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**

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"). The parties to this agreement are the Wisconsin Department of Health Services ("State") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective January 1, 2010, unless otherwise specified. This Demonstration is approved through December 31, 2012.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility Determination, Enrollment and Disenrollment; Benefits, Cost Sharing and Payment Rate; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of Deliverables for the Demonstration Period.

II. PROGRAM DESCRIPTION

The SeniorCare program offers 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 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 covered drugs when submitted by the pharmacy as a prescription drug claim.

The key program goals include:

- Keeping Wisconsin seniors healthy by continuing to provide a necessary primary health care benefit;

- 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.

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.

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.

    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 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.

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) An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;

   b) 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;

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

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

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

   As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

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

   b) STCs: The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following

areas, they need not be documented a second time. Consistent with Federal law, CMS reserves the right to deny approval for a requested extension 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.

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

d) Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in these STCs) demonstrating that the State has maintained and will maintain budget neutrality for the requested period of extension. 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.

e) Interim Evaluation Report: The State must provide an evaluation report reflecting the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. The State must provide advance notice in writing to CMS, Demonstration enrollees, and all other affected parties at least 30 days prior to suspending or terminating services to Demonstration enrollees. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10, a phase-out plan shall not be shorter than 6 months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out.** Notwithstanding the situation described in paragraph 18, if the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 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 the CMS 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 paragraph 6, are proposed by the State.

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

17. **Payor of Last Resort.** The Medicaid program is the payor of last resort; 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.

18. **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 10 business days of reinstating benefits.

19. **Promoting Medicaid Eligibility.** The State must inform all Demonstration applicants of their option to apply for full Medicaid benefits in lieu of enrolling in the Demonstration.

IV. ELIGIBILITY DETERMINATION, ENROLLMENT AND DISENROLLMENT

20. **Eligibility.** Aged individuals eligible for this demonstration are defined as individuals age 65 or older with income that does not exceed 200 percent of the FPL**.** They are

individuals who do not otherwise receive Medicaid benefits other than as a low-income Medicare beneficiary.

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

a) Must be at least 65 years of age;

b) Must not receive full Medicaid benefits under the State plan, other than as a low-income Medicare beneficiary (QMB, SLMB, or QI);

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 (SSN) (or proof of application for an SSN) in accordance with section 1903(x) of the 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 by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) – Pub. 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	N/A
Gross Wages	N/A
Interest, Dividends and Capital Gains	N/A
Net Self-Employment Income	Business costs, business losses, depreciation of business assets and other deductions allowed by the Internal Revenue Service
Retirement Income	N/A
Other Income	N/A

21. **Retroactive Eligibility.** Enrollees who qualify as members of the Aged Population will not be provided retroactive coverage. The beginning 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 as members of the Aged Population 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 for the Aged Population are required to complete an application. The State must verify the full legal name, date of birth, SSN, 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 within 6-8 weeks if the applicant is not eligible to enroll in the Demonstration.

24. **Redetermination of Eligibility**. Redetermination of eligibility for the Aged Population 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, COST SHARING, AND PAYMENT RATE

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 legend drugs as currently provided under the Wisconsin Medicaid State plan and at the Medicaid payment rate.

27. **Cost Sharing.** Upon implementation, the Aged Population 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 within 6-8 weeks 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.

    c) **Deductible**: Enrollees with income above 160 percent, and at or below 200 percent of the FPL, are required to pay the initial $500 of prescription drug costs each year.

VI. 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 serve persons eligible as members of the Aged Population.

VII. GENERAL REPORTING REQUIREMENTS

29. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in Section VII.

30. **Reporting Requirements Related to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section VIII.

31. **Conference 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 update on covered services and cost sharing. The State needs to confirm actual covered services and co-payments required as described in Attachment A for the demonstration in each quarterly progress report.

33. **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 120 days after the close of the Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

VIII. GENERAL FINANCIAL REQUIREMENTS

34. **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 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 IX.

35. **Reporting Expenditures Subject to the Budget Neutrality Agreement.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

a) 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 Form CMS-64 reporting instructions outlined in section 2500 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).

b) Each quarter, the State must submit separate Forms CMS-64.9 Waiver and/or 64.9P Waiver reporting Aged Population expenditures, using waiver name "SeniorCare." Each quarter, the State must also submit separate Forms CMS-64.9 Waiver and/or 64.9P Waiver reporting total expenditures for the Medicaid Aged Population, using waiver name "Aged Medicaid."

c) For monitoring purposes, cost settlements associated with 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) 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 Demonstration Year (DY).

e) **Manufacturer Rebates.** The State has the capacity to use its Medicaid Management Information 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 Form 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.

36. **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."

37. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 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 2 years after the conclusion or termination of the Demonstration. During the latter 2-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.

38. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall 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 and Federal share) subject to the budget neutrality agreement must be separately reported by quarter for each Federal fiscal year (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.

39. **Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, 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.

40. **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 timeframes 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.

    c) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State 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.

41. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.

IX. MONITORING BUDGET NEUTRALITY

42. **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.

43. **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.

44. **Budget Neutrality Expenditure Limit.** The following table gives the total computable budget neutrality limits for each DY. DY 09 is defined as calendar year 2010, DY 10 is defined as calendar year 2011, and DY 11 is defined as calendar year 2012.

Demonstration Year	Budget Neutrality Limit – Total Computable
DY 09	$1,882,753,501
DY 10	$1,889,341,177
DY 11	$1,936,291,306

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 3 DYs 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 and Medicaid Aged Population expenditures during the 3-year waiver extension period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of the expenditures reported in accordance with paragraph 32) by total computable Demonstration and Medicaid Aged Population expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternatively agreed upon method.

45. **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.

46. **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.

47. **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.

X. EVALUATION OF THE DEMONSTRATION

48. **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. At a minimum, the draft 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 discuss 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.

49. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 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.

50. **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.

51. **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.

52. **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.

XI. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date	Deliverable
Per paragraph 48	Submit Draft Evaluation Design
Per paragraph 8	Submit Demonstration Extension Application
Per paragraph 49	Submit Interim Evaluation Report
Quarterly	**Deliverable**
Per paragraph 32	Quarterly Progress Reports
Per paragraph 34	Quarterly Expenditure Reports
Annual	**Deliverable**
Per paragraph 33	Draft Annual Report

ATTACHMENT A
Summary Chart of the Comprehensive Prescription Drug Benefit and Cost Sharing for Aged Individuals

Comprehensive Prescription Drug Benefit for Aged Individuals	
Description of Coverage	**Co-Payment, 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 must be paid each year by beneficiaries with income above 160 percent of the FPL, and at or below 200 percent of the FPL. The Medicaid payment rate to pharmacies.

ATTACHMENT B
QUARTERLY REPORT FORMAT AND CONTENT

Under Section VII, paragraph 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 2010: (01/01/2010 – 12/31/2010)

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 Form 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, facsimile, and address that CMS may contact should any questions arise.

Date Submitted to CMS: