EVALUATION DESIGN FOR THE WISCONSIN SENIORCARE SECTION 1115 PHARMACEUTICAL BENEFIT DEMONSTRATION

I. INFORMATION ABOUT THE DEMONSTRATION

This Evaluation Design is for project number 11-W-00149/5, the Wisconsin SeniorCare Section 1115 Demonstration. The Centers for Medicare and Medicaid Services (CMS) approved this Demonstration for the period January 1, 2013 through December 31, 2015. This is a renewal of the existing demonstration.

A. BRIEF HISTORY AND DESCRIPTION

As health care costs continue to rise, access to prescription medication is increasingly important as a primary health care benefit. Studies estimate that use of prescription drugs is cost-effective compared to the cost of hospitalization or long term care, yet inadequate insurance coverage for prescription drugs leads many low-income individuals to reduce their use of clinically essential medications, potentially increasing health care costs in the aggregate through increased office visits and hospital and nursing home admissions. The Wisconsin SeniorCare program was designed to address this issue by providing assistance to low-income seniors with the costs of prescription drugs.

The SeniorCare Program was approved by the Centers for Medicare and Medicaid Services (CMS) as a section 1115 demonstration for a period of five years beginning in 2002. 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, 2012. On September 26, 2012 the State of Wisconsin submitted a new request, which CMS approved, to extend its SeniorCare demonstration for the period January 1, 2013 through December 31, 2015.

The SeniorCare Program offers a comprehensive prescription drug benefit to Wisconsin residents 65 and older with income at or below 200 percent of the Federal Poverty Level (FPL) who are not otherwise receiving full Medicaid benefits. The program includes several innovative 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. Since 2002, SeniorCare has provided drug coverage to more than 152,000 seniors in Wisconsin. Prior to the implementation of the Medicare Drug Benefit (Part D) in 2006, SeniorCare was the only pharmacy coverage available to low-income seniors in Wisconsin, and since 2006 it has served as creditable alternative coverage and a wrap-around for Part D. Individuals with prescription drug coverage under other health insurance plans may enroll in SeniorCare, which coordinates benefit coverage with all other health insurance coverage, including Medicare Part D.

B. POPULATION GROUPS

The target population for services under this demonstration project is Wisconsin residents 65 years of age or older who are U.S. citizens or have proof of immigration status, have an income at or below 200

percent of the Federal Poverty Level (FPL), are not receiving full Medicaid benefits, and who pay the applicable annual program enrollment fee of $30 per person.[1]

C. Special Terms & Conditions Requirements for the Evaluation

The evaluation requirements for the Demonstration are enumerated in Section XI (Evaluation Plan and Design) of the Special Terms and Conditions, and are as follows:

> **50. 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 (in effect by April 19, 2013). 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.
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> 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.

In addition, the Special Terms and Conditions note that: a) In the event that the state requests to extend the demonstration beyond the period currently approved, the state must submit an interim evaluation report as part of the request for each subsequent renewal; b) the CMS must comment on the draft evaluation design within 60 days of receipt, and the state must then submit a final design within 60 days after receiving CMS comments; c) the state shall report to CMS on the progress of the evaluation in the quarterly and annual progress reports; d) the state must submit to CMS a draft of the final evaluation report within 120 days after the end of the waiver period; the CMS has 60 days to provide comments on the report to DHS, and the state must then submit the final report within 60 days after receipt of CMS comments; and e) the state shall cooperate fully with CMS by providing data to CMS or an independent evaluator hired by CMS, should CMS undertake an independent evaluation of any component of the SeniorCare program.

D. Purposes of the Demonstration

As described in Section II of the Special Terms and Conditions, the primary purposes of the demonstration project are to keep Wisconsin seniors healthy by continuing to provide a necessary primary health care benefit; reduce 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; and

[1] Although Wisconsin offers identical pharmacy benefits to seniors between 200% and 240% of the FPL, benefits provided to these individuals are funded entirely through state money and are not part of the waiver demonstration. This evaluation design focuses solely on the SeniorCare waiver program.

help 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.

The overall demonstration hypothesis is that extending pharmacy benefits to the aged population will result in a reduction in the rate at which the aged population spends down to full Medicaid benefit eligibility levels, thereby controlling overall costs for this population.

