DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

April 6, 2021

Jim Jones
Medicaid Director
Division of Medicaid Services, Department of Health Services
1 West Wilson Street, Room 350
Madison, WI 53702

Dear Mr. Jones:

On February 12, 2021, the Centers for Medicare & Medicaid Services (CMS) sent you a letter regarding the October 31, 2018 extension of the section 1115 demonstration project entitled "BadgerCare Reform" (Project Number 11-W-00293/5). The letter advised that CMS would commence a process of determining whether or not to withdraw the authorities previously approved in the BadgerCare Reform demonstration that permit the state to require work and other community engagement activities as a condition of continued Medicaid eligibility through the demonstration. It explained that in light of the ongoing disruptions caused by the COVID-19 pandemic, Wisconsin's community engagement requirement risks significant coverage losses and harm to beneficiaries. For the reasons discussed below, CMS is now withdrawing approval of the community engagement requirement in the October 31, 2018 extension of the BadgerCare Reform demonstration, which is not currently in effect and which would have expired by its terms on December 31, 2023.

Section 1115 of the Social Security Act (the Act) provides that 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 programs under the Act. In so doing, the Secretary may waive Medicaid program requirements of section 1902 of the Act, and approve federal matching funds per section 1115(a)(2) for state spending on costs not otherwise matchable under section 1903 of the Act, which permits federal matching payments only for "medical assistance" and specified administrative expenses.[1] Under section 1115 authority, the Secretary can allow states to undertake projects to test changes in Medicaid eligibility, benefits, delivery systems, and other areas across their Medicaid programs that the Secretary determines are likely to promote the statutory objectives of Medicaid.

As stated in the above referenced letter sent on February 12, 2021, under section 1115 and its implementing regulations, CMS has the authority and responsibility to maintain continued oversight of demonstration projects in order to ensure that they are currently likely to assist in promoting the objectives of Medicaid. CMS may withdraw waivers or expenditure authorities if it "find[s] that [a] demonstration project is not likely to achieve the statutory purposes." 42 C.F.R. § 431.420(d); see 42 U.S.C. § 1315(d)(2)(D).

As the February 12, 2021 letter explained, the BadgerCare Reform community engagement requirement is not in effect. Although the amendment and extension was approved in October

[1] 42 U.S.C. § 1315.

2018, the state has not yet implemented the community engagement requirement. Since that time, the COVID-19 pandemic and its expected aftermath have made the BadgerCare Reform community engagement requirement infeasible. In addition, implementation of the community engagement requirement is currently prohibited by the Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, Div. F, § 6008(a) and (b), 134 Stat. 208 (2020), which conditioned a state's receipt of an increase in federal Medicaid funding during the pandemic on the state's maintenance of certain existing Medicaid parameters. Wisconsin has chosen to claim the 6.2 percentage point FFCRA Federal Medical Assistance Percentage (FMAP) increase, and therefore, while it does so, must maintain the enrollment of beneficiaries who were enrolled as of, or after, March 18, 2020.

The February 12, 2021 letter noted that, although the FFCRA's bar on disenrolling such beneficiaries will expire after the COVID-19 public health emergency ends, CMS still has serious concerns about testing policies that create a risk of substantial loss of health care coverage and harm to beneficiaries even after the expiration of the bar on disenrolling beneficiaries. The COVID-19 pandemic has had a significant impact on the health of Medicaid beneficiaries. Uncertainty regarding the current crisis and the pandemic's aftermath, and the potential impact on economic opportunities (including job skills training, work and other activities used to satisfy the community engagement requirement, i.e., work and other similar activities), and access to transportation and affordable child care, have greatly increased the risk that implementation of the community engagement requirement approved in this demonstration will result in substantial coverage loss. In addition, the uncertainty regarding the lingering health consequences of COVID-19 infections further exacerbates the harms of coverage loss for Medicaid beneficiaries.

Accordingly, the February 12, 2021 letter indicated that, taking into account the totality of circumstances, CMS had preliminarily determined that allowing the community engagement requirement to take effect in Wisconsin would not promote the objectives of the Medicaid program. Therefore, CMS provided the state notice that we were commencing a process of determining whether to withdraw the authorities approved in the BadgerCare Reform demonstration that permit the state to require work and other community engagement activities as a condition of Medicaid eligibility through the demonstration. See Special Terms and Conditions ¶ 11. The letter explained that if CMS ultimately determined to withdraw those authorities, it would "promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date." *Id*. The February 12, 2021 letter indicated that, if the state wished to submit to CMS any additional information that in the state's view may warrant not withdrawing those authorities, such information should be submitted to CMS within 30 days. We have not received any additional information from Wisconsin in response to the February 12, 2021 letter.

In light of these concerns, for the reasons set forth below, CMS has determined that, on balance, the authorities that permit Wisconsin to require work and community engagement as a condition of eligibility are not likely to promote the objectives of the Medicaid statute. Therefore, we are withdrawing the community engagement authorities that were added in the Secretary's October 31, 2018 extension approval of the BadgerCare Reform demonstration.

Background of Wisconsin's Demonstration

The BadgerCare Reform demonstration was originally approved by CMS on December 30, 2013. Wisconsin has not adopted the Affordable Care Act (ACA) new adult group population (beneficiaries authorized under 1902(a)(10)(a)(i)(VIII) of the Act), but the 2014 approval of the BadgerCare Reform section 1115 demonstration expanded coverage to a childless adult population through expenditure authority under section 1115(a)(2) of the Act. The BadgerCare Reform demonstration primarily provides authority for the state to provide most Medicaid 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).

On October 31, 2018, CMS approved an amendment as part of the demonstration extension requiring most of the childless adult beneficiaries, ages 19 to 49, with certain exceptions, to participate in and timely document and report 80 hours per month of community engagement activities, such as employment, job skills training, or community service, as a condition of continued Medicaid eligibility. Failure to comply with the requirement for 48 cumulative months (or qualify for an exemption) would result in disenrollment from the demonstration and the individual would be locked out of re-enrollment for six months (unless eligible during the six-month period under a different Medicaid eligibility group). After completing the six-month lockout period, the individual would be eligible to reapply for coverage in the childless adult demonstration population, if otherwise still eligible.

Early Experience from the Implementation of Community Engagement Requirements through Medicaid Section 1115 Demonstrations in Other States

The community engagement requirement under the BadgerCare Reform demonstration has never been implemented due to delays initiated by the state prior to the COVID-19 pandemic,[2,3] and subsequently because of the pandemic. A Medicaid and CHIP Payment and Access Commission (MACPAC) Issue Brief from June 2020 indicated that Wisconsin had not yet specified how it would track and verify beneficiary compliance with the community engagement requirement, or exemptions from it, in any public documents,[4] and this information was not provided in the state's preliminary draft implementation plan submitted to CMS.

Although the demonstration's community engagement requirement was never implemented, data suggest that there is a relatively small minority of beneficiaries who would have been subjected to the community engagement requirement. According to research from the Kaiser Family Foundation using the Current Population Survey (CPS) data,[5] in Wisconsin, 75 percent (63

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[2] The Associated Press. (2020). Wisconsin seeks to delay Medicaid work requirement again. Retrieved from https://apnews.com/article/39766cea4e958a8845738b729a850186

[3] State of Wisconsin Joint Committee on Finance. (2019). 14-Day Passive Review Approval – DHS. Retrieved from https://docs.legis.wisconsin.gov/misc/lfb/jfc/100_section_16_505_16_515_passive_review_requests/2019_10_08_health_services_badgercare_reform_demonstration_project.pdf

[4] MACPAC Issue Brief. (2020). Medicaid Work and Community Engagement Requirements. Medicaid and CHIP Payment and Access Commission. Retrieved from https://www.macpac.gov/wp-content/uploads/2019/10/Medicaid-Work-and-Community-Engagement-Requirements.pdf

[5] Garfield, R., Rudowitz, R., Guth, M. Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from

percent nationally) of Medicaid beneficiaries aged 19 to 64 without Supplemental Security Income (SSI) in 2019 were working, and of those who were not working in Wisconsin, 32 percent (27 percent nationally) indicated that their reason for not working was due to illness or disability. While data for Wisconsin were too limited to be conclusive, more than half of Medicaid beneficiaries not working nationally indicated they were caretaking or attending school. Under Wisconsin's community engagement requirement, illness, disability, educational activities, and caregiving are qualifying exemptions. Accordingly, these data suggest that the vast majority of beneficiaries who could be subject to Wisconsin's community engagement requirement but were not working would have been otherwise exempt from the requirement. Thus, if implemented, there would be little margin for the program to increase work or community engagement in Wisconsin.

This is consistent with research indicating more generally that most Medicaid beneficiaries are already working or are likely to be exempt from a potential community engagement requirement.[6,7,8,9] For example, the Kaiser Family Foundation found that 81 percent of adults with Medicaid coverage live in families with a working adult, and 6 in 10 are working themselves.[10] Similarly, a study published in 2017 reported that, out of the 22 million adults covered by Medicaid nationwide (representing 58 percent of all adults on Medicaid) who could be subject to a community engagement requirement designed like that in the BadgerCare Reform demonstration, 50 percent were already working, 14 percent were looking for work, and 36 percent were neither working nor looking for work.[11] For those beneficiaries not working or looking for work, 29 percent indicated that they were caring for a family member, 17 percent were in school, and 33 percent noted that they could not work because of a disability (despite excluding from analysis those qualifying for Medicaid on the basis of disability, highlighting the difficulty with disability determination), with the remainder citing layoff, retirement, or a temporary health problem.

Thus, overall, prior to the pandemic, the available data indicated that the substantial majority of the population that would be targeted by a community engagement requirement in Wisconsin's

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https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/

[6] Garfield, R., Rudowitz, R., Guth, M. Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/

[7] Huberfeld, N. (2018). Can work be required in the Medicaid program? N Engl J Med;378:788-791. DOI: 10.1056/NEJMp1800549

[8] Goldman, A.L., Woolhandler, S, Himmelstein, D.U., Bor, D.H. & McCormick, D. (2018). Analysis of work requirement exemptions and Medicaid spending. JAMA Intern Med, 178:1549-1552. DOI:10.1001/jamainternmed.2018.4194

[9] Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center of Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed

[10] Garfield, R., Rudowitz, R., Guth, M. Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/

[11] Leighton Ku, L & Brantley, E. (2017). Medicaid Work Requirements: Who's At Risk? Health Affairs Blog. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20170412.059575/full/

demonstration were already meeting the terms of the community engagement requirement or would qualify for an exemption from it. This makes it challenging for community engagement requirements to produce any meaningful impact on employment outcomes by incentivizing behavioral changes in a small fraction of beneficiaries, all the while risking substantial coverage losses among those subject to the requirements.

Arkansas, Michigan, and New Hampshire, three states where a community engagement requirement as a condition of Medicaid eligibility was in effect, provide some early evidence on potential enrollment impacts.[12,13] Experience from these states indicates that large portions of the beneficiaries subjected to these states' community engagement requirements failed to comply with the community engagement reporting requirements or became disenrolled once the requirements were implemented. In Arkansas, for instance, before the court halted the community engagement requirement, the state reported that from August 2018 through December 2018, 18,164 individuals were disenrolled from coverage for "noncompliance with the work requirement."[14] During these five months, the monthly rate of coverage loss as a percentage of those who were required to report work and community engagement activities fluctuated between 20 and 47 percent.[15] In New Hampshire, almost 17,000 beneficiaries (about 40 percent of those subject to the requirement) were set to be suspended for non-compliance with the requirement and lose Medicaid coverage within the span of just over a month when that state's community engagement requirement was in effect.[16,17,18] Based on that early data, another study projected that between 30 and 45 percent of New Hampshire beneficiaries subject to the community engagement requirement would have been disenrolled within the first year of implementation.[19] And in Michigan, before the policy was vacated by the courts, 80,000

[12] Utah and Indiana also briefly implemented the community engagement requirement that was part of these states' section 1115 demonstrations, but the program designs in these states did not require beneficiaries subject to the community engagement requirement to comply with reporting minimum-hours requirement within the period the requirement was in effect in each state.

[13] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from https://aspe.hhs.gov/pdf-report/medicaid-demonstrations-andimpacts

[14] Arkansas Department of Human Services (DHS). (2018 & 2019). Arkansas Works Section 1115 Demonstration Annual Reports. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf; https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-annl-rpt-jan-dec-2019.pdf

[15] Arkansas Department of Human Services (DHS). (2018). Arkansas Works Section 1115 Demonstration Annual Report: January 1, 2018 – December 31, 2018. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf

[16] Wagner, J., & Schubel, J. (2020). States' experiences confirming harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[17] New Hampshire Department of Health and Human Services. (2019). DHHS Community Engagement Report: June 2019. Retrieved from https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf

[18] Hill, I., Burroughs, E., & Adams, G. (2020). New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results. Urban Institute. Retrieved from https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results

[19] The Commonwealth Fund Blog. (2019). New Hampshire's Medicaid Work Requirements Could Cause More Than 15,000 to Lose Coverage. Retrieved from https://www.commonwealthfund.org/blog/2019/new-hampshires-medicaid-work-requirements-could-cause-coverage-loss

beneficiaries—representing nearly 33 percent of individuals subject to the community engagement requirement—were at risk of suspension, if not loss of coverage, for failing to report compliance with the community engagement requirement.[20]

Despite state assurances in the demonstration's Special Terms and Conditions that Wisconsin would provide the necessary outreach to Medicaid beneficiaries, experience from other states with similar community engagement requirements shows that despite similar assurances, lack of awareness of and administrative barriers associated with community engagement requirements create serious challenges for beneficiaries, which could result in significant coverage losses.[21] In fact, there was evidence of widespread confusion and lack of awareness among demonstration beneficiaries regarding the community engagement requirements[22] in the states where the requirements were implemented. For example, many beneficiaries in New Hampshire reportedly did not know about the community engagement reporting requirement or received confusing and often contradictory notices about whether they were subject to the requirement.[23,24] Moreover, in Arkansas, Michigan, and New Hampshire, evidence suggests that even individuals who were working or those who had serious health needs, and therefore should have been eligible for exemptions, lost coverage or were at risk of losing coverage because of complicated administrative and paperwork requirements.[25] Beneficiaries also reported barriers to obtaining exemptions from the community engagement requirement. For example, beneficiaries with physical and behavioral health conditions reported that their providers were resistant to signing forms needed to establish that the beneficiary was unable to work so that the beneficiary could qualify for an exemption.[26]

Losing health care coverage undoubtedly has negative consequences for affected beneficiaries down the road. For example, according to Sommers et al. (2020), in Arkansas, those ages 30–49 who had lost Medicaid or Marketplace coverage in the prior year experienced significantly higher medical debt and financial barriers to care, compared to similar Arkansans who

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[20] Wagner, J., & Schubel, J. (2020). States' Experiences Confirm Harmful Effects of Medicaid Work Requirements. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[21] Margo Sanger-Katz. (2018). Hate Paperwork? Medicaid Recipients Will Be Drowning in It. New York Times. Retrieved from https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html.

[22] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from https://aspe.hhs.gov/pdf-report/medicaid-demonstrations-andimpacts.

[23] Solomon, D. (2019). Spreading the Word on Medicaid Work Requirement Proves Challenging. Union Leader. Retrieved from https://www.unionleader.com/news/health/spreading-the-word-on-medicaid-work-requirement-proves-challenging/article_740b99e7-9f48-52d4-b2d8-030167e66af8.html

[24] Moon, J. (2019). Confusing Letters, Frustrated Members: N.H.'s Medicaid Work Requirement Takes Effect. New Hampshire Public Radio. Retrieved from https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0

[25] Wagner, J., & Schubel, J. (2020). States' Experiences Confirm Harmful Effects of Medicaid Work Requirements. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[26] Hill, I., Burroughs, E., & Adams, G. (2020). New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results. Urban Institute. Retrieved from https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results

maintained coverage.[27] Specifically, 50 percent of Arkansans affected by disenrollment in that age group reported serious problems paying off medical bills; 56 percent delayed seeking health care and 64 percent delayed taking medications because of cost considerations.[28] These rates were all significantly higher than among individuals who retained coverage in Medicaid or Marketplace all year. Evidence also indicates that those with chronic conditions were more likely to lose coverage,[29] which could lead to worse health outcomes in the future.

