DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

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Casey Himebauch
Deputy Medicaid Director
Administrator, Division of Medicaid Services
Wisconsin Department of Health Services
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Madison, WI 53703

Dear Mr. Himebauch:

Under Section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services (HHS) may approve any experimental, pilot or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain Act programs including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115 of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115 of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Wisconsin's request for extension and amendment of its Medicaid demonstration project entitled, "BadgerCare Reform" (Project No. 11-W-00293/5), in accordance with section 1115(a) of the Act.

This amendment and extension approval (the "approval"), among other things, extends the operation of Wisconsin's Medicaid demonstration past its current expiration of December 31, 2018. The approval is effective October 31, 2018 through December 31, 2023, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. After December 31, 2018, the state will no longer have the authority to charge premiums to the Transitional Medical Assistance adults through the demonstration. CMS's approval is subject to the limitations specified in the attached expenditure authorities, waivers, and special terms and conditions (STC). The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 if, in his judgment, the project is likely to assist in promoting the objectives of title XIX. The purposes of Medicaid include the appropriation of funds to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Act § 1901. This appropriations provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries and that it is appropriate for the state to structure its demonstration program in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care, and focus on evidence-based interventions that drive better health outcomes and quality of life improvements, and may increase beneficiaries' financial independence. Such policies may include those designed to address certain health determinants and those that encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." Act § 1115(d)(1). But in the long term they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better "enabling each [s]tate, as far as practicable under the conditions in such [s]tate" to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need. For instance, measures designed to improve health and wellness may reduce the volume of services consumed, as healthier, more engaged beneficiaries tend to consume fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage may decrease the number of individuals who need financial assistance from the state. Such measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.[1] By

[1] States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom

the same token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

Our demonstration authority under section 1115 allows us to offer states more flexibility to experiment with different ways of improving health outcomes and strengthening the financial independence of beneficiaries. Demonstration projects that seek to improve beneficiary health and financial independence improve the well-being of Medicaid beneficiaries and at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide more medical services to more Medicaid beneficiaries. Accordingly, such demonstration projects advance the objectives of the Medicaid program.

Background on Medicaid Coverage in Wisconsin

Wisconsin has not adopted the Affordable Care Act (ACA) adult expansion population, but it implemented its BadgerCare Reform section 1115 demonstration on January 1, 2014, to expand coverage to a childless adult demonstration-only population using expenditure authority under section 1115(a)(2) of the Act. BadgerCare Reform primarily provides authority for the state to provide a robust benefit package which includes most state plan benefits to non-pregnant, non-disabled, non-elderly childless adults with incomes of up to and including 100 percent of the federal poverty level (FPL). As of June 30, 2018, more than 178,000 individuals receive coverage under this demonstration authority.

In addition to providing this coverage for the BadgerCare Reform population, Wisconsin's state plan provides coverage for other optional populations such as parents and caretaker relatives with income up to 100 percent of the FPL and pregnant women above 138 percent of the FPL. In addition, the Wisconsin state plan currently covers an array of optional services including prescription drugs, dental services, and occupational therapy.

Extent and Scope of Demonstration

The BadgerCare Reform demonstration primarily provides authority for the state to provide a robust benefit package to non-pregnant, non-disabled, non-elderly childless adults with incomes of up to and including 100 percent of the FPL. This demonstration approval continues coverage for this population for five years. It also allows Wisconsin to require these childless adult beneficiaries, ages 19 through 49, with certain exceptions, to participate in and timely document and report 80 hours per month of community engagement activities. Qualifying activities include employment, job training, community service, or enrollment in an allowable work

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their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to offer Medicaid coverage to populations not specifically included in the statute by using expenditure authority under section 1115(a)(2) of the Act. This authority has been used to allow a number of states, including Wisconsin, to expand Medicaid eligibility beyond the allowable statutory categories. The same authority at section 1115(a)(2) of the Act can be used for states to cover benefits beyond what is authorized by statute as well. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

program. The community engagement incentive will not apply to beneficiaries ages 50 and older so as to ensure alignment and consistency with the state's Supplemental Nutrition Assistance Program (SNAP) requirements, which is intended to minimize confusion for beneficiaries who may receive both SNAP and Medicaid. To help ensure the success of these beneficiaries, CMS is allowing states to align the community engagement requirements in Medicaid with the work requirements in other federal programs.

Beneficiaries subject to the community engagement requirement who have been enrolled in the demonstration, but who have not met the community engagement requirements for 48 aggregate months (without qualifying for an exemption) will be disenrolled from the demonstration and unable to re-enroll as a childless adult for six months. However, if that individual reapplies for Medicaid during that six-month period of non-eligibility and is found eligible under another Medicaid eligibility group (MEG), the individual will be enrolled into Medicaid.

CMS also is providing authority to allow the state to implement additional features, including:

- Implementing premiums on childless adults with incomes from 50 percent up to and including 100 percent of the FPL as a condition of eligibility;
- Allowing termination and a period of non-eligibility as a childless adult for up to six months for childless adults who do not pay the required premium, with on-ramps to reactivate coverage during the non-eligibility period;
- Allowing the state to vary premiums for childless adults based on the responses on a health risk assessment (HRA) and avoiding health risk behaviors;
- Charging childless adults an $8 co-payment for non-emergency use of the emergency department (ED), consistent with 42 CFR § 447.54(b); and
- Requiring full completion of an HRA as a condition of eligibility, as a part of the application for childless adults, in order to identify healthy behaviors.

The eligibility conditions discussed above will apply only to the non-mandatory population receiving coverage through BadgerCare Reform. In addition, this demonstration will also include a substance use disorder (SUD) program (described in STCs 26–32) available to all Wisconsin Medicaid beneficiaries. The purpose of the program is to ensure that a broad continuum of care is available to Wisconsin Medicaid beneficiaries with a substance use disorder, which will help improve the quality, care, and health outcomes for those Medicaid beneficiaries. The SUD program contributes to a comprehensive statewide strategy to combat prescription drug abuse and opioid use disorders and expands the SUD benefits package to cover short-term residential services in facilities that qualify as institutions for mental diseases (IMDs) for all Medicaid enrollees.

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

For reasons discussed below, the Secretary has determined that BadgerCare Reform is likely to assist in promoting the objectives of the Medicaid program.

The demonstration provides coverage beyond what the state plan provides.

CMS has determined that BadgerCare Reform is likely to promote the objective of furnishing medical assistance because it gives the state the expenditure authority to continue, past the demonstration's expiration date at the end of 2018, to offer Medicaid coverage under section 1115(a)(2) of the Act to the population of non-pregnant, non-disabled, childless adults with incomes up to and including 100 percent of the FPL. While new features to the demonstration, like the addition of community engagement, requirement to complete the HRA, and premium requirements may impact overall coverage levels if the individuals subject to these demonstration provisions choose not to comply with them, the amended demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. Should this demonstration not be approved, the amended BadgerCare demonstration would not continue past its current expiration of December 31, 2018, and the individuals currently covered by that demonstration would likely lack access to any source of affordable health coverage. In addition, Wisconsin expects that the demonstration will result in healthier, more financially independent beneficiaries and as a result, the demonstration will "improve health outcomes, reduce unnecessary services, and improve the cost-effectiveness of Medicaid services." Such goals are in furtherance of Wisconsin's broader stated objective of creating a program that is "sustainable" so Wisconsin's health care safety net is available to those who need it most. Implementing the new features discussed further below facilitate Wisconsin's ability to extend coverage to the demonstration population under BadgerCare from 2019 through 2023, thereby furthering Medicaid's purpose of enabling states to furnish medical assistance.

This approval will also allow the state to offer the SUD program. The SUD program will improve access to high-quality addiction services and is critical to addressing Wisconsin's substance use epidemic. Under this initiative, all Medicaid beneficiaries will continue to have access to all current mental health and SUD benefits. In addition, all beneficiaries ages 21 through 64 will have access to additional covered services, authorized under section 1115(a)(2) of the Act, including SUD treatment services provided to individuals with SUD who are short-term residents in residential treatment facilities that meet the definition of an Institution for Mental Diseases (IMD). These services would otherwise be excluded from federal reimbursement.

The demonstration promotes the objectives of helping beneficiaries attain or retain independence.

BadgerCare Reform, as amended, is likely to promote the objective of helping beneficiaries attain or retain independence, which would lead to higher quality care at a sustainable cost. For example, the community engagement provisions generally require adults in this demonstration-

only population to work, look for work, or engage in activities that enhance their employability such as job training, or community service. The demonstration will thus help the state and CMS evaluate whether the community engagement requirement helps adults in this population transition from Medicaid to financial independence and commercial insurance, including the federally subsidized coverage that is available through the Exchanges. To help prepare individuals in this group for the commercial insurance market, other provisions of BadgerCare Reform give them experience with premiums, including the opportunity to pay a reduced premium for not engaging in certain behaviors that increase health risks.

To the extent that the community engagement requirements help individuals achieve financial independence and transition into commercial coverage, the demonstration may reduce dependency on public assistance while still promoting Medicaid's purpose of helping enable states to furnish medical assistance. By helping people to transition to commercial coverage, community engagement will help Wisconsin stretch its limited Medicaid resources and will thus promote Medicaid's purpose of helping enable states to furnish medical assistance. As Wisconsin noted in its amendment application and as explained further below, such increases in beneficiary independence also help to ensure that Wisconsin's Medicaid program is sustainable so its health care safety net is available for those Wisconsin residents who need it most. The state of Wisconsin currently finances almost 60 percent of the cost of care for this demonstration group.

BadgerCare Reform, as amended, contains provisions that could result in some beneficiaries losing coverage, including having their eligibility terminated with a non-eligibility period for up to six months for failure to comply with the community engagement or premium requirements, or being denied coverage for failure to complete a HRA. While CMS and the state are testing the effectiveness of an incentive structure that attaches penalties to failure to take certain measures, the program is designed to make compliance with requirements achievable. As an initial matter, the community engagement requirement does not result in a loss of eligibility until a person has failed to comply for 48 months, and individuals who are determined to be unfit for employment (which can include mentally or physically unfit), experiencing chronic homelessness, or participating in SUD treatment, do not accrue months of noncompliance. Moreover, Wisconsin has taken steps to include adequate beneficiary protections to ensure that the demonstration program requirements apply only to those beneficiaries who can reasonably be expected to meet them and to notify beneficiaries of their responsibilities under the demonstration. Any individual whose coverage is terminated for failure to meet the requirements, or who experiences any other adverse action, will have the right to appeal the state's decision as with other types of coverage terminations, consistent with all existing appeal and fair hearing protections. Furthermore, the incentives to meet the requirements, if effective, may result in individuals becoming ineligible because they have attained financial independence – a positive result for the individual.

The demonstration tests reforms designed to strengthen beneficiary engagement, incentivize responsible decision-making, and promote better health outcomes.

The demonstration will evaluate the effectiveness of policies that are designed to improve the health of Medicaid beneficiaries and encourage them to make responsible decisions about their health and accessing health care. BadgerCare Reform's community engagement requirement is designed to encourage beneficiaries to obtain employment and/or undertake other community engagement activities that may lead to improved health and wellness, which ultimately helps to keep health care costs at sustainable levels.

Additionally, the demonstration is designed to improve health by increasing beneficiary awareness about healthy behaviors and encouraging demonstration participants to engage in such behaviors by: (1) requiring completion of an HRA; and (2) rewarding those who avoid or manage certain health risk behaviors with lower premiums. More specifically, BadgerCare Reform requires that beneficiaries complete an HRA as a condition of eligibility. As discussed below, this policy is expected to improve beneficiaries' engagement in their health care choices by increasing their awareness of behaviors that might be detrimental to their health, while also encouraging them to make healthier choices. The completion of the assessment will also help the beneficiary's managed care plan identify health risks and improve the plan's ability to provide effective care management and address beneficiary health care needs. The state will reduce premiums for individuals who do not engage in certain behaviors that increase health risks or attest to actively managing certain unhealthy behaviors. Premium reductions will be based on beneficiary behaviors, not on a beneficiary's health status or pre-existing condition. Furthermore, beneficiaries who engage in behaviors that increase certain health risks but do so as a result of a health condition will also still be eligible for reduced premiums. Consistent with privacy laws, the state will share this information with beneficiaries' managed care plans which may offer additional supports.

Wisconsin will also evaluate whether the use of the HRA and the opportunity for beneficiaries who avoid or manage certain health risk behaviors to pay a reduced premium will strengthen beneficiary engagement in their personal health care plan and provide an incentive structure to support responsible consumer decision-making about accessing care and services. A prior evaluation of one demonstration project with beneficiary engagement components has shown some promise that these strategies can have a positive impact on beneficiary behavior.[2] Overall the research findings on the effects of healthy behavior incentives in Medicaid have shown some promising results but require further study. Wisconsin will include evaluation of the outcomes associated with these requirements in its evaluation design to further enrich the evidence regarding beneficiary engagement strategies.

Taken together, the evidence tying certain beneficiary behaviors to improved health outcomes supports a determination that all of the above-mentioned features of the demonstration promote the objectives of the Medicaid program. Promoting beneficiary health and independence advances the objectives of the Medicaid program; indeed, in 2012, HHS specifically encouraged

[2] The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf

states to develop demonstration projects "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes."[3] And to the extent that greater beneficiary health and independence make these individuals less costly for Wisconsin to care for, this outcome further advances the objectives of the Medicaid program by helping Wisconsin stretch its limited Medicaid resources and ensure the long-term fiscal sustainability of the program.

The demonstration also promotes responsible decision making and improved health by encouraging appropriate use of health care services and behavior that is mindful of health care value. This demonstration will allow the state, consistent with 42 CFR § 447.54(b), to charge beneficiaries an $8 copayment for utilization of the ED for non-emergency services. Wisconsin believes this will help beneficiaries learn about the importance of choosing appropriate care in the appropriate setting—which is generally not the ED—by educating beneficiaries about the direct cost of health care services and the importance of seeking preventive services and similar care in the most appropriate setting. Receiving preventive and similar care in non-emergency settings can improve the health of beneficiaries, because they can build and maintain relationships with their regular treating providers. Over time, this may lead to the prevention of chronic disease, as prevention and health promotion are difficult to achieve and sustain through episodic ED visits. Additionally, this policy will improve the ability of beneficiaries who truly need emergency care to access it, by preserving ED resources for those who are truly in need of timely emergency care. Moreover, we expect that this copayment policy will decrease the use of inefficient and costly care in less appropriate settings, thereby making beneficiaries less costly to care for and Wisconsin's Medicaid program more sustainable—both in furtherance of the Medicaid program's objectives.

The demonstration will provide beneficiaries with coverage that more closely aligns with commercial coverage and promotes independence.

Coverage for the adult demonstration-only group under BadgerCare Reform is designed to work more like insurance products sold on the commercial market. Many individuals in this group are estimated to move between Medicaid eligibility and Marketplace coverage. This approval seeks to provide beneficiaries with the tools to successfully utilize commercial market health insurance, thereby removing potential obstacles to a successful transition from Medicaid to commercial coverage, removing incentives for remaining on Medicaid, and enhancing the sustainability of Wisconsin's medical assistance program.

For instance, BadgerCare Reform, as amended, includes premium payment requirements (with a non-eligibility period for certain beneficiaries for non-payment, similar to provisions CMS has approved in other states[4]) and varies premium amounts based on beneficiary health behaviors, all of which beneficiaries are likely to encounter should they transition off of Medicaid and into commercial coverage.

[3] CMS, Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid at 15 (Dec. 10, 2012).
[4] Section 1115 demonstration, Healthy Indiana Plan, available at: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=25478

As described in the STCs, if monitoring or evaluation data indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, 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 beneficiaries' interest or promote the objectives of Medicaid.

Consideration of public comments

To increase the transparency of demonstration projects, the ACA directed the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 project that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. Act § 1115(d)(1), (2). The first comment period occurs at the state level before submission of the section 1115 application, *id.* §1115(d)(2)(A), and the second occurs at the federal level after the application is received by the Secretary, *id*. §1115(d)(2)(C).

The ACA specified that comment periods should be "sufficient to ensure a meaningful level of public input," id. § 1115(d)(2)(A) & (C), but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments. 42 C.F.R. § 431.416(d)(2); *see also* Medicaid Program; Review and Approval Process for Section 1115 Demonstrations, 75 Fed. Reg. 56947, 56953 (Sept. 17, 2010) (proposed rule).

CMS received 652 comments during the federal comment periods on the amendment and extension requests to BadgerCare Reform. Although CMS is not legally required to provide written responses to comments, CMS is addressing some of the central issues raised by the comments and summarizing CMS' analysis of those issues for the benefit of stakeholders.

General comments

The vast majority of the comments CMS received were from self-identified Wisconsin citizens who opposed either the demonstration as a whole or certain features of it. Many of those comments expressed general concerns that the demonstration will result in many poor citizens losing Medicaid. CMS shares the commenters' concern that everyone who needs Medicaid and meets programmatic eligibility criteria has access to it. As previously stated, however, CMS believes the features of this demonstration are worth testing to determine whether there is a more effective way to furnish medical assistance to the extent practicable under the conditions in Wisconsin. That is why CMS has carefully reviewed the demonstration as a whole to ensure it is likely to further Medicaid's objectives.

Specifically, this demonstration does not simply cut off benefits for any beneficiaries. Instead, it is designed to extend coverage. Were CMS to decline to approve this application, the current demonstration would automatically terminate on December 31, 2018, leaving able-bodied applicants who meet the criteria without coverage. This extension permits the state to continue

to provide coverage to this broader group. Also, the demonstration is designed to improve health outcomes and reduce dependency on public assistance by incentivizing healthy behaviors and giving beneficiaries the choice to either engage in those behaviors or to no longer participate in Medicaid. CMS has worked together with Wisconsin to include guardrails that will protect beneficiaries. These guardrails, which are contained in a series of assurances in the STCs, include requirements that the state: screen beneficiaries and determine eligibility for other bases of Medicaid eligibility and review for eligibility for insurance affordability programs prior to suspension; provide full appeal rights prior to disenrollment; develop and implement an outreach strategy to inform beneficiaries how to report compliance with the community engagement requirements; provide beneficiaries with periodic updates on how many months have counted towards the 48 months of noncompliance necessary to lose eligibility; and maintain a system that provides reasonable modifications related to meeting the community engagement requirements to beneficiaries with disabilities, among other assurances. The STCs include a provision granting CMS the authority to discontinue the demonstration if the agency determines that it is not furthering Medicaid's objectives. Moreover, CMS will regularly monitor BadgerCare Reform and will work with the state to resolve any issues that arise as Wisconsin works to implement the demonstration.

Some comments argued that a demonstration cannot advance the Medicaid program's objectives if the project is expected to reduce Medicaid enrollment or Medicaid spending. We recognize that some individuals may choose not to comply with the conditions of eligibility imposed by the demonstration, and therefore may lose coverage, as may occur when individuals fail to comply with other requirements like participating in the redetermination process. But the goal of the demonstration is to incentivize compliance, not reduce coverage. Indeed, CMS has incorporated safeguards into the STCs intended to minimize coverage loss due to noncompliance, and CMS is committed to partnering with Wisconsin to ensure that the demonstration advances the objectives of Medicaid. Furthermore, we anticipate that beneficiaries will be connected with employment, and may disenroll from Medicaid if they obtain employer-sponsored or other commercial coverage and no longer qualify for the program. Finally, we note that in some cases, reductions in Medicaid costs can further the Medicaid program's objectives, such as when the reductions stem from reduced need for the safety net or reduced costs associated with healthier, more independent beneficiaries. These outcomes promote the best interests of the beneficiaries whose health and independence are improved, while also helping to support the long-term fiscal sustainability of Medicaid programs.

In a similar vein, some comments suggested that it is impermissible for a demonstration to rely on disenrollment and a non-eligibility period as incentives for compliance with the project's requirements. As noted above, section 1115 explicitly contemplates that demonstrations may "result in an impact on eligibility" and the amended demonstration as a whole is expected to provide greater access to coverage for low-income individuals than would be available absent the demonstration. Other comments predicted that BadgerCare Reform or its component parts will fail to achieve their objectives. For instance, some comments argued that beneficiaries subject to the community engagement requirement will be unable to comply. To some extent, these comments reflect a misunderstanding of the nature of the community engagement requirement, which the comments described as a work requirement. In fact, the community engagement requirement is designed to help beneficiaries achieve success, and CMS and the state have made

every effort to devise a requirement that beneficiaries should be able to meet. For example, the community engagement requirement may be satisfied through an array of activities including education, job training, job search activities, and community service.

More generally, these comments reflect a misunderstanding of the nature of a demonstration project. It is not necessary for a state to show in advance that a proposed demonstration will in fact achieve particular outcomes; the purpose of a demonstration is to test hypotheses and develop data that may inform future decision-making. As HHS previously explained, demonstrations can "influence policy making at the State and Federal level, by introducing new approaches that can be a model for other States and lead to programmatic changes nationwide." 75 Fed. Reg. at 56947. For example, the Temporary Assistance for Needy Families (TANF) work requirements that Congress enacted in 1996 were informed by prior demonstration projects. *See*, *e.g.*, *Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973) (upholding a section 1115 demonstration project that imposed employment requirements as conditions of AFDC eligibility). Regardless of the degree to which Wisconsin's demonstration project succeeds in achieving the desired results, the information it yields will provide policymakers real-world data on the efficacy of such policies. That in itself promotes the objectives of the Medicaid statute.

Comments addressing coverage losses

Some comments argued that the demonstration will cause individuals to lose Medicaid coverage and, for that reason, the project cannot be consistent with the objectives of the Medicaid program. First, it is important to acknowledge that otherwise potentially eligible Medicaid beneficiaries lose coverage today for many reasons where they have failed to comply with program requirements, like completing their annual redetermination. Second, we note that the demonstration provides coverage to individuals that are not eligible under the state plan. Any potential loss of coverage that may result from a demonstration must be considered in the context of a state's substantial discretion to eliminate optional benefits, cease demonstration projects, or otherwise eliminate coverage for existing (but optional or demonstration) populations. Experiments designed to help able-bodied adults transition out of Medicaid are particularly appropriate in light of the fact that beneficiaries who receive coverage under an expansion under section 1115(a)(2) of the Act that is less generous than state plan coverage for categorically eligible beneficiaries are still better off than receiving no coverage at all. Finally, conditioning eligibility for Medicaid coverage on compliance with certain measures is an important element of the state's efforts, through experimentation, to improve beneficiaries' health and independence and enhance programmatic sustainability. To create an effective incentive for beneficiaries to take measures that promote health and independence, it may be necessary for states to attach penalties to failure to take those measures, including with conditions designed to promote health and financial independence. This may mean that beneficiaries who fail to comply will lose Medicaid coverage, at least temporarily. However, the demonstration is not designed to encourage this result; rather, the demonstration is intended to incorporate achievable conditions of continued coverage. And any loss of coverage as the result of noncompliance must be weighed against the benefits Wisconsin hopes to achieve through the demonstration project, including both the improved health and independence of the beneficiaries who comply and the state's enhanced ability to stretch its Medicaid resources and maintain the fiscal sustainability of the program.

Commenters expressed concern over the state disenrolling individuals from the demonstration who are non-compliant for 48 months of enrollment as a childless adult and then subjecting those individuals to a six month period of non-eligibility before they are able to enroll as a childless adult again. The state addressed these concerns by pointing out that for every month that a beneficiary engages in a qualifying community engagement activity or meets an exemption, beneficiaries are able to remain in the demonstration. Coverage loss would occur only if the individual chooses not to comply with the program's requirements for an aggregate period of 48 months; therefore, we anticipate that very few beneficiaries will be subject to the period of non-eligibility. In those cases, we note that individuals always are able to re-apply for Medicaid and have eligibility determined for other Medicaid groups for which they can be immediately enrolled. Additionally, we believe this feature of the demonstration provides an important incentive to ensure that beneficiaries are engaged with their communities.

It would be counterproductive to deny states the flexibility they need to implement demonstration projects designed to examine innovative ways to incentivize beneficiaries to engage in desired behaviors that improve outcomes and lower healthcare costs, given that states have the prerogative to terminate coverage for non-mandatory services and populations. Because a demonstration project, by its nature, is designed to test innovations, it is not possible to know in advance the actual impact that its policies will have on enrollment. That is one of the metrics to be measured. But even assuming that BadgerCare Reform would result in the loss of coverage for some individuals as commenters suggested, and even assuming that most of these individuals would not transition to commercial coverage, such losses are likely dwarfed by the 166,000 childless adults who would not otherwise have coverage if Wisconsin elects not to extend the demonstration.

Furthermore, the Wisconsin state plan covers other optional populations such as parents/caretakers with incomes up to 100 percent of the FPL as well as optional services such as prescription drug, dental, and occupational therapy benefits. As a matter of federal law, it is a state's prerogative to reduce or eliminate non-mandatory coverage. Such judgments are left to the policy preferences of the state government and its electorate, and states are to be given great latitude in making tradeoffs in how the state furnishes medical assistance "as far as practicable under the conditions" in the state. Act § 1901. In evaluating Wisconsin's demonstration project, it is appropriate to consider the possibility of coverage loss among the demonstration population against the benefits that may accrue to members of the childless adult demonstration-only population who comply with the conditions of eligibility and receive coverage they may not otherwise have received, as well as benefits that may accrue to the traditional Medicaid population as a result of the demonstration population growing more independent, healthier, and less expensive to cover. Wisconsin will measure actual effects on enrollment as part of the demonstration, and that information should be useful in informing future Medicaid policy.

Comments addressing the community engagement requirements

Many commenters also expressed concerns regarding the demonstration's community engagement requirements, including: (1) that the reporting requirement will cause beneficiaries to lose Medicaid coverage because of failure to report their hours, changes in circumstances, or

because of clerical errors by Wisconsin's Medicaid agency; (2) that the community engagement program will be an additional burden on beneficiaries, particularly those who have chronic illnesses, are homeless, or are domestic violence victims; (3) that many beneficiaries are already working, going to school, or engaging in some other employment and training activity; and (4) that allowing individuals to maintain health coverage better enables individuals to obtain and maintain employment. Some commenters suggested reducing the 80-hour per month requirement.

CMS has worked closely with Wisconsin to ensure there are substantial beneficiary protections in place. Beneficiaries already have a responsibility to report changes in income or circumstances to the state, and the state must maintain and process that information. The state also included exemptions for individuals who have been determined unfit for employment (which can include mentally or physically unfit), experiencing chronic homelessness, or participating in SUD treatment, so individuals that have additional burdens are not required to complete the requirements. Both CMS and the state acknowledge what commenters noted—many beneficiaries are already working or attending school; therefore, those activities are included as meeting the community engagement component and these beneficiaries' access to coverage should not be impacted.

The STCs provide for Wisconsin to educate and reach out to beneficiaries and contain assurances that Wisconsin will seek data from other sources, including SNAP, TANF, and other existing systems. This is expected to reduce the burden on beneficiaries and allow the state to efficiently verify community engagement hours and process beneficiary redeterminations. The STCs require the state to provide CMS with a community engagement implementation plan and assurances regarding timely and adequate notices to beneficiaries.

Other comments suggest that a community engagement requirement which many people will fulfill by working one or multiple part-time, minimum-wage jobs or through unpaid means (volunteering), will not directly lead to financial independence. CMS disagrees with that conclusion. While some of the activities that meet the community engagement requirement may not immediately cause all beneficiaries to be financially independent, those activities are nonetheless positive steps for beneficiaries to take on their path to financial independence. In addition, participation in these activities may reduce social isolation, which multiple studies have linked to higher rates of mortality.[5] At the very least, whether BadgerCare Reform's community-engagement requirement will lead to beneficiaries' financial independence is an open question, which is why this demonstration project is necessary to test whether the incentive structure will have the desired effect. That is also why CMS will regularly evaluate the effects of BadgerCare Reform on affected beneficiaries and reserves the right to discontinue specific waiver and expenditure authorities if CMS determines that it would no longer be in the beneficiaries' interest or promote Medicaid's objectives. Moreover, even if those activities do not cause beneficiaries to become financially independent, they are nevertheless linked to improved health outcomes, which itself furthers Medicaid's objectives.

[5] Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. Perspect Psychol Sci 2015;10:227–37. [PubMed]

Some commenters also suggest that suspending eligibility for beneficiaries that fail to comply with the community engagement requirement will make it harder for beneficiaries to find employment, and some cited research that shows that individuals' access to health coverage improves their ability to find employment. CMS has reviewed and considered the research cited by commenters and notes that other research shows a positive link between community engagement and improved health outcomes.[6,7,8,9,10,11] None of the existing research, however, definitively shows whether a community engagement requirement as a condition for continued Medicaid coverage will help beneficiaries attain financial independence and improve health outcomes. Thus, CMS has determined that it is appropriate to permit states to use section 1115 demonstration projects to determine whether they can achieve such an outcome using community-engagement requirements.

Comments addressing community engagement for American Indian/Alaska Native beneficiaries

During tribal consultation, the tribes informed the state that they were concerned that American Indian/Alaska Native beneficiaries are required to participate in the community engagement program or that cultural work programs are not included as qualifying activities. CMS understands the tribes' concerns and the state has committed to working with the tribes after approval on how to make community engagement a program in which American Indian/Alaska Native beneficiaries can succeed. The STCs require the state to submit a plan to CMS with a timeline for addressing any tribal concerns related to the impact of the community engagement requirements. The STCs also include, as an activity that counts toward meeting the community engagement requirement, participation in an allowable work, job training, or job search program, such as a tribal work program. The state also exempts from the community engagement requirement persons who are regularly participating in an alcohol or other drug abuse (AODA) treatment or rehabilitation program, including verified participation in cultural interventions specific to the Native American community, as well as other analogous programs.

Comments related to premiums

Many commenters agreed with Wisconsin's goal of encouraging beneficiaries to engage in their own health care; some acknowledge that requiring beneficiaries to pay a premium is a successful way to encourage such engagement. However, there were many concerns about whether beneficiaries living at poverty would be able to afford the premium and still pay for other basics,

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[6] Waddell, G. and Burton, AK. Is Work Good For Your Health And Well-Being? (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK.
[7] Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper,K. Health effects of employment: a systemic review of prospective studies. BMJournals. Occupational and Environmental Medicine. 2014: 71 (10).
[8] Crabtree, S. In U.S., Depression Rates Higher for Long-Term Unemployed. (2014). Gallup. http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx.
[9] United Health Group. Doing good is good for you. 2013 Health and Volunteering Study.
[10] Jenkins, C. Dickens, A. Jones, K. Thompson-Coon, J. Taylor, R. and Rogers, M.Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteersBMC Public Health 2013. 13 (773).
[11] Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. JAMA. 2016; 315(16):1750-1766.

such as food or housing, and whether or not beneficiaries will have a bank account or credit card to pay the premium. In addition, commenters were concerned about the administrative complexity of the premium structure and whether the state would spend more money trying to enforce the premium requirements. Wisconsin considered the state level comments and in response, restructured the multiple tiers in the draft proposal into two tiers so beneficiaries with incomes above 50 percent of the FPL up to and including 100 percent of the FPL will pay one flat rate premium, and those individuals with income at or below 50 percent of the FPL will not pay a premium. In addition, beneficiaries will receive benefits upon enrollment, regardless of when the first payment is made, and beneficiaries will only be disenrolled for failure to pay premiums if the individual has unpaid premiums at the annual redetermination. In addition to the potential benefits to beneficiaries of aligning with the commercial health insurance approach, establishing premiums may encourage members to place increased value on their health care and utilize it more effectively. Interim evaluation findings regarding premiums in one state found that beneficiaries who paid premiums are more likely to obtain primary care and preventive care, have better drug adherence, and rely less on the emergency room for treatment compared to those who do not.[12] Therefore, preventive care service utilization is expected to increase as members seek to utilize appropriate health care services. As a result, high costs related to emergency department usage may decline since health care needs will be met before conditions reach the level that require an emergency department visit. These trends would enhance program sustainability. As part of its demonstration, Wisconsin will test these hypotheses.

Comments related to the Health Risk Assessment (HRA)

Commenters were supportive of the use of an HRA to help beneficiaries understand their health care needs and to encourage avoidance of health risk behaviors, but some expressed concern about beneficiaries having to pay a higher premium for not "managing" risky behavior. The state acknowledged these responses and revised its proposal so that individuals with income at or below 50 percent of the FPL will not pay a premium.

All beneficiaries, however, will be required, as a condition of eligibility, to complete the HRA. This reflects the state's interest, not only in helping individuals identify their own health risks, but also to help managed care plans address health care needs, identify appropriate treatment plans, ensure provision of care management, and give individuals the opportunity to facilitate their access to treatment. As part of the state's initiative to tackle SUD, the state initially requested authority to require applicants and beneficiaries to complete a drug screening assessment, and if indicated from the assessment, a drug test. In response to concerns identified by CMS and commenters, Wisconsin revised its approach to include completion of the HRA as a condition of eligibility. Responses to questions on the HRA will result in a referral for treatment, as applicable, but not impact an applicant's Medicaid eligibility.

Comments related to non-emergency use of the emergency department

Commenters at the state level expressed concern with a high copayment amount for beneficiaries who visit the ED, because some beneficiaries might have no other avenue to seek acute care,

[12] The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016), available at: https://www.in.gov/fssa/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

particularly those beneficiaries who suffer from chronic conditions. In response, the state lowered the copayment for non-emergency use of the ED to $8, which is the amount currently permitted in Medicaid regulations and has been imposed by other states. We do not believe this amount will be prohibitive, and we expect that this policy will result in improved health outcomes for both the beneficiaries who no longer visit the ED for non-emergency services and those who need emergency services and will now have greater access to the ED. Furthermore, as inefficient and costly care in less appropriate settings decreases, we expect that beneficiaries will become less costly to care for, thereby improving the sustainability of Wisconsin's Medicaid program and making available more program resources for those who need them most. Finally, we remind commenters that this copayment will not be imposed on beneficiaries who visit the emergency department because they are experiencing an emergency and need emergency department care. The copayment will only apply to beneficiaries who choose not to seek non-emergency care through a more appropriate avenue.

Other Information

CMS's approval is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Shanna Janu. She is available to answer any questions concerning your section 1115 demonstration. Ms. Janu's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Shanna.Janu@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to your project officer and Ms. Ruth Hughes, Associate Regional Administrator in our Chicago Regional Office. Ms. Hughes's contact information is as follows:

Ms. Ruth Hughes
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children Health Operations
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601-5519
Email: Ruth.Hughes@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.
Thank you for all your work with us, as well as stakeholders in Wisconsin, over the past months to reach approval.

Sincerely,

[redacted]

Seema Verma

Enclosures

cc: Ruth Hughes, Associate Regional Administrator, Region V

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **11-W-00293/5**

TITLE: **Wisconsin BadgerCare Reform**

AWARDEE: **Wisconsin Department of Health Services**

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the affected populations, as described for the demonstration project from October 31, 2018 through December 31, 2018, as these two waivers will sunset on December 31, 2018.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the state plan requirements contained in section 1902 of the Act are granted in order to enable Wisconsin to implement the Wisconsin BadgerCare Reform Medicaid section 1115 demonstration.

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

To the extent needed to enable the state to enforce premium payment requirements under the demonstration by not providing medical assistance for a period of three months for adults that qualify for Medicaid only under section 1925, or sections 1902(e)(1) and 1931(c)(1), of the Act whose eligibility has been terminated as a result of not paying the required monthly premium.

2. Premiums — **Section 1902(a)(14) insofar as it incorporates section 1916** **Section 1902(a)(52)**

To the extent needed to permit the state to impose monthly premiums based on household income on individuals that qualify for Medicaid only under Transitional Medical Assistance (TMA). This waiver allows the state to apply premiums to TMA Adults with income above 133 percent of the federal poverty level (FPL) starting from the date of enrollment, and to TMA Adults with income from 100-133 percent of the FPL starting after the first six calendar months of TMA coverage.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00293/5**

TITLE: **Wisconsin BadgerCare Reform 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, incurred during the period of this demonstration, shall be regarded as expenditures under the state's title XIX plan.

The following expenditure authority shall enable the state to operate its BadgerCare Reform section 1115 Medicaid demonstration beginning October 31, 2018 through December 31, 2023.

1. **Childless Adults Demonstration Population.** Expenditures for health care-related costs for eligible non-pregnant, uninsured adults ages 19 through 64 years who have family incomes up to 95 percent of the federal poverty level (FPL) (effectively 100 percent of the FPL including the five percent disregard), who are not otherwise eligible under the Medicaid State plan, other than for family planning services or for the treatment of Tuberculosis, and who are not otherwise eligible for Medicare, Medical Assistance, or the State Children's Health Insurance Program (CHIP).

2. **Former Foster Care Youth from Another State.** Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Wisconsin or tribe in such other state on the date of attaining 18 years of age (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid on that date, and are now applying for Medicaid in Wisconsin.

3. **Residential and Inpatient Treatment Services for Individuals with Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

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 Childless Adults Demonstration Population beginning October 31, 2018, through December 31, 2023.

Title XIX Requirements Not Applicable to the Demonstration Population:

1. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to require enrollment of eligible individuals in managed care organizations.

2. Premiums **Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**

To the extent necessary to the state to charge an $8 monthly premium to the childless adult population with household incomes over 50 percent of the FPL, up to and including 100 percent of the FPL.

3. Comparability **Section 1902(a)(17)/Section 1902(a)(10)(B)**

To the extent necessary to enable the state to vary monthly premiums for the childless adult population based on health behaviors and health risk assessment completion.

To the extent necessary to enable the state to establish a non-emergency use of the emergency department copayment of $8 for the childless adult population.

4. Eligibility **Section 1902(a)(10) and 1902(a)(52)**

To the extent necessary to enable the state to deny eligibility and prohibit reenrollment for up to six months for beneficiaries, between the ages of 19 and 49 years old, who have been enrolled in Medicaid as childless adults for 48 months and who have not otherwise met the employment and training incentive or an exemption, as described in these special terms and conditions (STC).

To the extent necessary to enable the state to deny eligibility and prohibit reenrollment for up to six months for the childless adults population who are disenrolled for failure to pay premiums.

To the extent necessary to enable the state to deny eligibility for the childless adults population who does not complete a health risk assessment.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00293/5

TITLE: Wisconsin BadgerCare Reform

AWARDEE: Wisconsin Department of Health Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) to enable Wisconsin (state) to operate the Badger Care Reform section 1115(a) BadgerCare demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (the Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and amendments and the state's obligations to CMS related to this demonstration and amendments. The STCs are effective October 31, 2018 and the BadgerCare Reform demonstration is approved through December 31, 2023.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Community Engagement Program
VI. Benefits
VII. Cost Sharing (Premiums, Copays, and Healthy Behavior Incentive)
VIII. Delivery System
IX. General Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality for the Demonstration
XII. Evaluation of the Demonstration
XIII. Schedule of State Deliverables during the Demonstration

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

Attachment A. Summary of Cost-sharing for TMA Adults Only
Attachment B. Substance Use Disorder Implementation Plan Protocol
Attachment C. Substance Use Disorder Monitoring Protocol
Attachment D. Developing the Evaluation Design
Attachment E Preparing the Evaluation Report
Attachment F. Evaluation Design
Attachment G. Community Engagement Implementation Plan
Attachment H. Monitoring Protocol

Attachment I. Tribal Consultation Plan

II. PROGRAM DESCRIPTION AND OBJECTIVES

With the implementation of the Affordable Care Act provisions, that will provide federally-funded subsidies to help individuals and families purchase private health insurance, Wisconsin saw the BadgerCare Reform amendment as an opportunity to reduce the uninsured rate and encourage beneficiaries to access coverage in the private market.
The Wisconsin BadgerCare Reform amendment provided state plan benefits, other than family planning services and tuberculosis-related services, to childless adults who had effective family incomes up to 100 percent of the Federal Poverty Level (FPL) (effective income is defined to include the five (5) percent disregard), and permitted the state to charge premiums to adults who were only eligible for Medicaid through the Transitional Medical Assistance eligibility group (hereinafter referred to as "TMA Adults") with incomes above 133 percent of the FPL starting from the first day of enrollment and to TMA Adults from 100-133 percent of the FPL after the first six (6) calendar months of TMA coverage.

The BadgerCare Reform amendment allowed the state to provide health care coverage for the childless adult population at or below an effective income of 100 percent of the FPL with a focus on improving health outcomes, reducing unnecessary services, and improving the cost-effectiveness of Medicaid services. Additionally, the amendment enabled the state to test the impact of providing TMA to individuals who were paying a premium that aligned with the insurance affordability program in the Marketplace based upon their household income when compared to the FPL.

In accordance with CMS' November 21, 2016 CMCS Informational Bulletin (CIB), *Section 1115 Demonstration Opportunity to Allow Medicaid Coverage to Former Foster Care Youth Who Have Moved to a Different State*, the BadgerCare Reform demonstration was amended in December 2017 to add coverage of former foster care youth defined as individuals under age 26 who were in foster care in another state or tribe of such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid at that time or at some point while in such foster care, and are now applying for Medicaid in Wisconsin. With the addition of this population, Wisconsin has a new demonstration goal to increase and strengthen overall coverage of former foster care youth and improve health outcomes for this population.

The 2017 amendment request was prompted by the Wisconsin 2015-2017 Biennial Budget (Act 55), which required the Wisconsin Department of Health Services (DHS) to request an amendment to the BadgerCare Reform amendment in order to apply a number of new policies to the childless adult population. Act 55 requirements included: establishing monthly premiums, establishing lower premiums for members engaged in healthy behaviors, requiring completion of a health risk assessment, limiting a member's eligibility to no more than 48 months, and requiring as a condition of eligibility that an applicant or member complete a drug screening, and if indicated, a drug test and treatment; however, a drug test as a condition of eligibility and a 48-month limit are not part of this approval. Policies not required by Act 55, but included in the amendment request in order to meet the program objectives involve charging an increased copayment for non-emergent use of the emergency department utilization for childless adults, establishing a work or community engagement option for childless adults, and providing full

coverage of residential substance use disorder treatment for all BadgerCare Plus and Medicaid members.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, understanding program rules and notices, establishing eligibility for an exemption from community engagement requirements on the basis of disability, meeting and documenting community engagement requirements and meeting other program requirements necessary to obtain and maintain benefits.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in law, regulation, and written policy, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature 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.

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 well as a modified allotment neutrality worksheet as necessary to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, 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, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPA) 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 instances, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, 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 Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP, whether administrative or service-based expenditures, will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

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 elements of a viable amendment request as found in this STC, and failure by the state to submit reports required in the approved STCs 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. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;

    b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include 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 detail 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. An explanation of the public process used by the state consistent with the requirements of STC 13; 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 a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in

accordance with the timelines contained in statute. Otherwise, no later than twelve months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-oute plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. 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 the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and 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 prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. Expiration Requirements. The state must include, at a minimum, in its demonstration authority expiration 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 prior to the termination of the demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b. Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to demonstration beneficiaries as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration

activities. Implementation of expiration activities must be no sooner than fourteen (14) days after CMS approval of the demonstration authority expiration plan.

d. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

11. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the beneficiaries' interest or promote the objectives of title XIX. CMS must 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, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

12. 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.

13. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.
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.

14. Federal Financial Participation (FFP). No federal matching for expenditures, both administrative and service, for this demonstration will take effect until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

15. Common Rule Exemption. The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or

alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

16. State Plan Eligibility Groups Affected By the Demonstration. The state plan populations affected by this demonstration are outlined in Table 1, which summarizes each specific group of individuals and specifies the authority under which they are eligible for coverage and the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed.

17. Demonstration Expansion Eligibility Groups. Table 1 summarizes the specific groups of individuals, and specifies the authority under which they are eligible for coverage. Table 1 also specifies the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed. Demonstration Population 2 in Table 1 is made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration. Coverage of Demonstration Population 2 is subject to Medicaid laws and regulations (including all enrollment requirements described in paragraph b. below) unless otherwise specified in the "Title XIX Requirements Not Applicable to the Demonstration Population" section of the expenditure authorities document for this demonstration.

Table 1: Eligibility Groups Affected by the Demonstration			
Medicaid State Plan Mandatory Groups	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Population 1. Parents and caretaker relatives who are non-pregnant, those who do not qualify for Medicaid on the basis of disability, and whose effective family income is above 100 percent FPL and who qualify for TMA under section 1925 of the Act	Parents and caretaker relatives eligible for Medicaid under Wisconsin's Medicaid State plan under section 1925 of the Act or 1931(c)(1) of the Act.	Title XIX	TMA Adults
Demonstration Expansion Groups	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting

Population 2. Non-pregnant childless individuals Age 19 through 64 with an effective monthly income that does not exceed 100 percent FPL	• Ages 19 through 64 • Effective monthly income at or below 100 percent of the FPL • Not pregnant • Do not qualify for any other full-benefit Medicaid or CHIP eligibility group • Are not receiving Medicare • Childless adults may have children, but do not qualify as a parent or caretaker relative (e.g., either the children are not currently living with them or those children living with them are 19 years of age or older) • Fully complete a Health Risk Assessment (HRA)	Title XIX	BC Reform Adults
Population 3. Former Foster Care Youth ("FFCY") from Another State	• Individuals under age 26, who we were in foster care under the responsibility of a state other than Wisconsin or a tribe in such other state when they turned 18 or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid at that time or at some point while in such foster care, are now applying for Medicaid in Wisconsin, and are not otherwise eligible for Medicaid.	Title XIX	FFCY

V. Community Engagement Program

18. Overview. The state will implement a community engagement requirement, otherwise known as the Employment and Training Incentive, as a condition of continued eligibility for BadgerCare Reform beneficiaries, ages 19 through 49, in Demonstration Population 2, who are not otherwise exempt, as defined below. To maintain Medicaid eligibility, non-exempt beneficiaries will be required to participate in specified activities and report on those activities periodically. The activities may include employment, training, or education as specified in STC 20. Beneficiaries who do not meet the community engagement requirement for 48 consecutive or non-consecutive months will be disenrolled and lose eligibility for a period of six months and may not qualify to regain eligibility during this six month period unless they are found eligible for Medicaid under a different eligibility group.

19. Exempt Populations. Childless adults under Demonstration Population 2, ages 19 through 49, are exempt from the community engagement requirement for a given month if any of the following is true for that month:

a. The beneficiary is unable to work or participate in the workforce training activities, which includes someone who is:

    i. Receiving temporary or permanent disability benefits from the government or a private source (e.g., social security disability insurance (SSDI));

    ii. Mentally or physically unable to work, as determined by the state;

    iii. Verified as unable to work in a statement from a health care professional or a social worker; or

    iv. Experiencing chronic homelessness.

b. The beneficiary is a primary caregiver for a person who cannot care for himself or herself.

c. The beneficiary is receiving or has applied for unemployment compensation (UC) and is complying with the UC work requirements.

d. Exempt from Supplemental Nutrition Assistance Program (SNAP) work requirements.

e. The beneficiary is regularly participating in an alcohol or other drug abuse (AODA) treatment or rehabilitation program (excluding alcoholics anonymous/narcatics anonymous (AA/NA), but including verified participation in cultural interventions specific to the Native American community, as well as other analogous programs).

f. The beneficiary is enrolled in an institution of higher learning (including vocational programs or GED classes) at least half-time.

g. The beneficiary is attending high school at least half-time.

20. Qualifying Activities. Beneficiaries in Demonstration Population 2 who are not exempt may be considered active in community engagement through a variety of activities, including but not limited to:

a. Working in exchange for money;

b. Working in exchange for goods or services (“in-kind”);

c. Unpaid work (e.g., volunteer work, community service);

d. Self-employment at any wage;

e. Taking part in an allowable work, job training, or job search program, such as:

    i. FoodShare Employment and Training (FSET), including FSET WorkFare component (the state’s SNAP program);

ii. Wisconsin Works (W-2);

iii. Workforce Innovation and Opportunity Act (WIOWA) programs;

iv. Refugee Employment and Training;

v. Trial Employment Match Program (TEMP);

vi. Children First;

vii. Programs under section 236 of the Trade Act;

viii. Tribal work programs; or

ix. Other state-approved workforce programs.

21. Hour Requirements. Beneficiaries under Demonstration Population 2 must complete at least 80 hours per calendar month of one, or any combination, of the qualifying activities to meet the community engagement requirement and report these activities to the state, in a manner to be specified by the state in the community engagement implementation plan (STC 46). The months in which a beneficiary meets the community engagement requirement will not count towards the 48 month period, described in STC 22.

22. Limits on Eligibility While Not Meeting Community Engagement Requirements.

a. Overview. For the duration of this demonstration project, unless amended, beneficiaries under Demonstration Population 2, ages of 19 and 49, who are not participating in work, training, or other activities referenced in STC 20, unless they qualify for an exemption as described in STC 19, will have 48 (consecutive or non-consecutive) months of eligibility for coverage of Medicaid benefits before losing eligibility for a period of six months. The count of the 48-month period for current beneficiaries who are not participating in work, training or other activities as described in STC 20 will begin no sooner than 12 months after waiver approval, or not sooner than the first of the month when eligibility of a beneficiary is established, provided that all beneficiaries who will be subject to this requirement have been adequately notified. Once a beneficiary has been enrolled in Medicaid for a cumulative 48 months while not participating in the workforce initiative or meeting the community engagement requirement, the beneficiary will be disenrolled and become ineligible for BadgerCare under this demonstration authority for a period of six months, unless the beneficiary meets another category of Medicaid assistance. After completing the six month non-eligibility period, the beneficiary will be able to reapply and regain eligibility under Population 2 provided that all other eligibility criteria are satisfied.

b. Good Cause. Beneficiaries may request a temporary exemption from the community engagement/workforce training initiative for good cause. Circumstances that could give rise to a finding of good cause include, but are not limited to, at a minimum, the following verified circumstances:

i. The beneficiary has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the beneficiary or an immediate family member who was living in the home with the beneficiary experiences a hospitalization or serious illness;

ii. The beneficiary experiences the birth, or death, of a family member living with the beneficiary;

iii. The beneficiary experiences severe inclement weather (including natural disaster) and therefore was unable to meet the requirement; or

iv. The beneficiary has a family emergency or other life-changing event (e.g., divorce or domestic violence).

23. Reasonable modifications. Wisconsin must provide reasonable accommodations for beneficiaries with disabilities protected by the ADA, Section 504 of the Rehabilitation Act, and Section 1557 of the Patient Protection and Affordable Care Act, when necessary, to enable them to have an equal opportunity to participate in and benefit from the program. The state must provide reasonable modifications for program protections and procedures, including but not limited to assistance with demonstrating eligibility for good cause exemptions; appealing disenrollment; documenting community engagement activities and other documentation requirements; understanding notices and program rules; and other types of reasonable modifications.

a. Reasonable modifications must include exemptions from participation where an individual is unable to participate for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the required number of hours, and provision of support services necessary to participate, where participation is possible with supports. In addition, the state must evaluate individuals' ability to participate and the types of reasonable modifications and supports needed.

24. State Assurances. Prior to implementation of community engagement requirements as a condition of eligibility, the state shall:

a. Maintain mechanisms to stop payments to a managed care organization when a beneficiary is terminated for failure to comply with program requirements.

b. Ensure that there are processes and procedures in place to seek data from other sources, including SNAP and TANF, and systems to permit beneficiaries to efficiently report community engagement hours or obtain an exemption, in accordance with 42 CFR 435.907(a), and 435.945, and to permit Wisconsin to monitor compliance.

c. If a beneficiary has requested a good cause, that the good cause has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial.

d. Assure that termination, disenrollment, or denial of eligibility will only occur after an individual has been screened and determined ineligible for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 435.916(f).

e. Ensure that there are timely and adequate beneficiary notices provided in writing, including but not limited to:

    i. When community engagement requirements will commence for that specific beneficiary;

    ii. Whether a beneficiary is exempt, and under what conditions the exemption would end;

    iii. A list of the specific activities that may be used to satisfy the community engagement requirements and a list of the specific activities that beneficiaries can engage in, as described in STC 20;

    iv. The specific number of community engagement hours per month that a beneficiary is required to complete to meet the requirement, and when and how the beneficiary must report participation or request an exemption;

    v. Information about resources that help connect beneficiaries to opportunities for activities that would meet the community engagement requirement, and information about the community supports that are available to assist beneficiaries in meeting the community engagement requirement;

    vi. Information about how community engagement hours will be counted and documented;

    vii. Periodic updates on how many months have counted towards the 48 months;

    viii. What gives rise to a termination of eligibility, what a termination would mean for the beneficiary, and how to avoid a termination, including how and when to apply for good cause and what kinds of circumstances might give rise to good cause;

    ix. How beneficiaries are expected to report the hours and exemptions and that this is communicated to the beneficiaries; and

    x. If a beneficiary's eligibility is terminated, how to appeal the termination.

f. Ensure application assistance is available to beneficiaries (in person and by phone).

g. Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements.

h. Maintain ability to report on and process applications in-person, via phone, via mail and electronically;

i. Provide full appeal rights as required under 42 CFR, Part 431, subpart E prior to termination of eligibility, and observe all requirements for due process for beneficiaries whose eligibility will be terminated for meeting 48 months of non-compliance with the community engagement requirement, including allowing beneficiaries the opportunity to raise additional issues in a hearing, including whether the beneficiary should be subject to the suspension or termination, and provide additional documentation through the appeals process.

j. Make good faith efforts to connect beneficiaries to existing community supports that are available to assist beneficiaries in meeting the community engagement requirement, including available non-Medicaid assistance with transportation, child care, language access services and other supports.

k. Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas that lack public transportation to determine whether there should be further exemptions from the community engagement requirement and/or additional mitigation strategies, so that the community engagement requirement will not be impossible or unreasonably burdensome for beneficiaries to meet.

l. Provide each beneficiary who has been disenrolled from BadgerCare Reform with information on how to access primary care and preventative care services at low or no cost to the individual. This material will include information about free health clinics and community health centers including clinics that provide behavioral health and substance use disorder services. Wisconsin shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries who have lost coverage.

m. Makes the general assurance that it is in compliance with protections for beneficiaries with disabilities under ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act.

VI. BENEFITS

25. Wisconsin BadgerCare Demonstration. All enrollees in this demonstration (as described in Section IV) will receive benefits as specified in the Medicaid state plan, to the extent that such benefits apply to those individuals. Beneficiaries in Demonstration Population 2 will not receive family planning services or tuberculosis-related services. In addition, beneficiaries in the Demonstration Population 2 will not receive pregnancy related services, but instead must be administratively transferred to the pregnant women group in the state plan if they are

pregnant. Refer to the state plan for additional information on benefits. Former foster care youth from another state receive full Medicaid State Plan benefits.

26. Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program. Effective upon CMS' approval of the SUD Implementation Protocol, the demonstration benefit package for all Wisconsin Medicaid recipients will include OUD/SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matched expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Wisconsin Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Wisconsin will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 28 below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The coverage of OUD/SUD treatment services and withdrawal management during short term residential and inpatient stays in IMDs will expand Wisconsin's current SUD benefit package available to all Wisconsin Medicaid recipients as outlined in Table 2. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as impatient facilities under section 1905(a) of the Act.

Table 2: Wisconsin OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefits	Wisconsin Medicaid Authority	Expenditure Authority
Outpatient Services	State Plan	n/a
Intensive Outpatient Services	State Plan	n/a
Medication Assisted Treatment	State Plan (Individual services covered)	Services provided to individuals in IMDs
Residential Treatment Services	State Plan (Individual services covered)	Services provided to individuals in IMDs
Inpatient Services	State Plan (Individual services covered)	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	State Plan	Services provided to individuals in IMDs

27. SUD Implementation Plan Protocol. The state must submit a SUD Implementation Plan Protocol within ninety (90) days after approval of the SUD program under this demonstration approval. The state may not claim FFP for services provided in IMDs until CMS has approved the SUD Implementation Plan Protocol. Once approved, the Implementation Plan Protocol will be incorporated into the STCs, as Attachment B, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Plan Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Plan Protocol or failure to obtain CMS approval will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such,

would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in funding deferral. At a minimum, the SUD Implementation Protocol will describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD program in this demonstration:

a. Access to Critical Levels of Care for OUD and other SUDs: Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;

b. Use of Evidence-based SUD-specific Patient Placement Criteria. Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

c. Patient Placement. Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

d. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities. Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Wisconsin administrative code. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;

e. Standards of Care. Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

f. Standards of Care. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval.

g. Sufficient Provider Capacity at each Level of Care, including Medication Assisted Treatment for OUD. An assessment of the availability of providers in the key levels of

care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval.

h. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

i. SUD Health IT Plan**.** Implementation of the milestones and metrics as detailed in STC 32.

j. Improved Care Coordination and Transitions between levels of care. Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

28. SUD Monitoring Protocol. The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of the SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment C. At a minimum, the SUD Monitoring Protocol will include reporting of the average length of stay for residential treatment and reporting relevant to each of the program implementation areas listed in STC 27. The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 46 of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the SUD Monitoring Protocol will be reported via the quarterly and annual monitoring reports.

29. Mid-Point Assessment. The state must conduct an independent mid-point assessment of the demonstration. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones

and targets not yet met and about the risk of possibly missing those milestones and performance targets. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report. For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Plan Protocol and SUD Monitoring Protocols for ameliorating these risks subject to CMS approval.

30. SUD Evaluation. The SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections VIII General Reporting Requirements and XII Evaluation of the Demonstration of the STCs.

31. SUD Evaluation Design. The state must submit, for CMS review and approval, a revision to the Evaluation Design to include the SUD program, no later than one-hundred-and-eighty (180) days after the effective date of these amended STCs. Failure to submit an acceptable and timely evaluation design along with any required monitoring, expenditure, or other evaluation reporting will subject the state to a $5 million deferral. The state must use an independent evaluator to design the evaluation.

a. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

b. Evaluation Questions and Hypotheses Specific to SUD Program. The state must follow the general evaluation questions and hypotheses requirements as specified in guidance provided in Attachment D of the STCs. In addition, hypotheses for the SUD program should include an assessment of the objectives of the SUD component of this section 1115 demonstration, to include, but is not limited to: initiation and compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes such as deaths due to overdose. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of

Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

32. SUD Health Information Technology (Health IT). The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, will be submitted as a component of the State Medicaid Health IT Plan (SMHP), and included as a section of the state's "Implementation Plan" to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

a. The SUD Health IT section of the Implementation plan will include implementation milestones and dates for achieving them (see Attachment B).

b. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

c. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP).[1]

d. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

e. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.
[2] *Ibid*.

f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[3]

g. In developing the Health IT Plan, states should use the following resources.

   i. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

   ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

   iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

h. The state will include in its Monitoring Protocol (see STC 28) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 46).

j. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

k. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

l. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

33. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Protocol and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

VII. COST SHARING (PREMIUMS, COPAYS, AND HEALTHY BEHAVIOR INCENTIVE)

34. Cost sharing. For all enrollees in this demonstration, cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies and be reflected in the state plan, except for premiums for Demonstration Population 1 (TMA Adults), and except for copayments for non-emergency use of the ED for Demonstration Population 2.

a. Premiums for Demonstration Population 1 (TMA Adults). TMA Adults with income of 133 percent of the FPL or greater are subject to monthly premiums based on the sliding scale as outlined in Attachment A from the date of enrollment. TMA Adults with effective income over 100 percent but less than 133 percent of the FPL are subject to monthly premiums based on a sliding scale starting six calendar months after the date of enrollment. There will be a 30-day grace period for non-payment of the monthly premium before being disenrolled. Eligibility and enrollment for TMA will be terminated for a maximum period of three months for demonstration participants who fail to make a required premium payment before the end of the grace period. However, a participant may re-enroll at any point during this three -month period by paying owed premiums. After the three-month period of non-eligibility, TMA Adults must be reenrolled in TMA on request, even if they have an outstanding unpaid premiums, provided their respective 12-month TMA period has not yet expired. The three-month period of non-eligibility does not toll the 12-month TMA period. If section 1925 of the Act sunsets or is otherwise inapplicable and TMA is then available only for a four month extension, Demonstration Population 1 individuals may not re-enroll in TMA. No premium may be charged during the three-month period of non-eligibility, and nonpayment of premiums that remain unpaid from a prior TMA enrollment period may not be used as a basis for terminating a beneficiary's enrollment during a subsequent period of TMA enrollment after the three-month period of non-eligibility.

i. Premiums for TMA Adults whose income changes after time of application (i.e., decreases or increases, including an increase in which the individual's income increases to 200 percent of the FPL or more), but before his/her annual redetermination, will be recalculated after the individual has reported the change. Once the state has calculated an individual's new monthly premium amount based on the sliding scale outlined in Attachment A, the state will provide the individual with at least a 10-day notice prior to effectuating the new monthly premium amount. If income increases to 133 percent FPL or more for TMA demonstration

enrollees who had income under 133 percent FPL when their TMA began, premiums will be due immediately after the 10-day notice.

ii. Consistent with 42 CFR 447.56, American Indians and Alaska Natives (AI/AN) who are eligible to receive or who have received an item or services furnished by an Indian health care provider or through referral under contract health services are exempt from the premium amounts outlined above.

iii. TMA adults may be disenrolled for failure to pay premiums after a 30-day grace period. Once they are disenrolled, they will be restricted from re-enrollment during a three month period of non-eligibility. They may enroll in Medicaid under another eligibility group if they become eligible under such other eligibility group during the three-month non-eligibility period. At any point during this three-month period, they may pay the owed premiums to re-enroll in TMA for the remainder of the 12-month TMA extension period and be re-enrolled. After the three-month period, they may re-enroll for TMA for the remainder of the 12-month TMA extension period, if requested, even if they have an outstanding unpaid premiums from the prior TMA enrollment period. In this case, nonpayment of premiums that remain unpaid from the prior TMA enrollment period may not be used as a basis for terminating the beneficiary's enrollment during the subsequent period of TMA enrollment.

STC 34(a) will sunset on December 31, 2018 and demonstration premiums will no longer be charged to the TMA adults after this date.

b. Premiums for Demonstration Population 2. For individuals in demonstration population 2, a monthly premium payment is required for those with monthly household income above 50 percent of the FPL. Monthly premium amounts are divided into the following two income tiers:

Table 3: Income Tiers for Monthly Premiums for Demonstration Population 2	
Monthly Household Income	**Monthly Premium Amount**
0 to 50 percent of the FPL	No premium
Above 50 percent of the FPL	$8 per household

i. Beneficiaries with household income up to 50 percent of the FPL are exempt from paying monthly premiums. AI/AN who are eligible to receive or who have received an item or services furnished by an Indian health care provider or through referral under contract health services are also exempt from the monthly premiums outlined above, consistent with section 1916(j) of the Act and with 42 CFR 447.56.

ii. Beneficiaries in Demonstration Population 2 may be disenrolled for failure to pay premiums only at annual redetermination. The state will notify beneficiaries who have unpaid premium amounts for the coverage year and provide a reasonable opportunity for the beneficiary to pay before disenrolling the beneficiary for the next coverage year. If a beneficiary is disenrolled at annual redetermination for

failure to pay premiums who would have continued to have a premium requirement during the next coverage year if not disenrolled, the beneficiary will be subject to a period of non-eligibility for up to six months. Such a beneficiary may reenroll at any time prior to the end of the six-month period if he or she pays all owed premiums, or if his or her situation changes such that he or she would no longer be subject to a premium requirement. After the six-month period, the beneficiary may be re-enrolled in BadgerCare upon request, if he or she meets all program rules, even if he or she continues to have unpaid premiums from the prior period of enrollment.

c. The state will monitor and include in the quarterly report information related to disenrollments from the demonstration, including due to nonpayment of premiums.

35. Healthy Behavior Incentives. Beneficiaries enrolled in Demonstration Population 2 who are subject to a premium requirement will have their household premium requirement reduced by up to 50 percent if they demonstrate that they do not engage in behaviors that increase health risks ("health risk behaviors"). For beneficiaries who do not demonstrate that they do not engage in health risk behaviors, but attest to actively managing their behavior(s) and/or that they have a health condition that causes them to engage in one or more health risk behaviors, the premium will also be reduced by up to half. For beneficiaries who do not demonstrate that they do not engage in health risk behaviors and do not attest that they are actively managing their behavior(s) and/or that they have a health condition that causes them to engage in one or more health risk behaviors, the standard premium will apply. Beneficiaries will have the opportunity to update and self-attest to any changed health risk behavior or conditions that affect health risk behaviors at a minimum on an annual basis, when eligibility is re-determined. Health risk behaviors include, but are not limited to, excessive alcohol consumption, failure to engage in dietary, exercise, and other lifestyle (or "healthy") behaviors in attempt to attain or maintain a healthy body weight, illicit drug use, failure to use a seatbelt, and tobacco use. To identify beneficiaries who are engaging in health risk behaviors, individuals will be asked to complete a Health Risk Assessment (HRA) when applying for coverage under the demonstration or, for current beneficiaries, no sooner than 12 months after waiver approval. Beneficiaries will also use the HRA to self-attest to their active management of a health risk behavior and/or to having an underlying health condition that causes them to engage in one or more health risk behaviors, if either of these is applicable.

Because health risk is assessed at an individual level, a married couple may include one beneficiary who qualifies for a premium reduction and one beneficiary who does not. If this happens, the household premium would be reduced by 25 percent. If both beneficiaries qualify for a premium reduction, the household's premium would be reduced by 50 percent.

Beneficiaries enrolled in Demonstration Population 2 must fully complete a HRA to be determined eligible for coverage at application and renewal. If an individual fails to answer all questions on the HRA, eligibility for the demonstration will be denied, but there is no period of non-eligibility and that individual can re-apply at any time.

36. Copayments for Use of the Emergency Department. Individuals in Demonstration Population 2 are required to pay a copayment for each non-emergent use of the emergency

room (ER). This copayment shall be charged consistent with 1916A(e)(1) of the Act and 42 CFR 447.54.

a. Under the provisions of section 1916A(e) of the Act, the state has the authority to impose a copayment for services received at a hospital emergency room if the services are not emergency services.

b. As provided under 42 CFR 447.54, the amount of this co-pay will be $8 for each non-emergent use of the emergency department.

c. The individual must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA provision of the Act.

d. Providers cannot refuse treatment for nonpayment of the co-payment.

e. AI/AN who are currently receiving or who have ever received an item or services furnished by an Indian health care provider or through referral under contract health services are exempt from the copayment requirements outlined above, consistent with section 1916(j) of the Act and 42 CFR 447.56.

VIII. DELIVERY SYSTEM

37. General. Demonstration Populations 1 and 2 will be enrolled in the managed care organizations (MCO) that are currently contracted to provide health care services to the existing Medicaid and BadgerCare programs in most of the state to serve persons eligible under this demonstration. Demonstration enrollees will be required to join a MCO as a condition of eligibility, as long as there is at least one MCO available in their county of residence, and the county has been granted a rural exception under Medicaid State plan authority. The state may mandate enrollment into the single MCO in the counties that have been granted the rural exception by CMS. If the county has not been granted a rural exception, the state must offer the option of either MCO enrollment or Medicaid fee-for-service. All demonstration eligible beneficiaries must be provided a Medicaid card, regardless of MCO enrollment. MCOs may elect to provide a MCO specific card to MCO enrollees as well. The state must comply with the managed care regulations published at 42 CFR §438. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR §438.6. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR §438 requirements prior to CMS approval of this demonstration authority as well as such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of sixty (60) days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

IX. GENERAL REPORTING REQUIREMENTS

38. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by

these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).

    i. CMS may decline the extension request.

    ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

    iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

39. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

40. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 waiver reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

41. General Financial Requirements. The state must comply with all general financial requirements under title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section X of these STCs.

42. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XI of these STCs.

43. Community Engagement Implementation Plan. The state must submit a Community Engagement Implementation Plan to CMS no later than 90 calendar days after approval of the demonstration. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment G. At a minimum, the Community Engagement Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach and implementation plan for those policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the implementation plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

44. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment H.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 46(b)), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g, operational updates as described in STC 46(a)), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

45. Tribal Consultation Plan. The state must consult with federally recognized tribal governments and with Indian health care providers, and through consultation, identify any tribal concerns. The state must deliver to CMS a plan and timeline for addressing any tribal concerns related to the impact of the community engagement requirements. The plan and timeline are due to CMS within 60 calendar days after approval of this demonstration and will be incorporated into the STCs, as Attachment I. CMS will work with the state if we determine changes are necessary to the state's submission, or if issues are identified as part of the review.

46. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The information for the fourth quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) days following the end of each demonstration quarter. The Annual Report is due no later than ninety (90 days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates - The operational updates will focus on progress towards meeting the milestones identified in CMS' framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS' framework. The performance metrics will reflect all components of the state's demonstration, and may include, but are not limited to, measures associated with eligibility and coverage (including community engagement). Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation

hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

47. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

48. Close-Out Report. Within 120 days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the Close-Out report.

c. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.

d. The final Close-Out Report is due to CMS no later than thirty (30) days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 38.

49. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

50. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

51. Transformed Medicaid Statistical Information Systems Requirements (T-MSIS). The state shall comply with all T-MSIS milestones and associated timelines indicated below. Failure to meet these milestones on the below timeline will result in a deferral, as described in STC 38:

a. By December 31, 2018 state will address and correct all post go-live corrective actions (except waiver population reporting).

b. By January 31, 2019, state will achieve and maintain currency in T-MSIS data reporting.

c. By June 30, 2019 state will implement corrective action for waiver reporting.

X. GENERAL FINANCIAL REQUIREMENTS. This project is approved for title XIX services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

52. Quarterly Financial Reports. The state must provide quarterly title XIX expenditure reports using Form CMS-64, to separately report total title XIX expenditures for services provided through this demonstration under section 1115 authority. 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 XI of the STCs.

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

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and state 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. All demonstration expenditures subject to the budget neutrality limit, including baseline data and member months, must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation 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 10C. 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.

b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c. Cost Sharing Contributions. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported by DY on the Form CMS-64 Narrative. 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.

d. Pharmacy Rebates. Using specific medical status codes, the state has the capacity to use its MMIS system to stratify manufacturer's rebate revenue that should be assigned to net demonstration expenditures for BC Reform Adults. The state will generate a demonstration-specific rebate report to support the methodology used to assign rebates to the demonstration. The state will report the portion of rebate revenue assigned to BC Reform Adults on the appropriate Forms CMS-64.9 WAIVER. 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 prescriptions.

e. Federally Qualified Health Center Settlement Expenses. Using specific medical status codes, the state will assign FQHC settlement expenses to claims covered under the demonstration for BC Reform Adults and will report these costs on the appropriate Forms CMS-64.9 WAIVER. The state will be able to generate reports using MMIS data to show the assignment of these settlement payments to demonstration expenditures.

f. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state will exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. These amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

g. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration (Section XI of these STCs). The state must complete separate waiver forms for the following Medicaid eligibility groups/waiver names:

    i. "BC Reform Adults"

    ii. "TMA Adults"

    iii. "FFCY"

iv. "SUD"

h. Demonstration Year Definition. The Demonstration Years (DYs) will be defined as follows:

January 1, 2014 through December 31, 2014	Demonstration Year 1 (DY1)
January 1, 2015 through December 31, 2015	Demonstration Year 2 (DY2)
January 1, 2016 through December 31, 2016	Demonstration Year 3 (DY3)
January 1, 2017 through December 31, 2017	Demonstration Year 4 (DY4)
January 1, 2018 through December 31, 2018	Demonstration Year 5 (DY5)
January 1, 2019 through December 31, 2019	Demonstration Year 6 (DY6)
January 1, 2020 through December 31, 2020	Demonstration Year 7 (DY7)
January 1, 2021 through December 31, 2021	Demonstration Year 8 (DY8)
January 1, 2022 through December 31, 2022	Demonstration Year 9 (DY9)
January 1, 2023 through December 31, 2022	Demonstration Year 10 (DY10)

54. Administrative Costs. The state must track administrative costs for state-approved workforce programs under Section V. Administrative costs, including state-approved workforce programs under Section V, will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name Local Administration Costs ("ADM").

55. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within two (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 two (2) 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 Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

56. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 46, the actual number of eligible member months for BadgerCare Reform Demonstration adults and separately the actual number of eligible member months for former foster care youth (i.e. FFCY). The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three (3) months contributes three (3) eligible member months to the total. Two individuals who are eligible for two (2) months each contribute two (2) eligible member months to the total, for a total of four (4) eligible member months.

57. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (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. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

58. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in Section X of these STCs:

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

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

59. Sources of Non-Federal Share. The state must certify 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, including up to date responses to the CMS standard funding questions

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

60. State Certification of Funding Conditions. The state must certify that the following conditions for non-Federal share of demonstration expenditures are met:

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

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

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

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid 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.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

61. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method and 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.

62. Risk. The state will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in Section IV, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

63. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, an annual budget limit will be calculated for each DY on a total computable basis. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 64 below.

The demonstration expenditures subject to the budget neutrality limit related to Demonstration Population 2 as described in STC 17 are those reported under the following Waiver Name: BC Reform Adults. The demonstration expenditures subject to the budget neutrality limit related to Demonstration Population 3 as described in STC 17 are those reported under the following Waiver Name: FFCY. The demonstration expenditures subject to the budget neutrality limit related to SUD as those reported under the following Waiver Name: SUD.

For each DY, separate annual budget limits of demonstration service expenditures will be calculated based on projected PMPM expenditures for BC Reform Adults, Former Foster Care Youth, and SUD. The PMPM amounts for BC Reform Adults, Former Foster Care Youth, and SUD are shown on the table below.

MEG	TREND RATE	2018 DY 5 – PMPM	2019 DY 6 - PMPM	2020 DY 7 PMPM	2021 DY 8 – PMPM	2022 DY 9 – PMPM	2023 DY 10 PMPM
BC Reform Adults	4.7%	$710.95	$744.36	$779.35	$815.98	$854.33	$894.48

Former Foster Care Youth	3.7%	$2,538.20	$2,632.11	$2,729.50	$2,830.49	$2,935.22	$3,043.82
SUD	4.6%	$5,561	$5,816.81	$6,084.38	$6,364.26	$6,657.02	$6,963.24

64. Hypothetical Eligibility Group. BC Reform Adults (as related to Demonstration Population 2 defined under STC 17), SUD, and Former Foster Care Youth (Demonstration Population 3) are considered to be a hypothetical populations for budget neutrality. BC Reform Adults consist of individuals who could have been added to the Medicaid program through the state plan, but instead are covered through demonstration authority.

Former Foster Care Youth from Another State are individuals that were or would have been eligible for state plan coverage as described in the January 22, 2013 CMS notice of proposed rulemaking that permitted the option to cover formerly out-of-state former foster care youth up to age 26 pursuant to section 1902(a)(10)(A)(i)(IX) of the Act. This coverage is now only permissible under the authority of this section 1115 demonstration as outlined in the November 21, 2016 CIB on transition coverage for Former Foster Care Youth.

As part of the SUD initiative, the state may receive FFP for the continuum of services specified in Table 2 to treat OUD and other SUDs that are provided to Medicaid beneficiaries in an IMD. These are state plan services that would be eligible for reimbursement if not for the IMD exclusion. Therefore, they are being treated as hypothetical. The state may only claim FFP via demonstration authority for the services listed in Table 2 that will be provided in an IMD. However, the state will not be allowed to obtain budget neutrality "savings" from these services. Therefore, a separate expenditure cap is established for SUD services.

The budget neutrality expenditure limits for these populations reflect the expected costs for these populations and there is no requirement that the state produce savings from elsewhere in its Medicaid program to offset hypothetical population costs. States may not accrue budget neutrality "savings" from hypothetical populations.

65. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual expenditures for BC Reform Adults during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. 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 alternative mutually agreed upon method.

66. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy

interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

67. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap on a PMPM basis by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition on a PMPM basis	Percentage
DY 1	Cumulative budget neutrality limit plus:	1 percent
DY 2	Cumulative budget neutrality limit plus:	0.75 percent
DY 3	Cumulative budget neutrality limit plus:	0.5 percent
DY 4	Cumulative budget neutrality limit plus:	0.25 percent
DY 5	Cumulative budget neutrality limit plus:	0 percent
DY 6	Cumulative budget neutrality limit plus:	0 percent
DY 7	Cumulative budget neutrality limit plus:	0 percent
DY 8	Cumulative budget neutrality limit plus:	0 percent
DY 9	Cumulative budget neutrality limit plus:	0 percent
DY 10	Cumulative budget neutrality limit plus:	0 percent

68. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

69. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data

and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 38.

70. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

71. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 days after approval of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

a. All applicable Community Engagement evaluation design guidance provided by CMS.

b. Attachment D (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD evaluation designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a draft evaluation design.

72. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

73. Evaluation Questions and Hypotheses. Consistent with Attachments D and E (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment

of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS' measure sets for eligibility and coverage (including community engagement), Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

74. **Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

75. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

    a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

    d. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

    e. The Interim Evaluation Report must comply with Attachment E (Preparing the Evaluation Report) of these STCs.

76. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment E (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's

current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

77. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's interim evaluation report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

78. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

79. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, Approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

80. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

ATTACHMENT A: SUMMARY OF PREMIUMS FOR TMA ADULTS ONLY

Individuals affected by, or eligible under, the demonstration will be responsible for premium payments in accordance with the table below. These premiums will sunset on December 31, 2018.

TMA Adults (Demonstration Population 1)

Monthly Premium Amount based on FPL Percentage	Monthly Premium Amount as a Percentage of Income
100.01 – 132.99%	2.0%
133 – 139.99%	3.0%
140 – 149.99%	3.5%
150 – 159.99%	4.0%
160 – 169.99%	4.5%
170 – 179.99%	4.9%
180 – 189.99%	5.4%
190 – 199.99%	5.8%
200 – 209.99%	6.3%
210 – 219.99%	6.7%
220 – 229.99%	7.0%
230 – 239.99%	7.4%
240 – 249.99%	7.7%
250 – 259.99%	8.05%
260 – 269.99%	8.3%
270 – 279.99%	8.6%
280 – 289.99%	8.9%
290 – 299.99%	9.2%
300% and above	9.5%

State of Wisconsin
BadgerCare Reform Demonstration Project

Substance Use Disorder Implementation Protocol

September 24, 2019

Table of Contents

1.0 Introduction

Wisconsin's Section 1115 BadgerCare Reform Demonstration Waiver was approved on October 31, 2018. The approved waiver includes expansion of coverage for the continuum of Substance Use Disorder (SUD) treatment. Although Wisconsin Medicaid currently covers a robust array of treatment for members with SUD, including outpatient counseling, day treatment, psychosocial rehabilitation, medication-assisted treatment (MAT), and inpatient treatment, some gaps remain in the availability of clinically-appropriate, evidence-based treatment.

The waiver authorizes federal funding for treatment provided to Medicaid members in Institutions for Mental Diseases (IMD), allowing Wisconsin Medicaid to establish a residential treatment benefit that provides coverage in all state-certified residential programs, regardless of size. As a result, Wisconsin Medicaid members will have access to high quality, evidence-based opioid use disorder (OUD) and other SUD treatment services.

This document serves as the BadgerCare Reform Demonstration Waiver Implementation Protocol. In accordance with Standard Terms and Conditions (STC) #27 in the waiver, the implementation protocol describes the strategic approach and project plan to meet required milestones for SUD treatment reform in Wisconsin.

Specifically, Wisconsin Medicaid's overall goals for SUD treatment reform include:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Wisconsin Medicaid has identified the following milestones to meet during the project implementation:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including MAT;
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

2.0 Milestone Completion

Over the course of the demonstration, Wisconsin Medicaid will work with internal and external stakeholders to develop, implement, and monitor SUD treatment initiatives designed to achieve the following milestones:

2.1 Access to Critical Levels of Care for OUD and Other SUDs

Wisconsin Medicaid will establish new coverage policies and enhance existing benefits to provide members access to the full continuum of care for SUD treatment. Currently, Wisconsin Medicaid's largest coverage gap is for the residential level of care. Under this demonstration, Wisconsin will develop coverage policies for residential facilities, including IMD facilities that are not otherwise eligible for matched expenditures under Section 1903 of the Social Security Act.

Following implementation of the new residential benefit by February 2020, Wisconsin Medicaid will reassess coverage for each level of care to identify any additional gaps or barriers to treatment. Initiatives to remove treatment barriers will be prioritized so that Wisconsin Medicaid members can access SUD treatment at the appropriate level of care.

The following table provides an overview of each critical level of care with current Wisconsin Medicaid coverage along with proposed changes.

Level of Care	Current State	Future State	Summary of Actions Needed
Outpatient Services	This is an existing service under the State Plan.	Continue to monitor and evaluate services and expenditures.	No immediate action. Will review coverage policies following implementation of residential benefit and update to State regulations.
Intensive Outpatient Services	This is an existing service under the State Plan.	Continue to monitor and evaluate services and expenditures.	No immediate action. Will review coverage policies following implementation of residential benefit and update to State regulations.
Medication Assisted Treatment	This is an existing service under the State Plan.	Continue to monitor and evaluate services and expenditures.	No immediate action. Will review coverage policies following implementation of residential benefit and update to State regulations.

Residential Treatment Services	The component services of Residential Treatment (e.g. outpatient counseling) are existing services under the State Plan.	Wisconsin Medicaid will develop a new benefit under this demonstration, designed to establish a bundled coverage and reimbursement approach for Residential Treatment. Wisconsin will enroll providers certified as transitional residential programs (Wisc. Admin. Code DHS 75.14) and medically monitored treatment services (Wisc. Admin. Code DHS 75.11). Although the regulations for these programs are not explicitly tied to ASAM guidelines, they align with the ASAM Level of Care 3. Transitional residential programs are most closely aligned with sub-level 3.1 and medically monitored treatment programs are most closely aligned with sub-level 3.7. Wisconsin's new benefit will cover both types of treatment programs.	Wisconsin Medicaid will establish coverage and reimbursement policies aligned with American Society of Addiction Medicine (ASAM) criteria and state regulations, including but not limited to: eligible provider criteria, medical necessity criteria, claims submission and reimbursement guidelines, and utilization management. Benefit design and implementation will be completed by February 2020.

Inpatient Services	This is an existing service under the State Plan.	Coverage for inpatient services will expand to include any previously excluded IMD providers.	Wisconsin Medicaid will provide coverage and reimbursement policy guidance to any facilities previously excluded from providing treatment due to categorization as an IMD. Policy guidance will be distributed to providers by November 2020.
Medically Supervised Withdrawal Management	This is an existing service under the State Plan.	Coverage for medically supervised withdrawal management will expand to include any previously excluded IMD providers.	Wisconsin Medicaid will provide coverage and reimbursement policy guidance to any facilities previously excluded from providing treatment due to categorization as an IMD. Policy guidance will be distributed to providers by November 2020.

2.2 Use of Evidence-based, SUD-specific Patient Placement Criteria

Wisconsin Medicaid establishes standards for the use of patient placement criteria in Administrative Code Chapter DHS 75, "Community Substance Abuse Service Standards." These standards already establish requirements for certified SUD treatment programs to use approved patient placement criteria. Further, the Wisconsin Department of Health Services (DHS) is currently drafting language to revise ch., DHS 75, including updated references to ASAM guidelines.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	Wis. Admin. Code ch. DHS 75 requires all certified programs to use the Wisconsin-Uniform Placement Criteria (UPC), ASAM patient placement criteria, or other similar patient placement criteria approved by the department. In practice, many certified programs are using the ASAM placement criteria. The WI UPC is a SUD-specific, multidimensional assessment tool first implemented in 1996. This tool established uniform definitions of levels of care, improved patient placement consistency, and established adoption of common standards of program admission, continued stay, and discharge criteria. Admission to a program is based on an intake procedure that includes screening, approved patient placement criteria, and initial assessment.	Wisconsin Medicaid will revise Wis. Admin. Code DHS 75 to update references to ASAM patient placement criteria and clarify whether any additional standards are approved.	The revisions to administrative code were authorized by Wisconsin's governor in July 2018. The new regulations will follow the state's rulemaking process. Listening sessions were held on 5/21/19, 5/23/19, 6/17/19, 6/20/19, 6/27/19, and 7/16/19. The input collected through these sessions is incorporated in rule drafting. A rule draft will then be shared with an Advisory Committee for discussion and comment. This phase of rulemaking will continue through 2019. Following revisions suggested by the Advisory Committee, the draft rule will be published for public comment and analysis of economic impact in 2020. Final rule approval by the Wisconsin legislature is anticipated by early 2021, but may occur sooner if comments on the draft are limited.

Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care (b) interventions are appropriate for the diagnosis and level of care (c) there is an independent process for reviewing placement in residential treatment settings	Wis. Admin. Code ch. DHS 75 requires all certified programs to establish intake procedures so that (a) individuals access services at the appropriate level of care and (b) interventions are appropriate for the diagnosis and level of care. DHS Division of Quality Assurance (DQA) (c) conducts site visits and documentation review to ensure providers comply with these standards. Certification reviews take place for the provider's initial application and renewal applications, including a site visit and license holder and employee background checks. Providers must update their program documentation at least annually and apply for certification renewal at least every 2 years. Wisconsin Medicaid requires prior authorization (PA) of SUD treatment for day treatment programs at the intensive outpatient level of care. PA requests are reviewed by licensed behavioral health clinicians to determine medical necessity, including determining that the	DQA will continue to survey certified SUD treatment programs for compliance with provider credentialing standards, including requirements for use of patient placement criteria. Wisconsin Medicaid will develop utilization management policies (e.g. service authorizations) for Medicaid reimbursement in the design of the residential treatment benefit. The benefit design team will establish policies that balance the need to verify a clinically-appropriate assessment has been performed prior to admitting the individual into residential treatment, including the use patient placement criteria, with the need to rapidly connect individuals with treatment to prevent recurrence of use. The Medicaid team consulted with residential treatment providers in July and August 2019 to solicit their input on the referral, screening, assessment, and admissions process for their programs. Using this information, the benefits team is developing	Wisconsin Medicaid will establish utilization management policies. Wisconsin Medicaid will publish authorization requests forms by December 2019 and provide training to residential treatment programs on request submission. Target date to implement coverage is no later than February 2020.

	requested treatment is at the appropriate level of care. Managed care organizations contracted with Wisconsin Medicaid can make decisions to provide or deny services on the basis of medical necessity and place appropriate limits on a service for the purpose of utilization management, but cannot define medical necessity in a way that is more restrictive than the definition used by Wisconsin Medicaid.	authorization guidelines for initial admittance to residential treatment and authorization guidelines for continued stays in residential treatment.	

2.3 Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Wisconsin Medicaid establishes provider qualifications in Administrative Code ch. DHS 75, "Community Substance Abuse Service Standards". DHS is currently drafting language to revise ch. DHS 75, including updated references to evidence-based guidelines.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, **the types of services, hours of clinical care, and credentials of staff for residential treatment settings**	Wisconsin establishes residential treatment provider qualifications in Wisconsin Administrative Code. State standards currently describe the types of services, hours of clinical care, and credentials of staff for transitional residential treatment programs and medically monitored treatment programs. Wisconsin Medicaid intends to use these provider qualifications to determine provider eligibility to deliver residential treatment aligned with ASAM Level of Care 3.	The Wisconsin Division of Care and Treatment Services (DCTS) has begun work to update state administrative code to further align provider qualifications with nationally recognized standards.	The revisions to administrative code were authorized by Wisconsin's governor in July 2018. The new regulations will follow the state's rulemaking process. Listening sessions were held on 5/21/19, 5/23/19, 6/17/19, 6/20/19, 6/27/19, and 7/16/19. The input collected through these sessions is incorporated in rule drafting. A rule draft will then be shared with an Advisory Committee for discussion and comment. This phase of rulemaking will continue through 2019. Following revisions suggested by the Advisory Committee, the draft rule will be published for public comment and analysis of economic impact in 2020. Final rule approval by the Wisconsin legislature is anticipated by early 2021, but may occur sooner if comments on the draft are limited.

Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	All community SUD programs seeking certification under Wisconsin's administrative code are certified by (DQA). DQA conducts site visits and documentation review to ensure providers comply with these standards.	DQA will continue to certify SUD treatment programs and monitor their compliance with state regulations.	No immediate action.
Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site.	There are no current requirements that residential treatment facilities offer MAT on-site or facilitate access off site.	The Wisconsin Division of Medicaid Services is working with partners in DCTS and DQA to determine the appropriate regulatory or policy document to establish a requirement for residential treatment facilities to offer MAT on-site or facilitate access off site. Staff will consider available options, including establishing regulatory requirements in state administrative code or reimbursement requirements in Medicaid coverage policies. Staff will assess the impact of the options on current and potential treatment programs and determine which approach will maximize the availability of residential SUD treatment in Wisconsin while ensuring individuals in treatment have access to evidence-based treatment approaches.	DHS staff will implement the requirement by November 2020.

2.4 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Wisconsin Medicaid will use data from the state's Medicaid Management Information System (MMIS) to evaluate provider capacity. Additional information regarding the data collection, reporting, and analytic methodologies will be described in the SUD Monitoring Protocol.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Completion of assessment of the availability of providers enrolled in Wisconsin Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT: • Outpatient services • Intensive outpatient services • MAT (medications as well as counseling and other services) • Intensive care in residential and inpatient settings • Medically supervised withdrawal management	Wisconsin Medicaid currently enrolls healthcare professionals and programs in categories aligned with their state licensure or certification. Wisconsin will use a combination of DEA registration, state program certification, and state licensure information collected during provider enrollment to identify SUD treatment providers, including those that offer MAT.	As Wisconsin Medicaid updates licensure or certification requirements, including revisions to Wis. Admin. Code ch. DHS 75, it will update its methodology to assign the new provider credentials with the appropriate level of care.	Wisconsin will complete baseline measurements for provider capacity at each level of care by November 2019.

2.5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Wisconsin Medicaid has and continues to make broad efforts across the state to address the drug abuse epidemic sweeping our communities. Initiatives included Medicaid program coverage revisions as well as broader community initiatives to address opioid addiction. The Wisconsin legislature enacted 30 bills for system improvements directly related to substance use disorders under the Heroin, Opioid Prevention and Education (HOPE) Agenda.

In Wisconsin, controlled substance dispensing initiatives resulted in a 29% decline in opioid prescriptions (1.5 million fewer prescriptions), a 19% decline in benzodiazepines (445,000 fewer prescriptions), and a flat trend in stimulant prescriptions from 2015 to 2018.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	Wisconsin Medicaid established prescribing guidelines in alignment with Centers for Disease Control and Prevention (CDC) guidance. The Wisconsin Medical Examining Board (MEB) published Opioid Prescribing Guidelines in 2016. The MEB published updated guidelines in 2018. Wisconsin Medicaid's Drug Utilization Review (DUR) Board has been focused on opioid related activities. These activities include targeted intervention focused on opioid prescribing when a member's medication use may be outside of published guidance (i.e., CDC Opioid Prescribing Guidelines). Wisconsin Medicaid has drug/drug related criteria that is used to send physicians education letters alerting them to a clinical concern and pharmacies receive a drug/drug alert informing them of a clinical concern before the medication is dispensed. Wisconsin Medicaid has an opioid script limit of five prescription fills a	Continue to monitor and evaluate.	No immediate action.

	month for opioids and some quantity limits for certain opioid products. There is a process in place for the pharmacy to receive an override in case a member needs to exceed the limits for clinically appropriate reasons.		
Expanded coverage of, and access to, naloxone for overdose reversal.	2013 Wisconsin Act 200 established expanded access to naloxone, allowing pharmacies to dispense naloxone via a standing order. In August 2016, DHS issued a statewide standing order allowing any pharmacy to use the order to dispense naloxone. Wisconsin Medicaid covers Naloxone as a preferred drug and does not require prior authorization for coverage. In 2018, Wisconsin Medicaid expanded reimbursement policy to allow Opioid Treatment Programs to be reimbursed for dispensing naloxone.	Continue to monitor and evaluate.	No immediate action.
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	See attachment A for additional detail.	See attachment A for additional detail.	See attachment A for additional detail.

2.6 Improved Care Coordination and Transitions between Levels of Care

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	Current certification requirements for community SUD treatment programs include requirements for assessment, referral, and aftercare services that are designed to ensure all health needs for an individual in treatment are identified and addressed. Wisconsin Medicaid integrates the majority of behavioral health services into its risk-based contracts for managed care. This approach to contracting ensures the managed care entity meets coverage requirements for both physical and behavioral health conditions and coordinates services across these domains.	Wisconsin Medicaid will continue to evaluate the array of services carved into its risk-based managed care contracts to further integrate physical and mental health services. The new residential SUD benefit will be carved into acute managed care plans effective January 2020 to ensure coordination between physical and behavioral health services. Wisconsin Medicaid will also identify opportunities to develop more intensive care coordination models for individuals with SUD, including health homes or other intensive care coordination models. Initial analysis of the health home model for enhanced core coordination for individuals with SUD will be completed in 2020.	Wisconsin Medicaid will revise acute managed care contracts by January 2020 and conduct ongoing monitoring through managed care provider network and quality monitoring.

3.0 Implementation Administration

Please see below for the Wisconsin Medicaid's point of contact for the Implementation Plan.

Name and Title: Sophia Lee, Behavioral Health Analyst, Division of Medicaid Services
Telephone Number: 608-266-2901
Email Address: sophia.lee@dhs.wisconsin.gov

4.0 Relevant Documents

No additional documents.

Attachment A – SUD Health Information Technology (IT) Plan

Section I.

This section is a continuation of milestone 5 to detail the use of the Prescription Drug Monitoring Program (PDMP) and the State Medicaid Health IT Plan (SMHP). As described in Table 1, Wisconsin Medicaid has developed and implemented an enhanced prescription drug monitoring program (ePDMP).

Wisconsin Medicaid recognizes the value of developing new and innovative tools to connect individuals with timely and appropriate SUD treatment and reduce administrative burden for treatment providers and other healthcare partners. The DHS eHealth Team conducts a Health Information Technology (HIT) landscape assessment each year to evaluate current HIT capabilities and define strategies Wisconsin Medicaid can pursue to advance health IT maturity and objectives.

Initial research identified key priorities to assess and further the adoption and use of HIT among treatment providers, including the need to conduct a behavioral health specific HIT landscape assessment, develop consent management tools to facilitate the flow of clinical information, and improve access to care through telehealth delivery of services. Details on Wisconsin Medicaid's strategic approach to these priorities will be included in an upcoming version of the SMHP.

Wisconsin Medicaid provides assurance that there is existing health IT infrastructure that may be leveraged in conjunction with future HIT initiatives to accomplish the goals of this demonstration.

Table 1.
State HIT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing to better track patient specific prescription data	Wisconsin Medicaid is connected to the National Association of Boards of Pharmacy (NABP) Prescription Monitoring Interconnect (PMPi) and is currently sharing data with 18 other states. Wisconsin Medicaid is in the process of connecting to RxCheck, an additional data sharing hub.	Wisconsin Medicaid will be connected to a second interstate data sharing hub in 2019 and will continue to connect with additional compatible states for interstate data sharing. Work is underway to ensure interstate data can be presented to end users who access PDMP reports from within the workflow of their	PDMP is awaiting determination from NABP about whether there will be a modified memorandum of understanding to address whether it is allowable for interstate data to be presented to end users who access the PDMP reports from within their EHR workflow. The timeline for

		electronic health record (EHR).	connecting to the additional data sharing hub is dependent on interstate coordination. Additional information on progress for interstate data sharing will be provided to CMS as Implementation Updates via quarterly monitoring reporting.
Enhanced "ease of use" for prescribers and other state and federal stakeholders	Wisconsin Medicaid developed and launched a new PDMP application in 2017 with extensive input from stakeholders to improve the PDMP's ease of use. The new web application streamlines registration and reduces the number of clicks for healthcare users to access patient reports. Analytics and visualizations are used in patient reports to bring the most relevant information from a patient's PDMP prescription history to the immediate attention of the user. Wisconsin has also developed a single sign on service offering for prescribers to be able to access patient reports from within their electronic medical record.	PDMP continues to gather feedback from stakeholders about desirable enhancements to continue to improve ease of use. This feedback has been developed as part of a user-led enhancement grant project through the U.S. Department of Justice, Bureau of Justice Assistance.	The user-led enhancement grant project will finalize the selection of any enhancements by October 2019.

Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	The Wisconsin Statewide Health Information Network is one of the entities that offer the single sign on connection to the PDMP from within the community health record.	Continue to monitor and evaluate.	No immediate action.
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns [1](see also "Use of PDMP" #2 below)	Long term opioid therapy is currently one of the data-driven alerts that are included in the patient report to help inform prescribers of concerning elements of their patients' prescription history. Alerts figure not only on patient reports but also on prescriber metrics reports that are available to prescribers as a self-assessment tool, to medical coordinators who oversee prescribers, and to the boards that review PDMP data to look for outlying prescribing practices.	PDMP is considering inclusion of an analytics-driven alert to flag patients who are opioid naïve/do not have history of long-term opioid use.	No immediate action.
Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	The PDMP uses data quality software to perform patient matching.	Continue to monitor and evaluate.	No immediate action.

[1] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	Wisconsin Medicaid has developed a single sign on (SSO) service offering for prescribers to be able to access patient reports from within their electronic medical record. Analytics and visualizations are used in patient reports.	Continue to monitor and evaluate.	No immediate action.
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	State law requires prescribers to review the PDMP prior to issuing a prescription order for a controlled substance. When prescribers review their patients' reports, they see alerts and visualizations based on analytics bring the most relevant information from a patient's PDMP prescription history to the immediate attention of the user.	Continue to monitor and evaluate.	No immediate action.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The PDMP uses data quality software to perform patient matching.	Continue to monitor and evaluate.	No immediate action.

Overall Objective for Enhancing PDMP Functionality & Interoperability			
Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, technical assistance or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Wisconsin Medicaid does not inappropriately pay for opioids	The Wisconsin Department of Safety and Professional Services sends a monthly data extract to DHS for purposes delineated in a Data Use Agreement between the two agencies. The medical coordinator role in PDMP allows those who oversee prescribers to view non-patient-identifiable prescribing practice assessment metrics for the patients they oversee, which allows them to better identify prescribers that may present an opportunity for education about safe opioid prescribing practices. Prescribers can view their own metrics to see how their prescribing compares to their peers of the same specialty, and prescribing boards review similar metrics to help identify critically dangerous prescribing practices for further investigation and possible disciplinary action.	Continue to monitor and evaluate.	No immediate action.

Attachment A, Section II – Implementation Administration

Please see below for Wisconsin Medicaid's point of contact for the SUD Health IT Plan.

Name and Title: Mitzi Melendez, eHealth Section Chief, Division of Medicaid Services
Telephone Number: 608-261-8871
Email Address: mitzi.melendezprodoehl@dhs.wisconsin.gov

Attachment A, Section III – Relevant Documents

No additional documentation.

ATTACHMENT C: SUBSTANCE USE DISORDER MONITORING PROTOCOL

(reserved)

ATTACHMENT D: DEVELOPING THE EVALUATION DESIGN

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

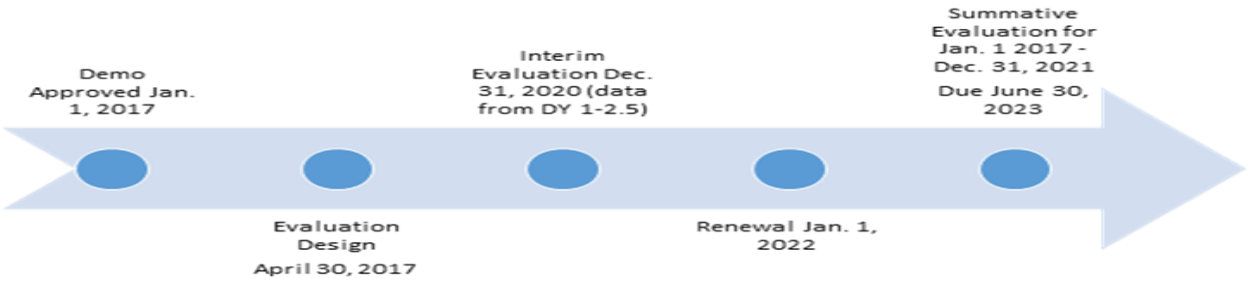
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working

to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
   a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
   b. Qualitative analysis methods may be used, and must be described in detail.
   c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

   If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
   b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
   c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
   d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				

Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

1) When the state demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure

no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT E: PREPARING THE EVALUATION REPORT

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

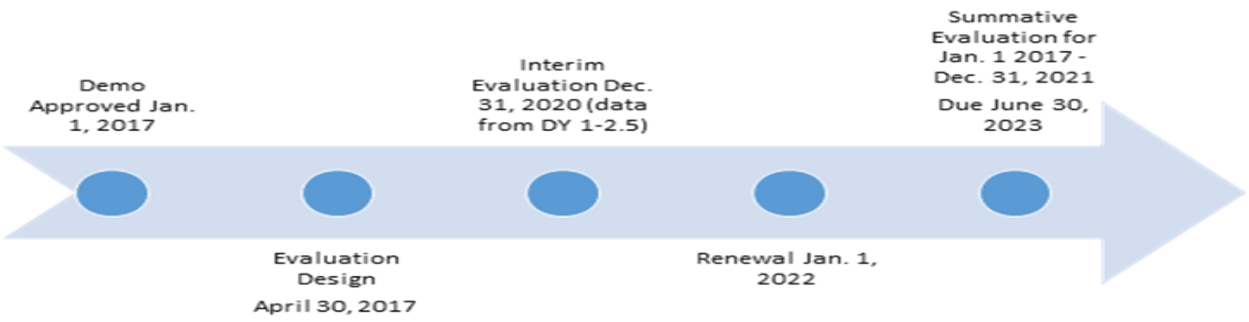
The format for the Interim and Summative Evaluation reports are as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;

G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?

2) *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period* – Describe the time periods for which data will be collected
4) *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic Methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations
This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.
1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:
1) What lessons were learned as a result of the demonstration?

2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1) Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT F: EVALUATION DESIGN

ATTACHMENT G: COMMUNITY ENGAGEMENT IMPLEMENTATION PLAN

ATTACHMENT H: MONITORING PROTOCOL

ATTACHMENT I: TRIBAL CONSULTATION PLAN