II. Evaluation Design

A. Organization Conducting the Evaluation

The evaluation will be conducted by the Policy and Research Section (PRS) of the Office of Policy Initiatives and Budget (OPIB). OPIB is an executive-level office attached to the Office of the Secretary of the Wisconsin Department of Health Services (DHS). OPIB oversees agency-level budget development, policy development and research. The OPIB/PRS provides policy and research services, including evaluation services, for the DHS. The unit does not have any administrative or program responsibilities for the Demonstration.

This evaluation will be managed by Linda McCart, Chief, PRS. The lead analyst for this evaluation will be Susan Cochran, Evaluation Analyst.

B. Plan for Measurement and Analysis

The evaluation will build on information about program enrollment, utilization, and costs as reported in the evaluation of the initial waiver period[2] as well as the more recent evaluation report completed in 2012.[3] The analysis will address trends in these measures during the current waiver period, assess the extent to which SeniorCare waiver members spend down to full Medicaid eligibility, examine the extent to which SeniorCare alleviates members' prescription-related financial hardship, and also assess the Medication Therapy Management (MTM) benefit which became available to SeniorCare members in September 2012.

The evaluation will use a number of methods for collecting information. Quantitative data for the evaluation— including SeniorCare enrollment, claims records and Medicaid data—will be provided by the SeniorCare program and other Wisconsin state programs as needed. It is expected that data related to the MTM benefit will be obtained from these program information systems as well. Currently Wisconsin pharmacies providing MTM services are required to document information about the type and outcomes of MTM services they provide, but they are not yet reporting detailed data about these services to the Department. DHS is still working with pharmacies on ways to track and monitor the MTM services provided to SeniorCare members as well as to Medicaid beneficiaries. Data from the Family Health Survey, an annual household-level survey of Wisconsin families, as well as other sources of population-

[2] See "Evaluation of State Pharmacy Assistance Programs in Illinois and Wisconsin" (August 31, 2007), prepared for the CMS by researchers at Brandeis University under contract number CMS 500-00-0031/T.O. #2.
[3] See "Evaluation of Wisconsin SeniorCare" (August 30, 2012) by Cindy Parks Thomas and Donald S. Shepard.

level data, will be used for comparison purposes as described in this evaluation design. Finally, a survey of recent SeniorCare enrollees will be used to obtain information about the extent to which SeniorCare has alleviated waiver members' difficulties in purchasing prescription drugs.

The following sections discuss descriptive analyses as well as the evaluation hypotheses and outcome measures for the evaluation of this demonstration project.

1. Program Description—Enrollment, Utilization and Costs

Descriptive analyses will provide the following background information on the SeniorCare waiver program:

- Levels of program enrollment and renewals; length of enrollment
- Enrollee demographic characteristics (e.g., age, gender, federal poverty level)
- Program utilization, e.g. number and type of drugs purchased
- The cost to SeniorCare waiver members and to the program of the drugs purchased
- Changes in these measures over time

Data for these measures will be drawn from SeniorCare program enrollment and claims data. Where relevant population-level data are available, the SeniorCare waiver population will be compared to the statewide senior population. Table 1 summarizes the measures, populations and data sources for the descriptive analyses.

Table 1—Measures, Data Sources and Populations for Descriptive Analyses

Measures/Indicators	*Data Sources*	*Population(s)*
Waiver enrollment and renewals over time	SeniorCare enrollment data	Waiver program population
Waiver member characteristics, compared to characteristics of statewide senior population—e.g. income (FPL category), age, gender	SeniorCare enrollment data; population data	Waiver program population and statewide senior population (where data are available)
Prescriptions filled by waiver members —number and type of prescriptions (e.g. brand name vs. generic, therapeutic class)	SeniorCare claims data	Waiver program population
Cost to members and the program of prescriptions filled through SeniorCare	SeniorCare claims data	Waiver program population

2. Evaluation Hypotheses and Measures

a. Effects of SeniorCare on Medicaid receipt among seniors

The SeniorCare program benefits seniors by providing access to medications that help to prevent and control adverse health conditions, thus helping to keep seniors healthy and avoid or delay Medicaid eligibility and spending on non-drug health services such as emergency room visits, hospitalizations, nursing home care, and so on.

The 2007 evaluation of the Illinois and Wisconsin SeniorCare pharmacy benefit programs compared Wisconsin SeniorCare enrollees to a matched comparison group from Ohio, which at the time did not have a pharmacy benefit program. While that study found higher rates of Medicaid entry for Wisconsin SeniorCare enrollees than for the Ohio controls, it found lower rates of nursing home entry and Medicaid expenditures for former SeniorCare members.

The program environment has changed considerably since SeniorCare began in 2002—with the start of Medicare Part D in 2006, all individuals 65 years and older have access to prescription drug coverage. For this reason it is no longer possible to easily identify or construct a comparison group of seniors similar to SeniorCare waiver enrollees who do not have access to a pharmacy benefit. Therefore the evaluation for this waiver demonstration will focus on a population-level analysis comparing several measures across a number of years before and after the implementation of SeniorCare, as discussed below.

> Hypothesis 1: The rate of Medicaid entry among Wisconsin seniors age 65 and older will be lower after SeniorCare implementation than before SeniorCare.

SeniorCare members cannot be receiving full Medicaid benefits at enrollment or renewal; a member whose income and/or assets decrease to allowable Medicaid eligibility levels must submit a Medicaid application and be determined eligible through existing Medicaid procedures to receive full benefits. That individual would then not be able to receive prescription drug coverage through SeniorCare. By assisting low-income seniors with the cost of their prescription medications, it is expected that SeniorCare will enable seniors to avoid or delay spending down their income/assets and reaching eligibility for full Medicaid benefits. Thus, the rate at which low-income seniors become eligible for Medicaid should be lower after the implementation of SeniorCare in 2002 than in the years before 2002.

> Hypothesis 2: The rate of hospital admissions among Wisconsin seniors age 65 and older for selected medical conditions such as diabetes and heart disease will be lower after SeniorCare implementation than before SeniorCare.

By assisting low-income seniors to obtain needed prescription medications at an affordable price, it is expected that SeniorCare will lead to reduced cost-related nonadherence, improved health and reduced use of other, non-drug health services. This evaluation will focus on changes in the rate of hospitalizations among Wisconsin seniors for several chronic medical conditions, including diabetes and heart disease, which are prevalent among seniors, amenable to drug therapy, and thus should be responsive to a program such as SeniorCare which provides prescription drug coverage.

Wisconsin's non-Veteran's Administration hospitals have been required by statute to report information from their billing systems on all inpatients since 1989. These data, which are compiled and edited by the Wisconsin Hospital Association and shared with DHS' Office of Health Informatics, will be used to

compare the rate of hospital admissions among seniors for selected health conditions, before and after SeniorCare implementation in 2002; it is expected that the hospitalization rates for seniors will be lower after SeniorCare implementation than before.

> Hypothesis 3: The rate of Medicaid-funded nursing home admissions among Wisconsin seniors age 65 and older will be lower after SeniorCare implementation than before SeniorCare.

Finally, as previously noted, it is expected that by leading to reduced cost-related nonadherence, better health, and reduced use of non-drug health services, SeniorCare implementation will also result in delayed or avoided nursing home entry by Wisconsin seniors. Thus the rate of nursing home admission for low-income seniors should be lower after SeniorCare implementation in 2002 than in the years before SeniorCare implementation. Due to resource limitations, the evaluation will focus on SeniorCare's effect on Medicaid-funded nursing home care.

Analyses related to Hypotheses 1–3 will utilize information from the Medicaid system, statewide hospital discharge data and statewide population data to compare the rates of Medicaid entry, hospitalizations for selected conditions, and Medicaid-funded nursing home admissions for Wisconsin seniors during several years prior to SeniorCare implementation, to the rates during the years since SeniorCare began. Medicaid eligibility data are maintained in the CARES system, an automated, integrated eligibility determination and case management system that supports the administration of BadgerCare Plus, Medicaid, FoodShare, Wisconsin Works, and other public programs in Wisconsin. CARES is administered by the Wisconsin Department of Children and Families. Hospital discharge data and population data will be obtained from the Office of Health Informatics, Division of Public Health, in DHS.

Table 2 summarizes the measures, data sources and populations addressed under Hypotheses 1–3.

Table 2—Measures, Data Sources and Populations for Evaluation Hypotheses 1–3

Measures/Indicators	*Data Sources*	*Population*
Medicaid enrollments by Wisconsin seniors – rate per 100,000	CARES system; statewide population data	Wisconsin seniors
Hospitalizations among Wisconsin seniors for selected medical conditions – rates per 100,000	Hospital discharge data; statewide population data	Wisconsin seniors
Medicaid-funded nursing home admissions by Wisconsin seniors – rate per 100,000	CARES system; statewide population data	Wisconsin seniors

b. *Effects of SeniorCare on cost-related non-adherence and financial burden*

Previous research has demonstrated widespread problems among low-income and elderly individuals in paying for prescription drugs, often because they lack prescription drug insurance. The 2007 evaluation of the state pharmacy programs in Illinois and Wisconsin conducted by Brandeis University included a survey of participants in those programs which documented that publicly-funded drug programs such as SeniorCare could alleviate this problem. Currently the SeniorCare program does not regularly obtain feedback from program participants, and the survey reported in the 2007 evaluation was conducted in 2003. Including a member survey as part of the current SeniorCare waiver evaluation provides a valuable opportunity to obtain updated feedback from program participants and determine whether the program still serves to alleviate drug-related financial hardship and provide a critical health benefit as intended. Therefore the evaluation will address the following hypothesis:

> Hypothesis 4: Recent enrollees in the SeniorCare waiver program will report lower levels of financial hardship and prescription nonadherence after enrolling in SeniorCare than for a comparable period prior to program enrollment.

A sample of recent SeniorCare waiver enrollees will be surveyed about changes in their access to needed medications and their ability to pay for those drugs. The one-time survey, administered to individuals recently enrolled in the program, will address two time periods, before and after SeniorCare enrollment. Questions to be addressed through the survey may include, but will not be limited to:

- Use of prescription medications before and after SeniorCare enrollment
- Insurance coverage (other than SeniorCare) for medications before and after SeniorCare enrollment
- Experience of cost-related nonadherence (e.g. skipping or delaying prescriptions, reducing dosages) or financial hardship (e.g. having someone else pay or going without other necessities in order to fill prescriptions) before and after SeniorCare enrollment
- Enrollee health status and recent hospital admissions, emergency room visits, or nursing home admissions before and after SeniorCare enrollment
- The adequacy of SeniorCare for meeting enrollees' medication-related needs
- Enrollee demographic characteristics

To test the hypothesis, respondents' answers regarding drug utilization, nonadherence and drug-related financial hardship during a pre-SeniorCare period will be compared to their responses for the post-enrollment period.

Table 3 summarizes the measures, populations and data sources for this hypothesis.

Table 3—Measures, Data Sources and Populations for Evaluation Hypothesis 4

Measures/Indicators	*Data Sources*	*Population*
Self-reported health status	Survey	New SeniorCare enrollees (e.g. enrolled in the past year) with at least one SeniorCare prescription claim and reporting prescription use prior to program enrollment
Self-reported hospital admissions, nursing home admissions or emergency room visits		
Self-reported use of prescription medication		
Self-reported insurance coverage for drugs (e.g. SeniorCare, Part D, commercial)		
Self-reported out-of-pocket spending on drugs and drug-administration devices		
Self-reported financial burden and nonadherence related to prescription medication		
Demographic characteristics		

The Department is mindful of the need to minimize any demands placed on members. However, a short survey for recent enrollees is the most feasible way to collect information about medication use prior to SeniorCare enrollment, since the majority of these individuals will be previously unknown to DHS. DHS will use information from pharmacy claims data to examine and describe drug utilization after SeniorCare enrollment.

c. *Effects of the medication therapy management (MTM) benefit on medication adherence and selected health outcomes*

A Medication Therapy Management (MTM) benefit was implemented for SeniorCare members in September 2012.[4] The benefit includes two levels of service—intervention-based services and Comprehensive Medication Review and Assessment (CMR/A) — and is intended to help members manage their medications and improve adherence,[5] which research has shown helps to improve health outcomes in a cost-effective way. The MTM benefit expands upon the former Pharmaceutical Care services model used during the previous waiver period; most services previously billed under Pharmaceutical Care will now be classified as Intervention-Based Services, which include generic substitutions, transitioning from one-month to three-month supplies, dosage changes, consultations about a lack of adherence, adding or eliminating medications based on clinical concerns, education about medication administration devices, and in-home medication management for those who are not able to pick up their medication. These services generally involve a pharmacist providing a brief consultation to a patient on an unscheduled, as-needed basis.

The Comprehensive Medication Review and Assessment (CMR/A) provides a more intensive opportunity for the pharmacist to provide in-depth analysis of the member's drug regimen and offer education and support. The CMR/A involves a scheduled, 60-minute consultation and up to three 30-minute follow-up consultations per year. This service is intended for members who are considered at high risk of medical complications due to the nature of the drug regimen being followed. While the service is optional and

[4] The MTM benefit is also covered for members in the state's BadgerCare Plus and Medicaid programs.

[5] Adherence refers to the extent to which a patient follows the recommendations made by a healthcare provider with respect to the timing, dosage and frequency of medication-taking.

members may decline the service, members must meet one of the following criteria in order to be offered a CRM/A:

- Member takes four or more prescription medications to treat two or more chronic conditions, one of which must be hypertension, asthma, chronic kidney disease, congestive heart failure, dyslipidemia, Chronic Obstructive Pulmonary Disease (COPD), or depression.
- Member has diabetes.
- Member requires coordination of care due to multiple prescribers.
- Member has been discharged from the hospital or long-term care setting within the past 14 days.
- Member has health literacy issues as determined by the pharmacist.
- Member has been referred for MTM services by the prescriber.

This component of the evaluation will use primarily SeniorCare prescription claims data. Because the electronic reporting system for MTM is still under construction, DHS will, in the interim, build any additional documentation fields needed to support this evaluation component into DHS' ForwardHealth system[6] so that pharmacy providers can enter the requested information directly into the system's portal.

The MTM benefit has been added within the past year, thus the SeniorCare program has little experience so far with the benefit. Therefore, the waiver evaluation will examine descriptive data related to this benefit, including the number of SeniorCare waiver members who receive MTM services, particularly CMR/A, the demographic characteristics (e.g., age, gender, FPL) of waiver program members who receive MTM services, particularly CMR/A and the extent to which the CMR/A is effectively targeted, that is, the extent to which members receiving CMR/A meet the criteria listed earlier.

Although MTM benefits are often expected to lead to lower drug utilization and lower drug-related costs, some recent research suggests that prescription costs do not decrease after implementing MTM.[7] Also, SeniorCare members are 65 years or older; seniors in general use a greater number of prescription medications and have greater prescription costs than younger adults. It is not clear to what extent the MTM benefit can provide savings or reduced utilization for this population, compared to say, the Medicaid program, whose members cover a wide age range. While the evaluation will compare prescription utilization, prescription load, and prescription costs for SeniorCare members who receive MTM services to the same measures for members not receiving MTM, no specific hypothesis is being made regarding the effect of the MTM benefit on these measures.

Regardless of whether MTM increases or decreases drug utilization and costs, the pharmacist analysis of the safety and appropriateness of members' drug regiments, combined with the individual education and support provided to SeniorCare members who receive CMR/A is expected to lead to improved adherence to their medications, and ultimately to improved health outcomes. MTM allows patients to take an active role in medication and healthcare self-management; it looks at all of the medications an individual is taking rather than looking at each prescription independently; and, it creates a partnership between pharmacist, patient and physician to better coordinate the delivery of medications. All of these features should serve to assist the patient in achieving better medication adherence and better outcomes from treatment. Although MTM is expected ultimately to lead to improved health, the inclusion of health-

[6] In 2009, DHS transitioned to a new Medicaid Management Information System (MMIS) called ForwardHealth interChange, which supports the day-to-day management of a number of crucial programs in DHS.

[7] Shah, Nilay, PhD. "Medication Therapy Management Services: Does the Evidence Support Policy?" University of Wisconsin-Madison School of Medicine and Public Health Population Health Sciences Seminar Series, March 18, 2013. Lecture. Available at http://videos.med.wisc.edu/presenters/4986. (A study of a MTM pilot program at Mayo Clinic showed that while drug costs did not decrease for members who received MTM services, there was a decrease in medical costs.)

related outcome data in the information that Wisconsin pharmacies report to DHS is still under development. For that reason, this evaluation does not plan to include a hypothesis related to improved health outcomes. The following hypothesis related to the MTM benefit will be addressed:

> Hypothesis 5: SeniorCare waiver program members who receive CMR/A services will have improved medication adherence, compared to members who do not receive CMR/A.

