Scott Walker
Governor

Linda Seemeyer
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF MEDICAID SERVICES

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December 29, 2017

Mr. Brian Neale
Deputy Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Re: Request to Extend Wisconsin's Section 1115 BadgerCare Reform Demonstration Project

Dear Mr. Neale:

I am pleased to submit Wisconsin's Section 1115 Demonstration Waiver Extension application for the BadgerCare Reform Demonstration Project. The Centers for Medicare & Medicaid Services (CMS) originally approved Wisconsin's BadgerCare Reform Demonstration Project in December of 2013. The demonstration permits Wisconsin to provide the Medicaid standard benefit plan to adults without dependent children and who have household incomes up to 100 percent of the federal poverty level. Additionally, it permits Wisconsin to require a monthly premium for parents and caretaker relatives who qualify for traditional medical assistance.

The Wisconsin Department of Health Services (DHS) is seeking approval to extend its current BadgerCare Reform Demonstration Project for an additional five years. The amendments previously submitted to CMS are included with this request, as is our previous application for the former foster care youth population. The requests in this application will allow Wisconsin to continue to innovate our Medicaid program while ensuring health care access for those who need it most.

We look forward to working with CMS to continue to innovate and improve the health for the citizens of Wisconsin.

Sincerely,

Leroy H. Himebauch, III
Acting Medicaid Director

State of Wisconsin

BadgerCare Reform Demonstration Project

1115 Waiver Extension Application

December 29, 2017

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1.0 Introduction

The Centers for Medicare & Medicaid Services (CMS) granted approval for Wisconsin to operate the BadgerCare Reform Section 1115(a) demonstration beginning on January 1, 2014, and expiring on December 31, 2018. As the granted waiver is nearing the completion of its fourth demonstration year, Wisconsin looks to extend the waiver demonstration. The current waiver has allowed Wisconsin to provide state plan benefits to childless adults who have family incomes up to 100 percent of the federal poverty level (FPL) and to charge premiums to adults in the transitional medical assistance (TMA) group. The demonstration has been positive for Wisconsin as more residents have been able to access affordable health insurance and the program continues to be sustainable. Wisconsin requests approval to continue the current program and looks forward to our work with CMS to improve and innovate our Medicaid program. We are fully committed to operating a program that serves our most vulnerable population while being a leader in Medicaid reform.

2.0 Historical Narrative and Program Description

Wisconsin has a history of successfully providing widespread access to health care to its residents. In 1999, Wisconsin implemented BadgerCare, which provided a health care safety net for low-income families transitioning from welfare to work. In addition, BadgerCare expanded coverage to families at income levels that had not previously been covered under the Medicaid program.

In 2008, Wisconsin Medicaid-eligible groups included all uninsured children through the age of 18, pregnant women with incomes at or below 300 percent of the FPL, and parents and caretaker relatives with incomes at or below 200 percent of the FPL.

In 2009, Wisconsin received approval through a Section 1115 demonstration waiver to expand coverage to childless adults with incomes at or below 200 percent of the FPL. This population became eligible for the BadgerCare Plus Core Plan, which provided a limited set of benefits.

In 2011, Wisconsin submitted and received approval to amend the BadgerCare and BadgerCare Plus Core Plan demonstrations, allowing Wisconsin to require that nonpregnant, nondisabled adult parents and caretaker relatives whose incomes exceed 133 percent of the FPL pay a monthly premium.

As the implementation of the Affordable Care Act provided federally funded subsidies to assist individuals and families with incomes from 100 to 400 percent of the FPL to purchase private health insurance, Wisconsin saw this opportunity to restructure BadgerCare through a demonstration waiver in order to reduce the uninsured rate and encourage beneficiaries to access coverage in the private market. In 2013, Wisconsin submitted and received approval for the BadgerCare Reform Demonstration Project.

The current waiver demonstrates Wisconsin's innovative approach to Medicaid reform to address the specific needs for its citizens. Residents at all income levels have access to health care coverage either through employer-sponsored or private insurance, a public assistance program, or the health insurance marketplace. As a result of this reform, everyone living in poverty in Wisconsin has access to health care services providing full benefits for the first time in history. This innovative approach to reform increased access to care for tens of thousands of individuals living below the federal poverty level.

Program Description and Objectives

The BadgerCare Reform Demonstration Waiver provides state plan benefits other than family planning services and tuberculosis-related services to childless adults who have family incomes up to 95 percent of the FPL (effectively 100 percent of the FPL considering a disregard of 5 percent of income). The demonstration permits the state to charge premiums to adults who are only eligible for Medicaid through the TMA 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 calendar months of TMA coverage.

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

Wisconsin's objectives for the program are to:

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

Over the past 3 ½ years, Wisconsin has successfully met these objectives.

Objective 1: Ensure every Wisconsin resident has access to affordable health insurance and reduce the state's uninsured rate.

Through the Affordable Care Act and BadgerCare Reform changes implemented in 2014, Wisconsin eliminated the gap in access for affordable health insurance. Wisconsin provides health care coverage for all adults, including those in the BadgerCare Reform Waiver, up to 100 percent of the FPL. Since implementing the reform changes in 2014, Wisconsin has enrolled over 145,000 childless adults in BadgerCare Plus.

The BadgerCare Reform changes have resulted in a decrease of the state's uninsured rate from 9.1 percent in 2013 to 5.7 percent in 2015, representing approximately 195,000 from 2013 to 2015 or a reduction of about 38 percent.

Objective 2: Provide a standard set of comprehensive benefits for low-income individuals that will lead to improved health care outcomes.

With the implementation of the BadgerCare Reform changes in 2014 and CMS's approval of the waiver, Wisconsin covers childless adults under the BadgerCare Plus standard plan, which is more comprehensive than the Affordable Care Act required plan for new adult populations.