In all states, consistent and stable employment is often out of reach for beneficiaries who might be subject to a community engagement requirement. Many low-income beneficiaries face a challenging job market, which often offers only unstable or low-paying jobs with unpredictable or irregular hours, sometimes resulting in spells of unemployment, particularly in seasonal work.[30,31,32] The Wisconsin BadgerCare Reform demonstration's rigid requirement for reporting 80 or more hours every month is a concern even for low-income adults who are working. For example, 46 percent of this group nationally, as well as 25 percent of those working as many as 1,000 hours during a year (which would be sufficient for meeting the 80-hour monthly requirement) could be at risk of losing coverage for one or more months because they would not meet the 80-hour minimum requirement in every month.[33,34]

Furthermore, research examining the outcomes of statutorily authorized work requirements in other public assistance programs, such as Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) indicates that such requirements generally have only modest and temporary effects on employment, failing to increase long-term

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[27] Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. Health Affairs, 39(9), 1522-1530. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538

[28] Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. Health Affairs, 39(9), 1522-1530. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538

[29] Chen, L. & Sommers, B.D. (2020). Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018. American Journal of Public Health, 110, 1208-1210. DOI https://doi.org/10.2105/AJPH.2020.305697

[30] Butcher, K. & Schanzenbach, D. (2018). Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in

[31] Center on Budget and Policy Priorities. (2020). Taking Away Medicaid for Not Meeting Work Requirements Harms Low-Wage Workers. Retrieved from https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-low-wage-workers

[32] Gangopadhyaya, A., Johnston, E., Kenney, G. & Zuckerman, S. (2018). Kentucky Medicaid Work Requirements: What Are the Coverage Risks for Working Enrollees? Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/98893/2001948_kentucky-medicaid-work-requirements-what-are-the-coverage-risks-for-working-enrollees.pdf

[33] Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center of Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed

[34] Aron-Dine, A., Chaudhry, R. & Broaddus, M. (2018). Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements. Retrieved from https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements

employment or reduce poverty.[35,36,37] Additionally, studies have found that imposing work requirements in the SNAP program led to substantial reductions in enrollment, even after controlling for changes in unemployment and poverty levels.[38] In fact, evidence suggests that there were large and rapid caseload losses in selected areas after SNAP work requirements went into effect, similar to what early data from Arkansas show, and what appeared would likely to happen in New Hampshire and Michigan after these states began implementing community engagement requirements, if those states' community engagement requirements had been implemented long enough to reach the scheduled suspensions or disenrollments.

Therefore, existing evidence from states that have implemented community engagement requirements through Medicaid demonstrations, evidence from other public programs with work requirements, and the overall work patterns and job market opportunities for the low-income adults who would be subject to such requirements all highlight the potential ineffectiveness of community engagement requirements at impacting employment outcomes for the target population. And while there are variations in the design and implementation of community engagement requirements in each state that has implemented such a requirement, as well as differences in employment and economic opportunities, findings from the states that implemented community engagement requirements point in the general direction of coverage losses among individuals subject to such requirements.

Thus, CMS is not aware of any reason to expect that the community engagement requirement as a condition of eligibility in Wisconsin's Medicaid demonstration project would have a different outcome in the future than what was observed during the initial implementation of such a requirement in other states. Accordingly, there is risk that Wisconsin's demonstration project, as extended and amended in October 2018, will lead to substantial coverage losses, a risk that is exacerbated by the ongoing COVID-19 public health emergency and its likely aftermath.

Impact of COVID-19 and its Aftermath

The COVID-19 pandemic and the uncertainty surrounding the long-term effects on economic activity and opportunities across the nation exacerbate the risks associated with tying a community engagement requirement to eligibility, making Wisconsin's community engagement requirement infeasible under the current circumstances. There is a substantial risk that the COVID-19 pandemic and its aftermath will have a negative impact on economic opportunities

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[35] Katch, H., Wagner, J. & Aron-Dine, A. (2018). Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce

[36] Danziger, S.K., Danziger, S., Seefeldt, K.S. & Shaefer, H.L. (2016). From Welfare to a Work-Based Safety Net: An Incomplete Transition. Journal of Policy Analysis & Management, 35(1), 231-238. DOI: https://doi.org/10.1002/pam.21880

[37] Pavetti, L. (2016). Work Requirements Don't Cut Poverty, Evidence Shows. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows

[38] Ku, L., Brantley, E. & Pillai, D. (2019). The Effects of SNAP Work Requirements in Reducing Participation and Benefits From 2013 to 2017. American Journal of Public Health 109(10), 1446-1451. DOI: https://doi.org/10.2105/AJPH.2019.305232. Retrieved from https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305232

for Medicaid beneficiaries. If employment opportunities are limited, Medicaid beneficiaries may find it difficult to obtain paid work in the aftermath of the COVID-19 pandemic.[39,40]
As discussed above, prior to the pandemic, most adult Medicaid beneficiaries who did not face a barrier to work were working full or part-time.[41] However, one in three working adult Medicaid beneficiaries was doing only part-time work prior to the COVID-19 public health emergency, often due to fewer opportunities for full-time employment. The pandemic is expected to only have aggravated the challenges of finding full-time employment, along with causing greater obstacles from lack of childcare options or increased caregiving responsibilities.[42]

