may 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. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

43**. State Certification of Funding Conditions**. 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 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, and 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.

44. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

45. **Limit on Federal Title XIX Funding**. The State will be subject to a limit on the amount of Federal Title XIX funding that the State may receive for expenditures subject to the budget neutrality agreement during the demonstration approval period. The budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64 and/or other method approved by CMS, consistent with paragraph 36 g.

46. **Risk**. The State shall be at risk for total expenditures for both the demonstration as well as the Medicaid Aged Population under this budget neutrality agreement.

47. **Calculation of the Budget Neutrality Limit and How it is Applied.**

The following table gives the total computable budget neutrality limits for each demonstration year which is equal to the calendar year (CY) (Demonstration year 15 is CY 16).

Demonstration Year	**Budget Neutrality Limit Total Computable**
CY 16	$1,849,442,237
CY 17	$1,922,276,957
CY 18	$1,998,319,778

The budget neutrality limit for the 3-year waiver extension period will be equal to the sum of the total computable budget neutrality limits for each of the three demonstration years multiplied by the composite Federal share. The composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the 3-year waiver extension period, as reported through the MBES/CBES and summarized on Schedule C report from the CMS-64 (with consideration of the expenditures reported in accordance with STC 36) by total computable demonstration expenditures for the same period as reported on the same forms.

48. **Impermissible DSH, Taxes, or Donations**. CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make

adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of Section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

49**. Exceeding Budget Neutrality**. If the budget neutrality expenditure limit has been exceeded at the end of this 3-year waiver extension period, the excess Federal funds shall be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

50. **Enforcement of Budget Neutrality**. CMS will enforce budget neutrality over the life of the 3-year waiver extension period rather than on an annual basis. However, if the State exceeds the budget neutrality expenditure limit in any given DY, the State must submit a Corrective Action Plan to CMS for approval.

51. **Future Adjustments to the Budget Neutrality Expenditure Limit**. CMS reserves the right to adjust the budget neutrality expenditure limit in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of Section 1903(w) of the Act. Adjustments to the budget neutrality agreement will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

XI. EVALUATION PLAN AND DESIGN

52. **Submission of Draft Evaluation Design**. The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after the effective date of the demonstration renewal. The draft Evaluation Design must include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must identify the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It shall 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 must be isolated from 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.

a. **Domain of Focus.** The report must, at a minimum, quantify the hypothesis that impact of providing prescription drug coverage curtails SeniorCare enrollees use of non-prescription drug cost services, thus impacting the number of individuals over the age of 65 spending down into full Medicaid eligibility.

b**. Interim Evaluation Reports**. In the event the State requests to extend the demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report according to the schedule outlined in Section XI. The State shall submit the final Interim Evaluation Report within 60 days after receipt of CMS comments.

53. **Final Evaluation Design and Implementation**. CMS must provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.

54. **Final Evaluation Report**. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS' comments.

55. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION

DATE DUE	DELIVERABLE
120 days from date of award letter	Submit Draft Evaluation Design
12 months prior to the expiration date of the demonstration	Submit Demonstration Extension Application
Must be submitted with each renewal request	Submit Interim Evaluation
Quarterly	Deliverable
60 days after the close of the quarter	Quarterly Progress Reports
Paragraph 33	Quarterly Expenditure Reports – CMS 64
Annual	Deliverable
120 days after the close of the demonstration year.	Draft Annual report
Within 60 days after receipt of CMS' comments.	Final Report

ATTACHMENT A

Summary Chart of the Comprehensive Prescription Drug Benefit and Cost Sharing for SeniorCare Individuals

Description of Coverage	Copayment, Deductible and Payment Rate
All prescription drugs covered under Wisconsin's Medicaid program are covered.	A $5 co-payment for generic drugs; $15 co-payment for brand name drugs. The first $500 in prescription drug costs and MTM costs must be paid each year by beneficiaries with income above 160% FPL, and at or below 200% FPL.
MTM services at the enrollee's option.	No copayment.

ATTACHMENT B
QUARTERLY REPORT FORMAT AND CONTENT

Under Section VIII, STC 32, 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. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – Wisconsin – SeniorCare Section 1115 Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Calendar Year 2016: (01/01/2016 – 12/31/2018)
Introduction

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".

Enrollment Count:

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

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	Disenrolled in Current Quarter SeniorCare

Member Month Reporting:

Enter the member months for the quarter.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
SeniorCare				

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, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues:

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the State's actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

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.

SeniorCare Advisory Committee:

Provide at a minimum an update on the activities and involvement of the SeniorCare Advisory Committee. Include any recommendations for changes to benefit design, quality of care health delivery system, emerging medical technologies and procedures and utilization controls for the demonstration.

Status of Benefits and Cost Sharing under the Core Benefit Plan:
Provide confirmation of the actual covered services and co-payments required as described in Attachment A for the demonstration in current quarter.

Demonstration Evaluation:

Discuss progress of evaluation design and planning.

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.

Date Submitted to CMS: