DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 30 2013

Brett Davis
Medicaid Director
Wisconsin Department of Health Services
1 West Wilson Street
Madison, WI 53703

Dear Mr. Davis:

This letter is to inform you that Wisconsin's request for a new section 1115 demonstration, entitled "BadgerCare Reform" (Project No. 11-W-00293/5), has been approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with section 1115(a) of the Social Security Act (the Act). In alignment with our correspondence sent to the state on December 20, 2013, the accompanying special terms and conditions (STCs), waivers, and expenditure authorities are effective January 1, 2014 through December 31, 2018. The demonstration will receive federal financial participation at the state's regular federal medical assistance percentage (FMAP).

This demonstration provides authority for the state to provide full state plan benefits to non-pregnant, non-disabled childless adults with effective incomes of up to 100 percent of the Federal Poverty Level (FPL) and the demonstration allows the state to require premiums to parent and caretaker adults who qualify for Medicaid through Transitional Medical Assistance (TMA) only and with incomes above 100 percent of the FPL. The sliding scale premiums under the demonstration will align with Marketplace premium levels. The demonstration permits the state to charge premiums to TMA Adults with incomes above 133 percent of the FPL from the date of TMA enrollment, and to TMA Adults with incomes from 100-133 percent of the FPL after the first 6 calendar months of TMA coverage. TMA adults who fail to pay premiums after a 30-day grace period may lose eligibility and ability to re-enroll in TMA for a period of 3 months, after which time they may re-enroll for TMA coverage, whether or not they have repaid the premiums. Individuals above 100 percent of the FPL who have completed their time-limited TMA will be reviewed first for Medicaid eligibility under other eligibility categories and, if not eligible, will be assessed for Marketplace eligibility. If appropriate, their account will be transferred to the Marketplace consistent with applicable regulations. We look forward to continuing to work with the state on its transition plan to facilitate a seamless transfer of coverage for those who will be eligible for Marketplace coverage.

The CMS' approval of the BadgerCare Reform demonstration is conditioned upon continued compliance with the enclosed set of Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated Federal involvement in the projects. The award is subject to

our receiving your written acknowledgement of the award and acceptance of both sets of STCs within 30 days of the date of this letter.

A copy of the BadgerCare Plus STCs, and waiver and expenditure authorities is enclosed. Your project officer is Leila Ashkeboussi. Leila is available to answer any questions concerning your section 1115 demonstration, and may be reached by phone at (202) 205-4730 or by email at Leila.Ashkeboussi@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted at the following address:

Division of State Demonstrations & Waivers
Center for Medicaid & CHIP Services
Mailstop: S2-01-16
7500 Security Blvd.
Baltimore, Maryland 21244-1850

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

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

If you have additional questions, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services at 410-786-5647.

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

Sincerely,

[redacted]

Marilyn Tavenner

Enclosures

cc: Verlon Johnson, 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 January 1, 2014 through 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 3 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 under TMA only. This waiver allows the state to apply premiums to TMA Adults with income above 133 percent of the FPL starting from the date of enrollment, and to TMA Adults with income from 100-133 percent of the FPL starting after the first 6 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 January 1, 2014 through December 31, 2018.

1. **Childless Adults Demonstration Population.** Expenditures for health care-related costs for childless, 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 5 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).

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 April 1, 2014, through December 31, 2018.

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.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00293/5

TITLE: Wisconsin BadgerCare Reform Demonstration Project

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) demonstration (demonstration). The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (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 the state's obligations to CMS during the life of the demonstration. The STCs are effective January 1, 2014, and the demonstration is approved through December 31, 2018.

The STCs have been arranged into the following subject areas:

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

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

Attachment A. Quarterly Report Content and Format
Attachment B. Summary of Cost Sharing
Attachment C. Demonstration Evaluation Plan (once approved)

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 sees the BadgerCare Reform demonstration as an opportunity to reduce the uninsured rate and encourage beneficiaries to access coverage in the private market.

The Wisconsin BadgerCare Reform demonstration provides state plan benefits other than family planning services and tuberculosis-related services to childless adults who have family incomes up to 95 percent of the Federal Poverty Level (FPL) (effectively 100 percent of the FPL considering a disregard of 5 percent of income), and permits the state to charge premiums to adults who are 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 6 calendar months of TMA coverage.

The demonstration will allow 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 demonstration will enable the state to test the impact of providing TMA to individuals who are paying a premium that aligns with the insurance affordability program in the Marketplace based upon their household income when compared to the FPL.

The state's goals for the program are to demonstrate whether the program will:

- Ensure every Wisconsin resident has access to affordable health insurance and reduce the state's uninsured rate.
- Provide a standard set of comprehensive benefits for low income individuals that will lead to improved healthcare outcomes.
- Create a program that is sustainable so Wisconsin's healthcare safety net is available to those who need it most.

Wisconsin had previously submitted a waiver (the BadgerCare demonstration) first implemented in April 1999 to provide coverage to uninsured children and families up to 200 percent of the FPL The demonstration was later amended to focus on providing coverage to parents and caretaker relatives with income from 150 to 200 percent of the FPL. This demonstration was last amended on July 1, 2012 to enable the state to test the effect of increased premiums on enrollment, utilization, and health outcomes on the non-pregnant, non-disabled parent/caretaker relative population. Under this existing demonstration, the state is permitted to charge premiums for TMA Adults with incomes above 133 percent of the FPL. The amendment permitted a 12-month restrictive re-enrollment policy as a penalty for non-payment of premiums, sliding scale premiums in excess of 5 percent of household income, and the application of the 9.5 percent affordability test.

Wisconsin also has prior experience providing medical assistance to childless adults up to 200 percent of the FPL under its BadgerCare Plus Health Insurance for Childless Adults

demonstration, which was approved in January 2009. This demonstration provided a limited set of benefits through the "Core Plan" for childless adults up to 200 percent FPL. Both demonstrations (BadgerCare and BadgerCare Plus Health Insurance for Childless Adults) are set to expire on March 31, 2014. The BadgerCare Reform demonstration will begin providing coverage on April 1, 2014. In addition to phasing out the BadgerCare Plus and BadgerCare demonstrations prior to the implementation of the BadgerCare Reform demonstration, the state also intends to make corresponding changes to Wisconsin's Medicaid state plan, effective April 1, 2014, which will limit Medicaid coverage for parents and caretaker relatives to those with MAGI at or below an effective income level 100 percent of the FPL.

Ultimately, the state estimates that nearly 99,000 childless adults will enroll in BadgerCare Reform in the first demonstration year. The state also estimates that nearly 5,000 childless adults will transition to the federal Marketplace and may be eligible to receive a federal tax subsidy to help them purchase private individual health insurance.

III. GENERAL PROGRAM REQUIREMENTS

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

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), 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 as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes shall be considered in force once the state accepts the changes in writing.

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

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

4. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid state plan governs.

5. **Changes Subject to the Amendment Process.** 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 **6** below.

6. **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 STC 7,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. Demonstration of Public Notice 42 CFR §431.408 and tribal consultation: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in STC 15 have been met.

   b. Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming title XIX state plan amendment, if necessary.

   c. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment.

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

e. A description of how the evaluation design will be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration.**

a. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, pursuant to 42 CFR 431.412, no later than 12 months prior to the expiration date of the demonstration when requesting an extension under section 1115(e), or no later than six months prior to the expiration date of the demonstration when requesting an extension under section 1115(f). The chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 9.

b. Compliance with Transparency Requirements at 42 CFR §431.412: As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.

c. Upon application from the state, CMS may temporarily extend the demonstration and make any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

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

   a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plans for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved Tribal Consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised transition and phase-out plan.

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

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

   c. Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR section 435.916.

   d. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX would be served or under circumstances described in 42 CFR section 431.416(g).

   e. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers

suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. **Expiring Demonstration Authority and Transition.** For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration expiration plan to CMS no later than 6 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 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 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 notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

    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 expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

    d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may amend, suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms amendment, reasons for the suspension or termination, together with the effective date.

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

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure

authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state 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.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.**

The state must comply with the public notice requirements set forth in 42 CFR § 431.416. The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)). In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR.§431.408(b)(3)).

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

15. **FFP.** No federal matching for expenditures, both administrative and service, for this demonstration will take effect until the effective date identified in the demonstration approval letter, or a later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.