Moreover, during the pandemic, the different sectors of the economy have seen disparate levels of disruption, which has affected labor market outcomes for certain populations more than the others. While the national employment rate[43] declined by 10.2 percent from January 2020 to January 2021, employment rates for workers in the bottom wage quartile decreased by a larger percentage than for workers in the highest wage quartile across that time period (28.7 percent vs. 1.7 percent).[44] In Wisconsin, employment rates for low-wage earners (i.e., annual wages under $27,000) declined by 25 percent, compared to virtually no change in employment rates for high-wage earners (i.e., wages above $60,000 per year) from January 2020 to January 2021.[45]

Further, declines in employment have been much higher for Black and Hispanic women and for workers in several low-wage service sectors, such as hospitality and leisure, while workers in other sectors, such as financial services, have seen virtually no change.[46] In April 2020, the estimated unemployment rates (including individuals who were employed but absent from work and those not in the workforce but who wanted employment) for the Black and Hispanic populations were as high as 32 and 31 percent, respectively, compared to 24 percent for the White population.[47] Hispanic populations specifically are more likely to be affected due to their

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[39] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[40] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

[41] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[42] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[43] Not seasonally adjusted.

[44] Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from www.tracktherecovery.org

[45] Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from www.tracktherecovery.org

[46] Rouse, C. (2021). The Employment Situation in February. The White House Briefing Room. Retrieved from https://www.whitehouse.gov/briefing-room/blog/2021/03/05/the-employment-situation-in-february/

[47] Fairlie, R., Couch, K. & Xu, H. (2020). The Impacts of COVID-19 on Minority Unemployment: First Evidence from April 2020 CPS Microdata. National Bureau of Economic Research. Retrieved from https://www.nber.org/system/files/working_papers/w27246/w27246.pdf

disproportionate representation in industries such as hospitality and construction, which have been most affected by the pandemic-related layoffs.[48,49,50]

Moreover, pandemic-related job and income losses have been more acute among the low-income population—those with the least wherewithal to withstand economic shocks, and who are disproportionately enrolled in Medicaid.[51] In fact, 52 percent of lower income adults (annual income below $37,500) live in households where someone has lost a job or taken a pay cut due to the pandemic.[52] Understandably, households with a job or income loss were two–to-three times more likely to experience economic hardship than those who did not experience such a loss.[53,54] Fifty-nine percent of lower-income adults said they worry every day or almost every day about paying their bills.[55] There are also racial and ethnic disparities in the likelihood of reporting hardships; for example, compared to White households, Black households reported significantly higher chances of putting off filling prescriptions and difficulties making housing and other bill payments. Also, Hispanic households were more likely to experience food insecurity compared to White households.[56,57]

Existing disparities in access to computers and reliable internet may also exacerbate issues in finding and maintaining employment during the pandemic. For example, 29 percent of adults in households with annual incomes below $30,000 did not own a smartphone, and 44 percent did

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[48] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[49] Industries like health care and transportation have been less affected by the pandemic, and that has provided some cushion for black workers. See Despard et al. (2020).

[50] Krogstad, J.M., Gonzalez-Barrera, A. & Noe-Bustamante, L. (2020). U.S. Latinos among hardest hit by pay cuts, job losses due to coronavirus. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2020/04/03/u-s-latinos-among-hardest-hit-by-pay-cuts-job-losses-due-to-coronavirus/

[51] Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/

[52] Parker, K., Horowitz, J.M., & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/

[53] Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/

[54] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

[55] Parker, K., Horowitz, J.M., & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/

[56] Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/

[57] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

not have home broadband services in 2019.[58] Moreover, fewer than 8 percent of Americans with earnings below the 25th percentile have the capabilities to work remotely.[59] These disparities will result in fewer opportunities for beneficiaries to satisfy a community engagement requirement, particularly as more jobs have shifted to telework or "work from home" during the public health emergency. Therefore, implementation of the community engagement requirement approved in this demonstration increases the risk of coverage loss for these low-income individuals.[60,61]

The pandemic also has disproportionately impacted the physical and mental health of racial and ethnic minority groups, who already experience disparities in health outcomes. Racial minorities and people living in low-income households are more likely to work in industries that are considered "essential services," which have remained open during the pandemic.[62] Additionally, occupations with more frequent exposure to COVID-19 infections, and that require close proximity to others (such as personal care aides and bus drivers) employ Black individuals at higher rates than White individuals.[63] As a result, Black people may be at higher risk of contracting COVID-19 through their employment. The pandemic's mental health impact also has been pronounced among populations experiencing disproportionately high rates of COVID-19 cases and deaths. Specifically, Black and Hispanic adults have been more likely than White adults to report symptoms of anxiety and/or depressive disorder during the pandemic.[64]

Since the start of the pandemic, individuals have delayed or postponed seeking care, either due to concerns with out-of-pocket expenses or to avoid risk of contact with infected individuals in health care settings. For example, one study showed that screenings for breast, colon, prostate, and lung cancers were between 56 and 85 percent lower in April 2020 than in the previous year.[65] Results of another survey-based study show that 40 percent of respondents canceled

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[58] Anderson, M. & Kumar, M. (2019). Digital Divide Persists Even as Lower-Income Americans Make Gains in Tech Adoption. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/

[59] Maani, N., Galea, S. (2020). COVID-19 and Underinvestment in the Health of the US Population. The Milbank Quarterly. Retrieved from https://www.milbank.org/quarterly/articles/covid-19-and-underinvestment-in-the-health-of-the-us-population/

[60] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[61] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