There are various ways of defining and measuring adherence to prescribed medication therapy; this evaluation will employ a measure that uses administrative data such as pharmacy claims for that purpose.

Table 4 summarizes the measures, populations and data sources to be used for Hypothesis 5 and the descriptive analyses.

Table 4—Measures, Data Sources and Populations for Evaluation Hypothesis 5

Measures/Indicators	*Data Sources*	*Population*
Member demographic characteristics (age, gender, FPL, etc.)	SeniorCare program claims data	Waiver program members who have a prescription claim
Prescription history -- Number, type and cost of drugs for which claims are filed, dates of refills, etc.	SeniorCare program claims data	Waiver program members who have a prescription claim
MTM service data –Number and type of MTM services received, including dosage changes, if recommended, and dates of service	SeniorCare program claims data	Waiver program members who have a prescription claim

Prescription histories (e.g., number, type and costs of drugs for which claims are filed, dates of refills, etc.), pharmacist service data (i.e. CMR/A or intervention-based services) and demographic data, as identified in Table 4, will be retrieved for each waiver member who has at least one prescription claim during the designated time period. These members will be categorized as receiving either CMR/A or intervention-based services based on the information provided by pharmacists. Comparable groups of members receiving or not receiving CMR/A will be created, and a measure of medication adherence will be calculated for each person included in the analysis.

Table 5, below, provides an overview of the design for the evaluation of the MTM component.

Table 5—Overview of Design for the MTM Component Evaluation

	Time Period	
Member Group	Before Receipt of MTM (or Before a Reference Date)	After Receipt of MTM (or After a Reference Date)
1. Received CMR/A 2. Received Intervention-Based Services	Measures compared: • Utilization/prescription load • Prescription costs • Adherence	Measures compared: • Utilization/prescription load • Prescription costs • Adherence

Prescription utilization, costs, and adherence (Hypothesis 5) will be compared for two time periods – before receiving CMR/A services (or before a reference date, for members who don't get CMR/A) and a comparable period after receiving CMR/A (or after a reference date, for members who don't get CMR/A).

These before-and-after comparisons will be made for members who receive CMR/A as well as for those who don't receive CMR/A (i.e., who receive intervention-based services).

III. Evaluation Timeline and Deliverables

As discussed in this evaluation design, the evaluation will describe the impact of Wisconsin's SeniorCare pharmacy care benefit from 2013 through 2015. Data collection and analysis will occur during 2013–2015, and report-writing will occur in early 2016. Reports to CMS on the progress of the evaluation will be included in the quarterly reports submitted to CMS by the program managers in DHCAA. As required in the Special Terms and Conditions, the State evaluator will send a draft evaluation report to CMS no later than 120 days following the expiration of the Demonstration (no later than April 30, 2016), and the final report will be submitted within 60 days after receipt of CMS comments on the draft, or no later than August 28, 2016. The timeline for significant deliverables is shown below.

January 1, 2013	Wisconsin SeniorCare renewal begins.
April 19, 2013	State Submits Draft Evaluation Plan to CMS (within 120 days)
June 18, 2013 or sooner	State receives CMS Comments on Draft Evaluation Plan
August 17, 2013 or sooner	State Submits Revised Evaluation Plan based on CMS Comments
Quarterly Progress Reports	State submits information about progress in implementing the evaluation design.
Annual Reports on January 30	State submits information about progress in implementing the evaluation design as part of annual reports.
December 31, 2015	SeniorCare Demonstration Expires
April 30, 2016	State submits Draft Evaluation Report to CMS (within 120 days after expiration of the Demonstration)
June 29, 2016 or sooner	CMS Comments on Draft Evaluation Report (within 60 days of receipt of Draft Evaluation Report)
August 28, 2016 or sooner	State Submits Final Evaluation Report based on CMS Comments (within 60 days)

For information about this evaluation design or the evaluation, contact:

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