IV. ELIGIBILITY

16. **State Plan Eligibility Groups Affected By the Demonstration.**

a. General requirements. Mandatory and optional state plan groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and

regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. Eligibility standards and methodologies for all state plan groups are as reflected in the state plan, unless expressly modified through the waivers, expenditure authorities, and STCs for this demonstration. Should the state amend the state plan to make any changes to eligibility for Medicaid state plan populations, upon submission of the state plan amendment, the state must notify the project officer in writing of the pending state plan amendment that has a material impact on the populations covered in this demonstration. The Medicaid Eligibility Groups (MEGs) listed in the Reporting and the Budget Neutrality sections of the STCs will be updated upon approval of changes to state plan eligibility and will be considered a technical change to the STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard will apply to this demonstration.

b. State plan populations affected by this demonstration. The state plan populations affected by the Wisconsin BadgerCare Reform demonstration are outlined in Table 1, which which summarizes each specific group of individuals; under what authority 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. For the purposes of eligibility, "disabled" is defined as meeting the disability standard for eligibility for federal supplemental security income under 42 USC 1382c(a)(3).

17. **Demonstration Expansion Eligibility Group.**

a. General. Table 1 summarizes the specific groups of individuals, under what authority 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. Population 1 is eligible under the state plan. Population 2 in Table 1 is made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration, and is subject to Medicaid laws or regulations (including all enrollment requirements described in paragraph b. below) unless otherwise specified in the not applicable expenditure authorities for this demonstration.

b. Seamless Coverage. Individuals whose incomes are determined by the Marketplace to be too low for advanced payments of the premium tax credit through the Marketplace will be considered income eligible for demonstration Population 2.

c. Application of Medicaid eligibility and enrollment policies. All Medicaid eligibility and enrollment requirements that apply to state plan groups shall apply to demonstration Population 2, including the following:

i. *Application of Modified Adjusted Gross Income (MAGI).* The state must use MAGI income rules for demonstration populations in the same manner that they are applied to the state plan.

ii. *Presumptive Eligibility*. The state will allow presumptive eligibility for demonstration population 2, to be determined and certified by qualified hospitals, in the same manner as for parents and caretaker relatives who could be eligible under the Medicaid state plan.

iii. *Redeterminations*. Redetermination of eligibility for demonstration population 2 must occur at least once every 12 months. An enrollee may request a redetermination of eligibility for the demonstration due to a change in family size (e.g., death, divorce, birth, marriage, adoption) at any time, and the state must perform such redeterminations upon request. Each redetermination must include a reassessment of the individual's eligibility for Medicaid to ensure that enrollees are not eligible for coverage under the Medicaid state plan prior to re-enrollment into the demonstration.

iv. *Disenrollment.* Demonstration Population 1 may be disenrolled for failure to pay premiums after a 30 day grace period. Once they are disenrolled, they may be restricted from re-enrollment for up to 3 months. They may enroll for other Medicaid if they become eligible during the 3-month restrictive re-enrollment period. At any point during this 3-month period, they may pay the owed premiums to re-enroll in TMA for the remainder of the 12-month TMA extension period. After the 3-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. Demonstration Population 2 beneficiaries may be disenrolled with the requisite notice (consistent with 42 CFR §431.206, §431.210, and §431.213) if they:

1. Become entitled to Medicare;
2. Become eligible for a full-benefit Medicaid state plan group;
3. Become eligible for CHIP coverage;
4. No longer reside in the state of Wisconsin;
5. Become incarcerated or are institutionalized in an institution for mental disease;
6. Have effective income greater than 100 percent of the FPL;
7. Attain age 65;
8. Are no longer living; or
9. Fail to meet other requirements that apply to state plan MAGI populations.
10. If section 1925 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.

Table 1: Eligibility Groups 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, non-disabled, 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 if section 1925 sunsets or is otherwise inapplicable, under sections 1902(e)(1) and 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 65 with an effective income that does not exceed 100 percent FPL	• Between the ages of 19 and 64 years • Effective 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 entitled to receive Medicare • Childless adults may have children, but do not qualify as a parent or caretaker relative (e.g. either the minor children are not currently living with them or those children living with them are 19 years of age or older). • The state will implement coverage for Population 2 effective April 1, 2014.	Title XIX	BC Reform Adults

19. **Transition to Marketplace Coverage.** Individuals in Population 1 above 100 percent of the FPL who have completed their time-limited TMA will be reviewed first for Medicaid eligibility under other eligibility categories and, if not eligible, will be assessed for Marketplace eligibility. If appropriate, their account will be transferred to the Marketplace consistent with applicable regulations. Beneficiaries in Populations 2 who become ineligible because of an increase in income will be transitioned to coverage through the Marketplace, as appropriate, according to the process described below:

    a. Ongoing Administrative Reviews to Determine Alternative Medicaid Eligibility Category. Before beginning the transition to the Marketplace, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different Medicaid eligibility category as discussed in the October 1, 2010 State Health Official Letter #10-008.

    b. Notice and Hearings and Appeals. The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.

    c. Transfer of Enrollees Eligibility Information to the Marketplace. The state must transfer all of an individual's eligibility information to the Marketplace.

V. BENEFITS

20. **Wisconsin BadgerCare Reform.** 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 those individuals. Beneficiaries in the demonstration childless adult demonstration population will not receive family planning services or tuberculosis-related services. In addition, beneficiaries in the demonstration adult population 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.

VI. COST SHARING

21. **Cost sharing.** For all enrollees in this demonstration, except for premiums for TMA Adults, 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. Cost sharing for BC Reform Adults will be the same as indicated in the Medicaid state plan as applicable to non-pregnant, individuals who are 19 to 64 years of age. The premium requirements described in this section for TMA Adults will be implemented by the state on April 1, 2014.

    a. Premiums for TMA Adults-- TMA Adults with income above 133 percent of the FPL are subject to monthly premiums based on the sliding scale as outlined in Attachment B from the date of enrollment. The 5 percent MAGI disregard does not apply for the

income thresholds for calculating premiums. TMA Adults with effective income between 100 percent and 133 percent of the FPL are subject to monthly premiums based on a sliding scale starting 6 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 3 months for demonstration participants who fail to make a premium payment. However, a participant may re-enroll at any point during this 3-month period by paying owed premiums. After the 3-month disenrollment period, 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. If section 1925 sunsets or is otherwise inapplicable and TMA is then available only for a 4-month extension, Demonstration Population 1 individuals may not re-enroll in TMA. No premium may be charged during the 3-month exclusion period, and premiums that remain unpaid from a prior TMA enrollment period may not be used as a basis for termination of the reenrollment period.

b. 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 exceeds 200 percent of the FPL), 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 above, 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 above 133 percent FPL 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.

c. American Indians are exempt from the premium amounts outlined above

d. The state will mail letters to the demonstration participants, who will be disenrolled for failure to pay premiums with notice of the disenrollment and right to an appeal.

e. The state will monitor and include in the quarterly report information related to disenrollments from the demonstration including nonpayment of premiums broken down by the income levels specified in the table in Appendix B.

VII. DELIVERY SYSTEM

22. **General.** BadgerCare Reform beneficiaries will be enrolled in the current managed care organization (MCO) provider network that provides health care services to the existing Medicaid and BadgerCare Reform programs in most of the state to serve persons eligible under this demonstration. Demonstration enrollees will be required to join an 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 enrolled in an MCO or not must be provided a Medicaid card. MCOs may elect to provide an MCO specific card to MCO enrollees as well. The state must comply with the manage 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 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.

VIII. GENERAL REPORTING REQUIREMENTS

23. **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 IX of these STCs.

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

25. **Monitoring Calls.** CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration, including early planning for potential future renewal activities. Areas to be addressed include, but are not limited to: transition and implementation activities, stakeholder concerns, including those raised at the Native American Advisory Board and the Native American Technical Advisory Subcommittee, MCO operations and performance, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the state is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

26. **Post Award Forum Transparency Requirement:** The state must comply with the Post Award Forum transparency requirements set forth in 42 CFR § 431.420. Within 6 months after the implementation date of the demonstration and annually thereafter the state must hold a public forum to solicit comments on the progress of a demonstration project. The state shall include a summary of the forum in the quarterly report associated with the quarter in which the forum was held, as well as in its annual report to CMS. The public forum to solicit feedback on the progress of a demonstration project must occur using one of the following:

    a. A Medical Care Advisory Committee that operates in accordance with 42 CFR § 431.412

    b. A commission or other similar process, where meetings are open to members of the public, and would afford an interested party the opportunity to learn about the demonstration's progress.

    The State must publish the date, time, and location of the public forum in a prominent location on the State's public Web site, at least 30 days prior to the date of the planned public forum.

27. **Quarterly Progress Reports.** The state must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include the following, but are not limited to:

    a. An updated budget neutrality monitoring spreadsheet;

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

    c. A summary of any issues identified or recommendations made during the semi-annual consultation meeting between the Department and the federally recognizes tribes in Wisconsin, as well as tribal consultations with the Wisconsin Tribal Health Directors Association and other ad hoc meetings with tribal representation;

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

    e. Monthly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population;

    f. Complaints, grievances and appeals filed during the quarter by type.

g. Evaluation activities and interim findings. 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. The discussion shall also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; status of Institutional Review Board approval, if applicable; and status of study participant recruitment, if applicable.

h. Identify any quality assurance/monitoring activity in current quarter.