[62] Raifman, M.A., & Raifman, J.R. (2020). Disparities in the Population at Risk of Severe Illness From COVID-19 by Race/Ethnicity and Income. American Journal of Preventive Medicine, 59(1), 137–139. https://doi.org/10.1016/j.amepre.2020.04.003

[63] Hawkins, D. (2020). Differential Occupational Risk for COVID-19 and Other Infection Exposure According to Race and Ethnicity. American Journal of Industrial Medicine, 63(9):817-820. DOI: 10.1002/ajim.23145

[64] Panchal, N., Kamal, R., Cox, C. & Garfield, R. (2021). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[65] Patt, D., Gordan, L., Diaz, M., Okon, T., Grady, L., Harmison, M., Markward, N., Sullivan, M., Peng, J., Zhau, A. (2020). Impact of COVID-19 on Cancer Care: How the Pandemic Is Delaying Cancer Diagnosis and Treatment for American Seniors. JCO Clinical Cancer Informatics, 4, 1059-1071. DOI: 10.1200/CCI.20.00134. Retrieved from https://ascopubs.org/doi/full/10.1200/CCI.20.00134

upcoming health care appointments due to the pandemic, and another 12 percent reported they needed care but did not schedule or receive services.[66] These unmet health care needs may lead to substantial increases in subsequent mortality and morbidity.[67] In addition to the health consequences associated with delaying care, pandemic-related delays in seeking care are estimated to increase annual health care costs nationwide by a range of $30 to $65 billion.[68]

The impact of the COVID-19 public health emergency on the economy has been significant, and, importantly, experience with previous recessions suggests the impact is likely to persist for an extended period of time. The unemployment rate went up from 3.5 percent in February 2020, prior to when the pandemic hit, to 14.8 percent in April 2020, and has subsequently fallen to 6.2 percent in February 2021.[69] The labor force participation rate (i.e., the percentage of the civilian noninstitutional population age 16 or older who are working or actively seeking work during the prior month) likewise dipped from 63.3 percent in February 2020 to 60.2 percent in April 2020 only to recover somewhat to 61.4 percent in February 2021.[70] Compared to pre-pandemic conditions, these data suggest that the labor force is still down by approximately 4.24 million individuals.[71]

Evidence shows that losing a job can have significant long term effects on an individual's future earnings. Studies have found that workers who lose their jobs in mass layoffs still earn 20 percent less than similar workers who kept their jobs, 15 to 20 years after the layoff, and the impacts are greater for individuals who lose their jobs during a recession. On average, men lost 2.8 years of pre-layoff earnings when the mass layoff occurred in a time when the unemployment rate was above eight percent.[72] Further, workers who enter the labor market during a recession also face long-term consequences for their earnings.[73] Additionally, non-White individuals and individuals with lower educational attainment have experienced larger and more persistent earning losses than other groups who enter the labor market during recessions.[74]

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[66] McKinsey & Company (2020). Understanding the Hidden Costs of COVID-19's Potential on U.S. Healthcare. Retrieved from https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-hidden-costs-of-covid-19s-potential-impact-on-us-healthcare#

[67] Chen, J. & McGeorge, R. (2020). Spillover Effects Of The COVID-19 Pandemic Could Drive Long-Term Health Consequences For Non-COVID-19 Patients. Health Affairs Blog, DOI: 10.1377/hblog20201020.566558. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20201020.566558/full/

[68] McKinsey & Company (2020). Understanding the Hidden Costs of COVID-19's Potential on U.S. Healthcare. Retrieved from https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-hidden-costs-of-covid-19s-potential-impact-on-us-healthcare#

[69] U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/cps/

[70] U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/cps/

[71] U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/web/empsit/cpseea08b.pdf

[72] Davis, S.J. & von Wachter, T. (2011). Recessions and the Costs of Job Loss. Brookings Papers on Economic Activity. Retrieved from https://www.brookings.edu/wp-content/uploads/2011/09/2011b_bpea_davis.pdf

[73] Schwandt, H. & von Wachter, T.M. (2018). Unlucky Cohorts: Estimating the Long-term Effects of Entering the Labor Market in a Recession in Large Cross-sectional Data Sets. NBER Working Paper 25141. Retrieved from https://www.nber.org/papers/w25141

[74] Schwandt, H. & von Wachter, T.M. (2018). Unlucky Cohorts: Estimating the Long-term Effects of Entering the Labor Market in a Recession in Large Cross-sectional Data Sets. NBER Working Paper 25141. Retrieved from https://www.nber.org/papers/w25141

Layoffs can also impact an individual's mortality and morbidity risks.[75] For example, workers experienced mortality rates that were 50-100 percent higher than expected in the year after a layoff occurred, and 20 years later, mortality rates remained 10-15 percent higher for these individuals.[76] Furthermore, workers experiencing layoff have reductions in health care utilization, especially among those who lose coverage, which suggests that access to coverage, and continuity of care, could be important in alleviating the long-term ill effects of layoffs on mortality.[77]

In summary, the short-to-long-term adverse implications of the COVID-19 pandemic on the economic opportunities for Medicaid beneficiaries, which have been aggravated further by challenges around shifting childcare and caregiving responsibilities as well as constraints on public transportation during the pandemic, heightens the risks of attaching a community engagement requirement to Medicaid eligibility for continued coverage. In addition, the uncertainty regarding the lingering health complications of COVID-19 infections exacerbates the risk of potential coverage losses for Medicaid beneficiaries. The likely ramifications of losing timely access to necessary health care also can be long lasting. As such, CMS believes that the potential for coverage loss among Medicaid beneficiaries—especially from a requirement that is difficult for beneficiaries to understand and administratively complex for states to implement—would be particularly harmful in the aftermath of the pandemic, and makes the community engagement requirement impracticable.

Withdrawal of Community Engagement Requirement in the October 31, 2018 Extension of the BadgerCare Reform Demonstration

Based on the foregoing, and pursuant to our obligation under section 1115 of the Act to review demonstration projects and ensure they remain likely to promote the objectives of Medicaid, CMS has determined that, on balance, the extension approval authorizing Wisconsin to implement a community engagement requirement as a condition of eligibility is not likely to promote the objectives of the Medicaid program. At a minimum, in light of the significant risks and uncertainties described above about the adverse effects of the pandemic and its aftermath, the information available to CMS does not provide an adequate basis to support an affirmative judgment that the community engagement requirement is likely to assist in promoting the objectives of Medicaid. Accordingly, pursuant to our authority and responsibility under applicable statutes and regulations to maintain ongoing oversight of whether demonstration projects are currently likely to promote those objectives, we are hereby withdrawing approval of that portion of the October 31, 2018 extension that permits the state to require work and community engagement as a condition of eligibility under the BadgerCare Reform

[75] Banks, J., Karjalainen, H. & Propper, C. (2020). Recessions and Health: The Long-Term Health Consequences of Responses to the Coronavirus. Journal of Applied Public Economics. DOI: 10.1111/1475-5890.12230. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1111/1475-5890.12230

[76] Sullivan, D. & von Wachter, T. (2009). Job Displacement and Mortality: An Analysis Using Administrative Data. Quarterly Journal of Economics. Retrieved from http://www.econ.ucla.edu/tvwachter/papers/sullivan_vonwachter_qje.pdf

[77] Schaller, J., Stevens, A. (2015). Short-Run Effects of Job Loss on Health Conditions, Health Insurance, and Health Care Utilization. Journal of Health Economics, 43, 190-203. DOI: 0.1016/j.jhealeco.2015.07.003. Retrieved from https://www.sciencedirect.com/science/article/pii/S0167629615000788

demonstration. The provisions of our letter approving the October 31, 2018 extension and the corresponding provisions of the expenditure authorities and Special Terms and Conditions that authorize the community engagement requirement are withdrawn.

The withdrawal of these authorities is effective on the date that is thirty days after the date of this letter, unless the state timely appeals, as discussed below. The waivers, expenditure authorities, and Special Terms and Conditions reflecting this change are attached to this letter and will govern the BadgeCare Reform demonstration from the effective date of the withdrawal of the community engagement authorities until the demonstration expires on December 31, 2023.

As indicated in CMS's February 12, 2021 letter, CMS is also reviewing the other authorities that CMS previously approved in the Wisconsin BadgerCare Reform demonstration. That review remains ongoing. The state and CMS will work together to update the evaluation design, as needed, to reflect all the key policies that are implemented during the approval period. The current established timeline for the interim and summative evaluation reports will remain in effect. CMS looks forward to continuing to work with the state on the evaluation design, interim and summative evaluation reports.

Procedure to Appeal This Decision

In accordance with Special Terms and Conditions ¶ 11 and 42 C.F.R. § 430.3, the state may request a hearing to challenge CMS's determination prior to the above-referenced effective date by appealing this decision to the Departmental Appeals Board (DAB or Board), following the procedures set forth at 45 C.F.R. part 16. This decision shall be the final decision of the Department unless, within 30 calendar days after the state receives this decision, the state delivers or mails (the state should use registered or certified mail to establish the date) a written notice of appeal to the DAB.

A notice of appeal may be submitted to the DAB by mail, by facsimile (fax) if under 10 pages, or electronically using the DAB's electronic filing system (DAB E-File). Submissions are considered made on the date they are postmarked, sent by certified or registered mail, deposited with a commercial mail delivery service, faxed (where permitted), or successfully submitted via DAB E-File. The Board will notify the state of further procedures. If the state faxes its notice of appeal (permitted only if the notice of appeal is under 10 pages), the state should use the Appellate Division's fax number, (202) 565-0238.

To use DAB E-File to submit your notice of appeal, the state's Medicaid Director or its representative must first become a registered user by clicking "Register" at the bottom of the DAB E-File homepage, https://dab/efile.hhs.gov/; entering the information requested on the "Register New Account" form; and clicking the "Register Account" button. Once registered, the state's Medicaid Director or its representative should login to DAB E-File using the e-mail address and password provided during registration; click "File New Appeal" on the menu; click the "Appellate" button; and provide and upload the requested information and documents on the "File New Appeal-Appellate Division" form. Detailed instructions can be found on the DAB E-File homepage.

Due to the COVID-19 public health emergency, the DAB is experiencing delays in processing documents received by mail. To avoid delay, the DAB strongly encourages the filing of materials through the DAB E-File system. However, should the state so choose, written requests for appeal should be delivered or mailed to U.S. Department of Health and Human Services, Departmental Appeals Board MS 6127, Appellate Division, 330 Independence Ave., S.W., Cohen Building Room G-644, Washington, DC 20201. Refer to 45 C.F.R. Part 16 for procedures of the Departmental Appeals Board.