Wisconsin will provide a final evaluation report on the impact to health care outcomes at the end of the waiver period but has provided CMS (as required) an interim evaluation report that includes preliminary findings from the survey completed following Year 2 of the demonstration.

Objective 3: Create a program that is sustainable so Wisconsin's health care safety net is available to those who need it most.

To date, Wisconsin has demonstrated that the coverage and benefits provided to the childless adult population under the waiver are cost neutral and sustainable. Appendix E provides a copy of the Demonstration Year 3 Annual Progress Report that includes a comprehensive update on the enrollment and costs.

As the BadgerCare Reform demonstration matures, Wisconsin looks to continue to provide residents with accessible health care coverage and further the health system by promoting improved health outcomes, increase participants' ability to obtain and maintain employment and employer-sponsored health care, slow down the rising costs of health care spending, and familiarize individuals with private health insurance practices, particularly for those with fluctuating incomes. As such, Wisconsin submitted a waiver amendment application in June of 2017 with the following amendments to the BadgerCare program:

- Establish a monthly premium of $8 for households with incomes from 51 to 100 percent of the FPL.
- Establish lower premiums for members engaged in healthy behaviors.
- Require completion of a health risk assessment.
- Limit a member's eligibility to no more than 48 months.
- Establish a work component that allows a member who engages in qualified activities for at least 80 hours a month to not have this time calculated in their eligibility time limit.
- Require, as a condition of eligibility, that an applicant or member complete a drug screening and, if indicated, a drug test.
- Charge an $8 copayment for emergency department utilization.
- Provide full coverage of residential substance use disorder treatment for all BadgerCare Plus and Medicaid members.

Amendment Objectives

In addition to the current waiver objectives, Wisconsin's new objectives related to the amendments include the following:

- Help more Wisconsin citizens become independent so as to rely less on government-sponsored health insurance.
- Empower members to become active consumers of health care services to help improve their health outcomes.
- Design a medical assistance program that aligns with commercial health insurance design to support members' transition from public to commercial health care coverage.
- Establish greater accountability for improved health care value.
- Expand the use of integrated health care for all individuals.

Wisconsin will continue to evaluate the objectives to ensure the program is providing quality and accessible care for residents and the demonstration is meeting CMS terms and conditions.

The complete waiver amendment application submitted to CMS can be found in Appendix C.

3.0 Program Changes

Wisconsin is requesting to retain the current program operations inclusive of the previously submitted amendments (Appendix C). We do not request any program changes in this extension.

4.0 Waiver and Expenditure Authorities

Waiver List

1. *Provision of Medical Assistance – Section 1902 (a)(8)*
   Eligibility – 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 under TMA only. This waiver allows the state to apply premiums to TMA adults with income above 133 percent of the FPL starting from the date of enrollment and to TMA adults with income from 100 to 133 percent of the FPL starting after the first six calendar months of TMA coverage.

Expenditure Authorities

1. *Childless Adults Demonstration Population*
   Expenditures for health care-related costs for childless, nonpregnant, uninsured adults ages 19 through 64 years who have family incomes up to 95 percent of the FPL (effectively 100 percent of the FPL including the 5 percent disregard), who are not otherwise eligible under the Medicaid State Plan, other than for family planning services or for the treatment of tuberculosis, and who are not otherwise eligible for Medicare, medical assistance, or the state Children's Health Insurance Program.

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.

Authority from Amendments

Waiver List

1. *Cost Sharing – Section 1902(a)(14) insofar as it incorporates 1916 and 1916A*
   To the extent necessary to enable Wisconsin to charge an $8 monthly premium to the childless adult population with household income from 51 through 100 percent of the FPL.

2. *Comparability – Section 1902(a)(17)/Section 1902(a)(10)(B)*
   - To the extent necessary to enable Wisconsin to vary monthly premiums for the childless adult population based on health behaviors and health risk assessment completion.

- To the extent necessary to enable Wisconsin to establish a time limit on eligibility for able-bodied childless adults between the ages of 19 and 49 years old while exempting other populations.

3. *Eligibility – Section 1902(a)(10)(A)*
   - To the extent necessary to enable Wisconsin to require the childless adult population, as a condition of eligibility, to complete a drug screening assessment and, if indicated, a drug test.
   - To the extent necessary to enable Wisconsin to deem a childless adult ineligible for six months after 48 months of enrollment.

4. *Reasonable Promptness – Section 1902(a)(3)/Section 1902(a)(8)*
   To the extent necessary to enable Wisconsin to establish a restrictive reenrollment period of six months for childless adults who are disenrolled for failure to pay premiums within the state-determined grace period.

5. *Cost Sharing for Emergency Department (ED) Utilization – Section 1916(f)*
   To the extent necessary to enable Wisconsin to establish an emergency department copay of $8 for the childless adult population.

Expenditure Authorities

Costs Not Otherwise Matchable – Section 1905(a)(29)(B)

- Wisconsin requests that expenditures for providing residential substance use disorder treatment in an institute for mental disease (IMD) be regarded as expenditures under the state's Medicaid Title XIX State Plan.
- Wisconsin requests that expenditures for providing residential substance use disorder treatment in an IMD for members enrolled in managed care are allowable to the same extent as those for Medicaid members covered through fee-for-service.
- Wisconsin requests that expenditures related to costs associated with employment training as a covered benefit for the childless adult population be regarded as expenditures under the state's Medicaid Title XIX State Plan.

5.0 Quality Monitoring

A quality monitoring report of the demonstration is available in Appendices E, H, and I (see *Quality Assurance/Monitoring Activity*).