28. **Demonstration Annual Report.** The annual report must, at a minimum, include the requirements outlined below. The state will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the Demonstration Year (DY) to CMS.

    a. All items included in the quarterly report pursuant to STC 27 must be summarized to reflect the operation/activities throughout the DY;

    b. A budget neutrality workbook that contains total annual expenditures for the demonstration population for each DY including a comparison analysis of the projected without waiver and with waiver cost analysis to the actual expenditures, with administrative costs reported separately;

    c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement.

    d. The number of TMA Adults who are disenrolled per month starting from April 1, 2014, due to non-premium payment.

29. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

IX. 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:

30. **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 **X** of the STCs.

31. **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, he 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 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 X 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"**

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 1through December 31, 2015	Demonstration Year 2 (DY2)
January through December 31, 2016	Demonstration Year 3 (DY3)
January 1 through December 31, 2017	Demonstration Year 4 (DY4)
January 1 through December 31, 2018	Demonstration Year 5 (DY5)

32. **Administrative Costs.** Administrative costs 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 "ADM".

33. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

34. **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 27, the actual number of eligible member months for BCReform Demo Adults. 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 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

35. **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 makefFederal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. 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.

36. **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.

37. **Sources of Non-Federal Share.** The state must certify that the matching non-federal share of funds for the demonstration are 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.

38. **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.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

39. **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.

40. **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.

41. **Calculation of the Budget Neutrality Limit:** For the purpose of calculating the overall budget neutrality limit for the demonstration, an annual budget limits 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 43 below. The demonstration expenditures subject to the budget neutrality limit related to demo population 2 as described in STC 17(c) are those reported under the following Waiver Name: BC Reform Adults.

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

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
BCReform Adults	5.1% (with 5.0% for Year 1 of waiver)	582.68	612.40	643.63	676.46	710.95

42. **Hypothetical Eligibility Group.** BC Reform Adults (as related to population 2 defined under pagragraph 17(c) of the STCs) is considered to be a hypothetical population for budget neutrality. BC Reform Adults consists of individuals who could have been added to the Medicaid program through the state plan, but instead are covered through demonstration authority. The budget neutrality expenditure limit for BC Reform Adults reflects the expected costs for this population, 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 that could be used to offset the cost of other, non-hypothetical expenditures.

43. **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.

44. **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.

45. **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

46. **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.

XI. EVALUATION OF THE DEMONSTRATION

47. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval within 120 days of the approval date of the new demonstration a draft evaluation design. At minimum, the draft design must include a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan must cover all elements in STC 48. The design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroguly documents.

    The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal per review, as appropriate for each aspect of the evaluation including standards for the evaluation design, conduct, interpretation, and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.
    The design must describe the state's process to contract with an independent evaluator, enrusing no conflict of interest.

    The design, including the contracting budget and adequacy of approach to assure the evaluation meets the requirements of STC 48, is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected in the paragraph above.

48. **Evaluation Design.**

    a. Domains of Focus – The state must propose as least one research question that it will investigate within each of the domains listed below. The research questions should focus on processes and outcomes that relate to the CMS Three-Part Aim of better care, better health, and reducing costs.

    b. Core Elements of Demonstration Evaluation. As outlined below, the evaluation describes whether the state met the demonstration goal and objectives with recommendations for future efforts. The state must submit to CMS for approval a revised evaluation design no later than September 1, 2014. At a minimum, the revised draft evaluation design must include a discussion of the goals, objectives, and evaluation questions specific to the entire demonstration. Specifically, the evaluation must test the following specific hypotheses related to sliding scale premiums required for those demonstration participants whose income exceeds the 100 percent FPL (TMA adults) and the effectiveness of the demonstration's expanded eligibility of Medicaid for BC Reform at or below an effective income of 100 percent FPL:

        i. For the TMA demonstration participants, will the premium requirement reduce the incidence of unnecessary services, slow the growth in healthcare spending, and increase the cost effectiveness of Medicaid services?

ii. Is there any impact on utilization and/or costs associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?
iii. Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for individuals that have disenrolled and then re-enrolled?
iv. What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment? Does this impact vary by income level (if so, include a break out by income level)?
v. What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?
vi. How is enrollment or access to care affected by the application of new, or increased, premium amounts?
vii. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries result in improved health outcomes, a reduction in the incidence of unnecessary services, an increase in the cost effectiveness of Medicaid services and an increase in the continuity of health coverage?