The state must attach to the appeal request, a copy of this decision, note its intention to appeal the decision, a statement that there is no dollar amount in dispute but that the state disputes CMS's withdrawal of certain section 1115 demonstration authorities, and a brief statement of why the decision is wrong. The Board will notify the state of further procedures. If the state chooses to appeal this decision, a copy of the notice of appeal should be mailed or delivered (the state should use registered or certified mail to establish the date) to Judith Cash, Acting Deputy Director, Center for Medicaid and CHIP Services at 7500 Security Blvd, Baltimore, MD 21244.

If you have any questions, please contact Judith Cash at (410) 786-9686.

Sincerely,

Elizabeth Richter
Acting Administrator

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 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. Benefits
VI. Cost Sharing (Premiums, Copays, and Healthy Behavior Incentive)
VII. Delivery System
VIII. General Reporting Requirements
IX. General Financial Requirements
X. Monitoring Budget Neutrality for the Demonstration
XI. Evaluation of 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 Interim and Summative Evaluation Reports
Attachment F. Evaluation Design
Attachment G. Monitoring Protocol

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, 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, 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-out 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. BENEFITS

18. 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.

19. **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 21 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

20. **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.

21. SUD Monitoring Protocol. The state must submit a SUD Monitoring Protocol within one hundred fifty (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 20. 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 38 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.

22. 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.

23. **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.

24. **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) calendar 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) calendar 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) calendar 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 (Developing the Evaluation Design) 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).

25. **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 21) 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 38).

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.

26. 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.

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

27. 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 27(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.

28. **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.

29. **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.

VII. DELIVERY SYSTEM

30. 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.

VIII. GENERAL REPORTING REQUIREMENTS

31. 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.

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

33. 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.

34. 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.

35. 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.

36. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than one hundred fifty (150) calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment G.

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 38(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 38(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.

37. 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 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.

38. 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) calendar days following the end of each demonstration quarter. The Annual Report is due no later than ninety (90) calendar 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's 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. 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, and 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.

39. **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.

40. **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 31.

41. **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.

42. **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.

43. 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 31:

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.

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.

44. 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.

45. 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)

46. 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").

47. 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.

48. 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 38, 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.

49. 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.

50. 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.

51. 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.

52. 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

53. **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.

54. **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.

55. **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 56 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

56. **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.

57. **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.

58. **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.

59. **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

60. **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

61. **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 31.

62. **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.

63. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than one hundred eighty (180) calendar 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. 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.

64. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval, the approved Evaluation Design 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) calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Monitoring Reports. 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 if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the evaluation design in monitoring reports.

65. **Evaluation Questions and Hypotheses.** Consistent with Attachments D and E (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) 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, 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).

66. **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.

67. **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 Interim 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 a revised Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website.

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

68. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment E (Preparing the Interim and Summative Evaluation Reports) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within eighteen (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 a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.

b. Upon approval from CMS, the final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

69. **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. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

70. **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 Report, and/or the summative evaluation.

71. **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 thirty (30) calendar days of approval by CMS.

72. **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 andOUD

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

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

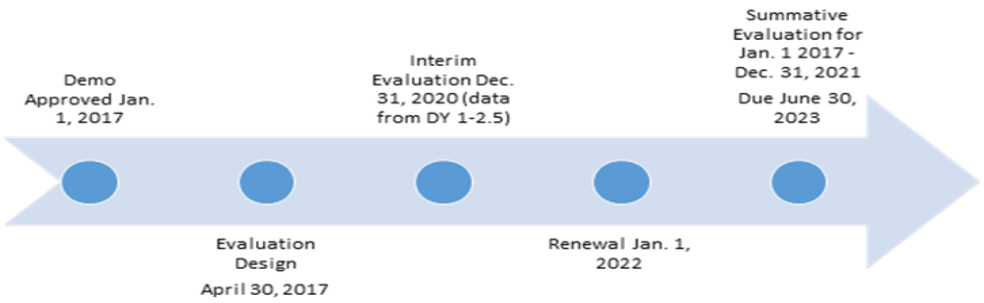
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, 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 for a 5-year demonstration). 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 thirty (30) calendar 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 INTERIM AND SUMMATIVE EVALUATION REPORTS

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 rigorous 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.

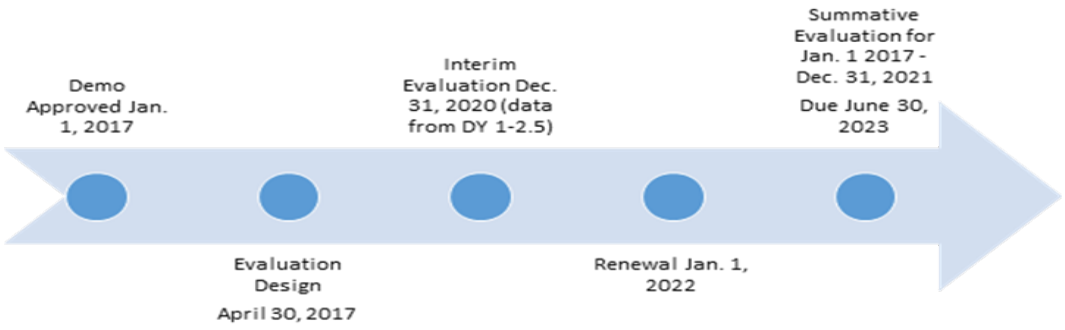
The format for the Interim and Summative Evaluation reports are as follows:

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 for a 5-year demonstration). 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 thirty (30) calendar 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 Evaluation 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 Report.

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: MONITORING PROTOCOL

ATTACHMENT H: TRIBAL CONSULTATION PLAN