6.0 Budget Neutrality and Monitoring

Federal policy requires Section 1115 waiver demonstrations be budget neutral to the federal government. This means that a demonstration should not cost the federal government more than what would have otherwise been spent absent the demonstration. Determination of federal budget neutrality for purposes of a Section 1115 demonstration application must follow a unique process that is distinct from federal and state budgeting and health plan rate setting. The processes, methods, and calculations required to appropriately demonstrate federal budget neutrality are for that express purpose only. Therefore, the budget neutrality model shown here should not be construed as a substitute for budgeting and rate setting or imply any guarantee of any specific payment.

To ensure budget neutrality for each federal fiscal year for this extension, Wisconsin uses a per-member per-month (PMPM) ;based methodology specific to the two waiver populations, the childless adult population with incomes not exceeding 100 percent of the FPL and adult parents and caretaker relatives with incomes greater than 100 percent of the FPL. The PMPM calculation has been established in the context of current federal and state law, and with the appropriate, analytically sound baselines and adjustments. The table below shows that the federal cost of this demonstration in each year is no greater than federal costs absent the new demonstration and therefore the demonstration is budget neutral to the federal government.

For historic enrollment and budgetary data refer to Appendix J.

Budget Neutrality for the Childless Adult Population Not Exceeding 100% FPL

Baseline Budget Neutrality Limit Projection for Childless Adult Population					
			PMPM	**Enrollment**	**Aggregate Expense Limit**
Original Waiver Approval	Year 1	CY 2014	$420.10	47,882	$20,115,347
	Year 2	CY 2015	$589.72	98,641	$58,170,441
	Year 3	CY 2016	$619.79	98,641	$61,137,133
	Year 4	CY2017	$651.40	98,641	$64,255,127
	Year 5	CY2018	$684.63	98,641	$67,532,138
Waiver Extension Request	Year 6	CY2019	$719.54	148,962	$107,183,970
	Year 7	CY2020	$756.24	149,706	$113,213,604
	Year 8	CY2021	$794.81	150,455	$119,582,435
	Year 9	CY2022	$835.34	151,207	$126,309,545
	Year 10	CY2023	$877.94	151,963	$133,415,089

Note: The above baseline expenditures reflect the estimated allowed amounts under federal budget neutrality limits in accordance with Section 1115 of the Social Security Act.

Budget Neutrality for TMA Adults

As described above, the demonstration includes continuation of Wisconsin's TMA program but with premiums for adult parents and caretaker relatives with income above

133 percent of the FPL starting from the date of enrollment and with income from 100 to 133 percent of the FPL starting after the first six calendar months of TMA coverage. The behavioral effect of the premium on enrollment is sufficient to ensure federal budget neutrality throughout the demonstration.

Baseline Budget Neutrality Limit Projection for TMA Adults					
			PMPM	**Enrollment**	**Aggregate Expense Limit**
Original Waiver Approval	Year 1	CY 2014	$282.10	15,000	$4,231,553
	Year 2	CY 2015	$296.49	11,550	$3,424,468
	Year 3	CY 2016	$311.61	11,550	$3,599,116
	Year 4	CY2017	$327.50	11,550	$3,782,671
	Year 5	CY2018	$344.21	11,550	$3,975,588
Waiver Extension Request	Year 6	CY2019	$361.76	28,872	$10,444,892
	Year 7	CY2020	$380.21	28,872	$10,977,581
	Year 8	CY2021	$399.60	28,872	$11,537,438
	Year 9	CY2022	$419.98	28,872	$12,125,847
	Year 10	CY2023	$441.40	28,872	$12,744,265

Note: The above PMPM baseline expenditures reflect the estimated allowed amounts under federal budget neutrality limits if budget neutrality is in effect in accordance with Section 1115 of the Social Security Act.

7.0 Demonstration Evaluation

An evaluation report of the demonstration is available in Appendices F and G.

8.0 Public Involvement and Public Comment

8.1 Public Notice Requirements

DHS followed requirements set forth in the Special Terms and Conditions (STC) for the currently approved waiver, the Wisconsin BadgerCare Reform Demonstration Project. STC 6 instructs the state on the amendment process and DHS has accordingly included the requirements in Public Notice 42 CFR 431.408. The following describes the actions taken by DHS to ensure the public was informed and had the opportunity to provide input on the waiver extension.

Public Notice

November 20, 2017: DHS published an abbreviated public notice to the Wisconsin Administrative Register: http://docs.legis.wisconsin.gov/code/register/2017/743A3/register/public_notices/public_notice_badgercare/public_notice_badgercare.

December 18, 2017: DHS published an updated abbreviated public notice to the Wisconsin Administrative Register: https://docs.legis.wisconsin.gov/code/register/2017/744A3/register/public_notices/public_notice_badgercare_reform_demonstration_project/public_notice_badgercare_reform_demonstration_project

The updated notice extended the comment period from December 24, 2017, to January 5, 2018.

Additionally, DHS informed the public of the abbreviated notice using the following forums:

- DHS BadgerCare Plus webpage: https://www.dhs.wisconsin.gov/badgercareplus/index.htm
- DHS Medicaid webpage: https://www.dhs.wisconsin.gov/medicaid/index.htm
- DHS ForwardHealth webpage: https://www.dhs.wisconsin.gov/forwardhealth/index.htm
- 1 W. Wilson Street (DHS Building)
- Wisconsin State Journal

On November 20, 2017, DHS published a press release made available to all Wisconsin media outlets, https://www.dhs.wisconsin.gov/news/releases/112017.htm, and posted a full public notice seeking input on the draft application for the BadgerCare Reform Demonstration Project Waiver extension. Copies of the abbreviated and full public notice are available in Appendices A and B.

The public comment period ran November 24, 2017, through January 5, 2018.

Webpage

DHS created a public webpage that includes the following:

- Public notice
- Public input process
- Public hearing dates, times, and locations
- Public hearing presentation available in English, Spanish, and Hmong
- Draft application
- Final application
- A link to the Medicaid.gov webpage on Section 1115 demonstrations

The webpage, which is updated as the extension process moves forward, can be found at https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm.

Public Hearings

Listed below are two public hearings in geographically distinct areas of the state that included a live webcast and teleconference capabilities for both hearings. An announcement regarding the hearings was provided to media outlets in Wisconsin via a press release: https://www.dhs.wisconsin.gov/news/releases/112017.htm. The press release, the public notice, and the webpage announce that the public can review the official waiver amendment request and provide comments for a 30-day period, as well as through written or verbal statements made at the public hearings listed below.

Tuesday, December 5, 2017
10 a.m.–1 p.m.
Pontiac Convention Center
The Regal Room
2809 N. Pontiac Drive
Janesville, WI 53545

Thursday, December 7, 2017
10 a.m.–1 p.m.
Brown County Central Library
Auditorium, Basement Level 1
515 Pine St.
Green Bay, WI 54301

Availability of Waiver Materials and Comment Mechanisms
The webpage and public notice state that a copy of the waiver extension documents can be obtained from DHS at no charge by downloading the documents from https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm or by contacting DHS via regular mail, telephone, fax, or email. The webpage and public notice further explain that public comments are welcome and accepted for 30 days (until January 5, 2018). Written comments on the changes could be sent by fax, email, or regular mail to the Division of Medicaid Services. The fax number is 608-266-1096, and the email address is wisconsin1115clawaiver@dhs.wisconsin.gov.

Tribal Consultation

Following 42 CFR 431.408, DHS will meet with representatives of the 11 federally recognized tribes located in Wisconsin during the regularly scheduled Wisconsin DHS/tribal consultation. The meeting will be held on January 11, 2018, in Wausau, WI. The BadgerCare Reform Demonstration Project is one of the topics for the meeting agenda. Comments from that meeting, and applicable response, will be included in the Appendix. This meeting is available via webinar and telephone for tribal representatives not on-site. A copy of the presentation provided during the consultation will be included in the Appendix.

Public Comment Availability: A summary of the comments received through the various mechanisms are available on the webpage for public view. In summary, DHS received 25 comments through email, fax, voicemail, mail, and public hearings held between November 24, 2017, and December 28, 2017. The majority came through email (21). The subsection that follows provides a summary of comments received from all comment mechanisms through December 28, 2017.

8.2 Summary of Public Comments and DHS Response

As stated in the public hearings and public notice documents, DHS gave all comments received through the various mechanisms the same consideration. A number of comments were wholly in opposition of approval of the proposed waiver extension. A significant number of comments addressed topics contained in the waiver amendment application, and as such, are not considered relevant to the waiver extension application. Below is a summary of all comments received followed by a response from DHS.

1. **Comment Summary:** Many comments stated that the current demonstration, which provides the standard BadgerCare benefits to all individuals below 100 percent FPL for the childless adult population and the graduated premium assistance to the TMA population, has been positive for Wisconsin, acknowledging an uninsured rate of 5.3 percent, which is considered the lowest in Wisconsin state history. Commenters supported the current waiver which they noted extends coverage to over 144,00 childless adults per year and that Wisconsin Medicaid is considered one of the more complete and expansive programs in the country. Many comments asked DHS to consider expanding BadgerCare eligibility to either 133 percent or 138 percent of the FPL.

   DHS Response: These comments concern the State's decision to forgo the ACA expansion, not DHS's BadgerCare Reform Demonstration waiver extension application. We do not consider these comments to be relevant to the waiver extension application we are submitting to CMS, and therefore, we are not able to respond directly to these comments and concerns.

2.

Comment Summary: A few commenters stated concerns with the proposed waiver amendment relating to copays for emergency department (ED) use noting that such policies may discourage appropriate use and access to emergency care. A few commenters were concerned that the proposed ED copays might violate EMTALA and other patient protections.

DHS Response: This comment is not relevant to the provisions contained in the waiver extension application. However, as previously stated in our response to comments regarding ED copays in our waiver amendment application, DHS would like to underscore that payment is not a requirement for services. DHS also maintains that collection of this copay will follow all applicable state and federal regulations.

3.

Comment Summary: One comment questioned DHS's compliance with federal notice requirements that require a comprehensive description with a sufficient level of detail to ensure meaningful input from the public, including a financial analysis of the proposed changes and evidence of how the objectives of the demonstration project have or have not been met, and an evaluation of the demonstration. Around the same time, CMS also advised the state that the information posted on DHS's website related to the waiver extension were not sufficient.

DHS Response: DHS corrected the information posted on the waiver website, and extended the public comment period until January 5, 2018, to ensure compliance with the 30-day public comment period requirements. Public notices on DHS's website and the State's Administrative Register were also updated to reflect extension of the public comment period through January 5, 2018.

8.2.1 Tribal Consultation Comment Summary

Comments received throughout the 30-day public comment period from Tribal governments are summarized below.

Tribal leaders and representatives provided additional written comments regarding the proposed waiver amendment, which was submitted in June 2017, and is currently under consideration by CMS. Commenters stated concerns that Indians are a unique population in the Medicaid program, and as such, they are likely to be adversely affected by the new eligibility requirements proposed in the amendment. They noted that unlike other Medicaid enrollees, American Indians and Alaskan Natives can access services through the Indian Health Service (IHS) at no cost to them, and as a result, the proposed work component and 48-month eligibility time limit will likely incentivize Indians to drop off Medicaid or elect not to enroll at all. Commenters

suggested that this will deprive IHS and other tribal facilities of an important source of funding. Commenters also stated concerns that having to demonstrate compliance with a work program to toll the 48-month eligibility limit on Medicaid creates a barrier to enrollment for Indians that does not exist to the same extent for other populations since many Indian communities face some of the highest unemployment rates in the state.

Commenters also noted that the proposed substance abuse identification and treatment process could act as a barrier to access to needed care since Indians have the option not to enroll in Medicaid and receive health care services through the IHS. Commenters further noted that since many Indian reservations are remote, Indians already face a lack of access to appropriate drug treatment providers that would be needed in the event drug screening indicated a need for testing and treatment, and are concerned this policy could diminish access to care. Many commenters requested an exemption from the 48-month eligibility limit and accompanying work component as well as the substance abuse identification and treatment requirement.

DHS Response: DHS appreciates all comments from tribes through any and all modes of communication. DHS will continue to work with tribes to address concerns as discussions continue with CMS.

The comments received to-date from tribes above pertains largely to policies proposed in the BadgerCare Reform Demonstration Amendment application, which was submitted to CMS in June, 2017. We do not consider these comments to be relevant to the policies contained in the waiver extension in submission to CMS. Therefore, we cannot respond directly to these comments and concerns in the waiver extension application. However, DHS will be holding Tribal Consultation on January 11, 2018, during the quarterly scheduled meetings with tribal health directors to discuss the policies contained in the waiver extension application. This process follows requirements found in the Section 1115 waiver submission regulations and Wisconsin's approved Medicaid State Plan regarding tribal consultation. We are eager to continue to receive any comments from tribes related to the waiver extension through January 11, 2018. DHS will summarize any comments received from tribes and issues discussed at the tribal health director's meeting and provide them to CMS in a timely updated submission. All tribal comments received through January 11, 2018, and a summary of tribal consultation will also be posted on DHS's website.

In addition, at the continued request of tribes, DHS has continued to consult with tribes on waiver amendment policies while also in discussions with CMS to ensure that tribal issues and concerns regarding amendment provisions are appropriately considered by our federal partners.

8.2.2 Consideration of Public Comments in Final Waiver

As stated in the previous subsection, each comment that was submitted to DHS through public hearings, the waiver amendment webpage, mail, or voicemail was reviewed as the final waiver amendment submission was developed. Since the vast majority of comments received through December 28, 2017, either pertained to policies proposed under the BadgerCare Reform Demonstration Amendment application, which followed proper public notice and comment requirements for submission in June 2017, or pertained to the State's decision to forgo the ACA

expansion, DHS is not able to consider these comments relevant to the BadgerCare Reform Demonstration Extension application. As a result, DHS is making no changes to the final application to the BadgerCare Reform Demonstration Extension based on comments received through December 28, 2017. DHS will continue to receive comments through January 5, 2018, after which DHS will summarize those comments and provide them to CMS in a timely updated submission. All public comments received through January 5, 2018 will also be posted on DHS's website.

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Wisconsin Department of Health Services
Section 1115 BadgerCare Reform Demonstration Project Waiver Extension

Overview

The Department of Health Services (DHS) intends to submit an application to the Centers for Medicare & Medicaid Services (CMS) requesting an extension of its Section 1115 demonstration waiver, known as the BadgerCare Reform Demonstration Project Waiver. Wisconsin was authorized to operate the waiver beginning January 1, 2014, through December 31, 2018. DHS is requesting an extension so the state may continue to operate the program beyond the current expiration date.

The Wisconsin BadgerCare Reform Demonstration Project Waiver provides state plan benefits other than family planning services and tuberculosis-related services to childless adults who have family incomes up to 95 percent of the federal poverty level (FPL) (effectively 100 percent of the FPL considering a disregard of 5 percent of income). It permits the state to charge premiums to adults who are only eligible for Medicaid through the transitional medical assistance (TMA) 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 calendar months of TMA coverage.

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

As we move forward, the state continually has a desire to build upon the positive outcomes we have been able to achieve and improve upon the current health care system. As such, in June 2017, DHS submitted a waiver amendment application. These program changes will be included in the waiver extension.

The proposed program changes only pertain to the childless adults' population unless otherwise stated:

- Establish a monthly premium of $8 for households with incomes from 51 to 100 percent of the FPL.
- Establish lower premiums for members engaged in healthy behaviors.
- Require completion of a health risk assessment.
- Limit a member's eligibility to no more than 48 months.

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- Require, as a condition of eligibility, an applicant or member complete a drug screening and, if indicated, a drug test.
- Charge an $8 copayment for emergency department utilization.
- Establish a work component that allows a member who engages in qualified activities for at least 80 hours a month to not have this time calculated in his or her eligibility time limit.
- Provide full coverage of residential substance use disorder treatment for all BadgerCare Plus and Medicaid members.

Public Comment
Providing information and obtaining input on changes from the public is of high importance for DHS as we prepare to submit the extension request. By law, you have the opportunity to review the official waiver extension application and provide comments for 30 days starting on November 24, 2017, and ending on January 5, 2018. You may also provide comments through written or verbal statements made during public hearings (see below). Public comments will be included in the waiver extension submitted to CMS and will be available on DHS's website at the address listed below.