Methods by which the state can evaluate these hypotheses include enrollment data, premium statistics, utilization and cost data associated with this population compared to childless adults and TMA adults outside of the demonstration, as well as similar populations covered under previous demonstrations prior to April 1, 2014.

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

c. Measures. The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:
   i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);
   ii. The baseline data that will be used and baseline value for each measure;
   iii. Any sampling methodology that may be used for assessing these outcomes; and
   iv. The methods and timing of data collection.

d. Sources of Measures. CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set

of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

49. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design and the draft evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS' comments. Once approved by CMS, the evaluation plan will become Attachment C of these STCs. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation final report by June 1, 2019 The state must submit the final evaluation report within 60 days after receipt of CMS' comments. The final report must include the following:
    a. An executive summary;
    b. A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;
    c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;
    d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);
    e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and
    f. Successes, challenges, and lessons learned.

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

51. **Completion of Expiring Demonstrations' Evaluations.** By September 30, 2014, the state must submit a draft final evaluation report (or reports) for the BadgerCare and BadgerCare Plus Health Insurance for Childless Adults demonstrations to CMS. This requirement supersedes any corresponding requirement included in the special terms and conditions for those demonstrations. The draft final report(s) will include reports on all evaluations conducted under the CMS-approved evaluation plans for those demonstrations. CMS will provide comments within 60 days after receipt of the report, and the State must submit the final evaluation report within 60 days after receipt of CMS's comments.

XII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date – Specific	Deliverables	STC Reference
Submission of notification letter and draft phase-out plan due 6 months before the effective date of demonstration's suspension or termination	Demonstration Transition and Phase Out Plan	STC 9
Within 6 months after the implementation date of the demonstration and annually thereafter	Post Award Public Forum pursuant to 42 CFR §431.420	STC 26
Submission due no later than 60 days following the end of each quarter	Quarterly Progress Reports	STC 27
Submission due 90 days after the end of each DY	Draft Annual Reports	STC 28
Submission due within 30 days of receipt of comments from CMS each DY	Final Annual Reports	STC 28
Submission due by June 30, 2019 (i.e. 120 days following the end of the demonstration) for CMS comments. The final report is due to CMS no later than 120 days after receipt of CMS' comments.	Final Report	STC 29
With quarterly reports	Quartery Financial Reports	STC 30
Submission of draft evaluation design within 120 days of the approval date. CMS shall provide comments on the draft design and the draft evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of	Evaluation Design	STC 47

receipt of CMS' comments (September 1, 2014).		
Submission of draft final report due to CMS by June 1, 2019. The state must submit the final evaluation report within 60 days after receipt of CMS' comments	Final Evaluation	STC 49
September 30, 2014	Final evaluation report for expiring BadgerCare and BadgerCare Plus Evaluation	STC 51

ATTACHMENT A. QUARTERLY REPORT CONTENT AND FORMAT

Pursuant to STC 27 *(Quarterly Progress Report)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One –Wisconsin BadgerCare Reform 1115 Waiver Demonstration
Title Line Two – Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
[Example: Demonstration Year: 1 (4/1/2014– 12/31/2014)
Federal Fiscal Quarter:
Footer: Date on the approval letter through December 31, 2018]

Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

Enrollment and Benefits Information

Discuss the following:
Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.
Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

Information about the beneficiary rewards program, including the number of people participating, credits earned, and credits redeemed.

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

Enrollment Counts for Quarter and Year to Date

Note: Enrollment counts should be unique enrollee counts, not member months

Demonstration Populations	Total Number of Demonstration participants Quarter Ending – MM/YY	Current Enrollees (year to date)	Disenrolled in Current Quarter	TMA Adults disenrolled due to non-payment of premiums
BC Reform Adults				
TMA Adults				

IV. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

VI. Operational/Policy/Systems/Fiscal Developments/Issues

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

IX. Financial/Budget Neutrality Development/Issues

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

X. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations[1]

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
BC Reform Adults				

XI. Consumer Issues

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

XII. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XIII. Managed Care Reporting Requirements

Address network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of MCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation. The state must include additional reporting requirements within the annual report as outlined in STC 28.

XIV. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XV. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XVI. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

Attachment B. Summary of Cost-sharing for TMA Adults Only

Individuals affected by, or eligible under, the demonstration will with the co-payments below.

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%

Attachment C. Demonstration Evaluation Plan