Public Hearings
Tuesday, December 5, 2017
10 a.m.–1 p.m.
Pontiac Convention Center
The Regal Room
2809 N. Pontiac Drive
Janesville, WI 53545

Thursday, December 7, 2017
10 a.m.–1 p.m.
Brown County Central Library
Auditorium, Basement Level 1
515 Pine St.
Green Bay, WI 54301

Copies of Waiver Documents
Copies of waiver documents, including the full public notice, which will be posted on November 24, 2017, and the final waiver extension application once complete, may be obtained from DHS at no charge by downloading the documents at www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm or by contacting Al Matano at:

Mail: Al Matano
Division of Medicaid Services
P.O. Box 309
Madison, WI 53707-0309

Scott Walker
Governor

Linda Seemeyer
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF MEDICAID SERVICES

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Written Comments

Written comments on the proposed changes are welcome and will be accepted from November 24, 2017, through January 5, 2018. Written comments may be sent to the Division of Medicaid Services at:

Fax: 608-266-1096
Email: wisconsin1115clawaiver@dhs.wisconsin.gov
Mail: P.O. Box 309
Madison, WI 53707-0309

PUBLIC NOTICE
Wisconsin Department of Health Services
BadgerCare Reform Demonstration Project Waiver Extension

In accordance with federal law, the Wisconsin Department of Health Services (DHS) must notify the public of its intent to submit to the Centers for Medicare & Medicaid Services (CMS) any new Section 1115 demonstration waiver project, extension, or amendment of any previously approved demonstration waiver project or ending of any previously approved expiring demonstration waiver projects and must provide an appropriate public comment period prior to submitting to CMS the new, extended, or amended Section 1115 demonstration waiver application.

This notice serves to meet those federal requirements and to notify the public that DHS intends to submit a request for an extension to the BadgerCare Reform Demonstration Project Waiver to CMS. You can review the official extension request and provide comments for the next 30 days (see below), as well as through written or verbal statements made at the following public hearings:

Tuesday, December 5, 2017
10 a.m.–1 p.m.
Pontiac Convention Center
The Regal Room
2809 N. Pontiac Drive
Janesville, WI 53545

Thursday, December 7, 2017
10 a.m.–1 p.m.
Brown County Central Library
Auditorium, Basement Level 1
515 Pine St.
Green Bay, WI 54301

Your comments will be considered as the extension request is finalized but will not impact proposed or enacted state and federal law. In addition, all public comments will be communicated to the U.S. Department of Health and Human Services (HHS) as part of the final waiver extension application.

ACCESSIBILITY
English
DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability or need an interpreter or translator, or if you need this material in another language or in an alternate format, you may request assistance to participate by contacting Al Matano at 608-267-6848. You must make your request at least 7 days before the activity.

Spanish
DHS es una agencia que ofrece igualdad en las oportunidades de empleo y servicios. Si necesita algún tipo de acomodaciones debido a incapacidad o si necesita un interprete, traductor o esta información en su propio idioma o en un formato alterno, usted puede pedir asistencia para participar en los programas comunicándose con Kim Reniero al número 608-267-7939. Debe someter su petición por lo menos 7 días de antes de la actividad.

Hmong
DHS yog ib tus tswv hauj lwm thiab yog ib qhov chaw pab cuam uas muab vaj huam sib luag rau sawv daws. Yog koj xav tau kev pab vim muaj mob xiam oob qhab los yog xav tau ib tus neeg pab txhais lus los yog txhais ntaub ntawv, los yog koj xav tau cov ntaub ntawv no ua lwm hom lus los yog lwm hom ntawv, koj yuav tau thov kev pab uas yog hu rau Al Matano ntawm 608-267-6848. Koj yuav tsum thov qhov kev pab yam tsawg kawg 7 hnub ua ntej qhov hauj lwm ntawd.

BACKGROUND
Wisconsin reimburses providers for services provided to medical assistance recipients under the authority of Title XIX of the Social Security Act and Chapter 49 of the Wisconsin Statutes. This program, administered by DHS, is called Medicaid, formerly known as medical assistance. In addition, Wisconsin has expanded this program to create the BadgerCare Plus program under the authority of Title XIX and Title XXI of the Social Security Act and Chapter 49 of the Wisconsin Statutes. Federal statutes and regulations require that a state plan be developed that provides the methods and standards for reimbursement of covered services. A plan that describes the reimbursement system for the services (methods and standards for reimbursement) is now in effect.

Section 1115 of the Social Security Act provides the Secretary of HHS broad authority to authorize research and demonstration projects, which are experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. In 2013, DHS requested and received approval of the BadgerCare Reform Demonstration Project Waiver from the HHS Secretary. Effective January 1, 2014, Wisconsin has been authorized to provide coverage to adults without dependent children who have attained the age of 19 and have not yet attained the age of 65 years with Medicaid coverage so long as their family income does not exceed 100 percent of the federal poverty level (FPL). Additionally, DHS began requiring a monthly premium for parents and caretaker relatives who qualify for transitional medical assistance.

The demonstration is approved for a five-year period and is set to expire on December 31, 2018. After the initial demonstration period, HHS allows states to continue to operate the demonstration though a waiver extension. As the BadgerCare Reform Demonstration Project Waiver has had positive outcomes, DHS plans to request for a waiver extension. DHS would like to continue to operate the current program and serve the needs of those who need it most while further innovating our Medicaid program.

PROJECT GOALS

- Ensure that every Wisconsin resident has access to affordable health insurance and reduce the state's uninsured rate.
- Create a medical assistance program that is sustainable so our health care safety net is available to those who need it most.
- Help more Wisconsin citizens become independent and rely less on government-sponsored health insurance.
- Increase members' responsibility and investment in their health care choices.
- Empower enrollees to become active consumers of health care services to help improve their health outcomes.
- Design a medical assistance program that aligns with commercial health insurance design to support members' transition from public to commercial health care coverage.
- Establish greater accountability and improved health care value.
- Expand the use of integrated health care for all individuals.

PROJECT DESCRIPTION

The Wisconsin BadgerCare Reform Demonstration Project Waiver provides state plan benefits other than family planning services and tuberculosis-related services to childless adults who have family incomes up to 95 percent of the FPL (effectively 100 percent of the FPL considering a disregard of 5 percent of income). It permits the state to charge premiums to adults who are only eligible for Medicaid through the transitional medical assistance (TMA) 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 calendar months of TMA coverage.

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

As we move forward, the state continually has a desire to build upon the positive outcomes we have been able to achieve and improve upon the current health care system. As such, in June 2017, DHS submitted a waiver amendment application. These program changes will be included in the waiver extension.

The proposed program changes only pertain to the childless adults' population unless otherwise stated:

- Establish a monthly premium of $8 for households with incomes from 51 to 100 percent of the FPL.
- Establish lower premiums for members engaged in healthy behaviors.
- Require completion of a health risk assessment.
- Limit a member's eligibility to no more than 48 months.

- Require, as a condition of eligibility, an applicant or member complete a drug screening and, if indicated, a drug test.
- Charge an $8 copayment for emergency department utilization.
- Establish a work component that allows a member who engages in qualified activities for at least 80 hours a month to not have this time calculated in his or her eligibility time limit.
- Provide full coverage of residential substance use disorder treatment for all BadgerCare Plus and Medicaid members.

BUDGET AND COST EFFECTIVENESS ANALYSIS
The extension application requires financial data demonstrating:

- Historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration.
- A financial analysis of changes to the demonstration requested by the state.

DHS will include in its financial demonstration historical expenditures that are regularly reported to CMS for budget neutrality monitoring. For projected costs, DHS will use the most recently approved budget neutrality calculations from the waiver amendment. We will continue to monitor expenditures through the lifetime of the demonstration.

HYPOTHESIS AND EVALUATION PARAMETERS
DHS will continue to monitor program effectiveness and outcomes by evaluating the currently approved demonstration questions:

- For the TMA demonstration participants, will the premium requirement reduce the incidence of unnecessary services, slow the growth in health care spending, and increase the cost-effectiveness of Medicaid services?
- Is there any impact on utilization and/or costs associated with individuals who were disenrolled but reenrolled after the three-month restrictive reenrollment period?
- Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for individuals that have disenrolled and then reenrolled?
- What impact does the three-month restrictive reenrollment period for failure to make a premium payment have on the payment of premiums and on enrollment? Does this impact vary by income level? (If so, include a breakout by income level.)
- What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?
- How is enrollment or access to care affected by the application of new, or increased, premium amounts?
- Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare Plus adult beneficiaries result in improved health outcomes, a reduction in the incidence of unnecessary services, an increase in the cost-effectiveness of Medicaid services, and an increase in the continuity of health coverage?

Additionally, the following new hypothesis will be added as a result of the amendment provisions:

- Completion of a health risk assessment and paying a premium will increase members' level of engagement in their health care choices.
- Increased emergency department copayments will motivate members to use the health care system more appropriately.
- Incentivizing employment and training will support members' transition to self-sufficiency.
- Access to full coverage of residential substance use disorder treatment will lead to improved health and employment outcomes.
- Drug screening and testing will lead to improved health and employment outcomes.

Interim and final evaluations will continue to be conducted to help inform DHS, CMS, stakeholders, and the general public about the performance of the demonstration. All evaluation reports will be made public and posted on the DHS website.

SPECIFIC WAIVER AND EXPENDITURE AUTHORITIES

DHS is requesting the same waiver and expenditure authorities as those approved in the current demonstration's special terms and condition.

Waiver List

1. *Provision of Medical Assistance – Section 1902 (a)(8)*
   Eligibility – 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 under TMA only. This waiver allows the state to apply premiums to TMA adults with income above 133 percent of the FPL starting from the date of enrollment, and to TMA adults with income from 100-133 percent of the FPL starting after the first six calendar months of TMA coverage.

Expenditure Authorities

Childless Adults Demonstration Population

Expenditures for health care-related costs for childless, nonpregnant, uninsured adults ages 19 through 64 years who have family incomes up to 95 percent of the FPL (effectively 100 percent of the FPL including the 5 percent disregard); who are not otherwise eligible under the Medicaid state plan, other than for family planning services or for the treatment of tuberculosis; and who

are not otherwise eligible for Medicare, medical assistance, or the state Children's Health Insurance Program (CHIP).

Title XIX Requirements Not Applicable to the Demonstration Population:
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.

Authority from Amendments
Waiver List

1. *Cost Sharing – Section 1902(a)(14) insofar as it incorporates 1916 and 1916A*

   To the extent necessary to enable Wisconsin to charge an $8 monthly premium to the childless adult population with household income from 51 through 100 percent of the FPL.

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

   - To the extent necessary to enable Wisconsin to vary monthly premiums for the childless adult population based on health behaviors and health risk assessment completion.
   - To the extent necessary to enable Wisconsin to establish a time limit on eligibility for able-bodied childless adults between the ages of 19 and 49 years old while exempting other populations.

3. *Eligibility – Section 1902(a)(10)(A)*

   - To the extent necessary to enable Wisconsin to require the childless adult population, as a condition of eligibility, to complete a drug screening assessment and, if indicated, a drug test.
   - To the extent necessary to enable Wisconsin to deem a childless adult ineligible for six months after 48 months of enrollment.

4. *Reasonable Promptness – Section 1902(a)(3)/Section 1902(a)(8)*

   To the extent necessary to enable Wisconsin to establish a restrictive reenrollment period of six months for childless adults who are disenrolled for failure to pay premiums within the state-determined grace period.

5. *Cost Sharing for Emergency Department Utilization – Section 1916(f)*

   To the extent necessary to enable Wisconsin to establish an emergency department copay of $8 for the childless adult population.

Expenditure Authorities
Costs Not Otherwise Matchable – Section 1905(a)(29)(B)

- Wisconsin requests that expenditures for providing residential substance use disorder treatment in an institution for mental disease (IMD) be regarded as expenditures under the state's Medicaid Title XIX state plan.
- Wisconsin requests that expenditures for providing residential substance use disorder treatment in an IMD for members enrolled in managed care are allowable to the same extent as those for Medicaid members covered through fee-for-service.
- Wisconsin requests that expenditures related to costs associated with employment training as a covered benefit for the childless adults' population be regarded as expenditures under the state's Medicaid Title XIX state plan.

COPIES OF DEMONSTRATION PROJECT WAIVER DOCUMENTS
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Mail: Al Matano
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WRITTEN COMMENTS
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Public comments will be included in the waiver extension submitted to CMS and will be available on DHS's website at the address listed above.

Scott Walker
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State of Wisconsin
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DIVISION OF MEDICAID SERVICES

1 WEST WILSON STREET
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June 7, 2017

Mr. Brian Neale
Deputy Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Re: Request to Amend Wisconsin's Section 1115 BadgerCare Reform Demonstration Project

Dear Mr. Neale:

I am pleased to submit Wisconsin's Section 1115 Demonstration Waiver Amendment application for the BadgerCare Reform Demonstration Project. The Centers for Medicare and Medicaid Services (CMS) originally approved Wisconsin's BadgerCare Reform Demonstration Project in December of 2013. The demonstration permits Wisconsin to provide the Medicaid standard benefit plan to adults without dependent children and who have household incomes up to 100 percent of the federal poverty level.

The Wisconsin Department of Health Services (DHS) is seeking approval to implement policies specific to the childless adult population, as required by the 2015 Wisconsin Act 55. Additional amendments are also included that align with DHS's goals of promoting health care value and member engagement. We believe the requests in this application will allow Wisconsin to continue to innovate our Medicaid program while ensuring health care access for those who need it most.

DHS is optimistic for a favorable response and looks forward to working with CMS to continue to innovate and improve health for the childless adult population.

Sincerely,

Michael Heifetz
Medicaid Director

State of Wisconsin
BadgerCare Reform Demonstration Project

Coverage of Adults Without Dependent Children with Income at or Below 100 Percent of the Federal Poverty Level

Section 1115 Demonstration Waiver Amendment Application

June 7, 2017

Table of Contents

1.0 Introduction

The State of Wisconsin's goal is to continuously improve its Medicaid programs while maintaining access to affordable, quality health care coverage for our residents. In 2013, the Centers for Medicare and Medicaid Services (CMS) approved Wisconsin's 1115 Demonstration Waiver, which permits the state to provide the Medicaid standard benefit plan to adults without dependent children, also known as the childless adult population. Over the past three years, the childless adult population has been served successfully by Medicaid plans and providers. Wisconsin is seeking the opportunity for further innovation by establishing policies that will promote improved health outcomes, increase participants' ability to obtain and maintain employment and employer-sponsored health care, slow down the rising costs of health care spending, and familiarize individuals with private health insurance practices, particularly for those with fluctuating incomes.

2.0 Background

Prior to the existing demonstration (BadgerCare Reform Demonstration Project), Wisconsin has a history of successfully providing widespread access to health care to its residents. In 1999, Wisconsin implemented BadgerCare, which provided a health care safety net for low-income families transitioning from welfare to work. In addition, BadgerCare Plus expanded coverage to families at income levels that had not previously been covered under the Medicaid Program.

In 2008, Wisconsin Medicaid eligible groups included all uninsured children through the age of 18, pregnant women with incomes at or below 300 percent of the federal poverty level (FPL), and parents and caretaker relatives with incomes at or below 200 percent of the FPL.

In 2009, Wisconsin received approval through a Section 1115 Demonstration Waiver to expand coverage to childless adults with incomes at or below 200 percent of the FPL. This population became eligible for the BadgerCare Plus Core Plan, which provided a limited set of benefits.

In 2011, Wisconsin submitted and received approval to amend the BadgerCare and BadgerCare Plus Core Plan demonstrations, allowing Wisconsin to require that non-pregnant, non-disabled adult parents and caretaker relatives whose incomes exceed 133 percent of the FPL pay a monthly premium.

Most recently, in 2013, CMS approved a five-year Section 1115 Demonstration Waiver known as the Wisconsin BadgerCare Reform Demonstration Project. The waiver became effective January 1, 2014, and expires on December 31, 2018. Under this waiver, Wisconsin is eligible for federal Medicaid matching funds for providing health care coverage for childless adults between the ages of 19 and 64 years old who have income at or below 100 percent of the FPL. The childless adult population receives the standard benefit plan, which is the same benefit plan that covers parents, caretakers, and children.

Additionally, the existing BadgerCare Reform Demonstration Project enables Wisconsin to test the impact of providing Transitional Medical Assistance to individuals who are paying a premium that

aligns with the insurance affordability program in the federal marketplace based on their household income when compared to the FPL.

With an innovative approach to Medicaid reform to address the specific needs of Wisconsin, residents at all income levels have access to health care coverage either through employer-sponsored or private insurance, a public assistance program, or the health insurance marketplace. As a result of this reform, everyone living in poverty in Wisconsin has access to health care services providing full benefits for the first time in history.

3.0 Demonstration Objectives and Summary

3.1 Project Objectives

Wisconsin is committed to the implementation of policies that are vital to a fair and vibrant marketplace that delivers affordable, high-quality health care to its citizens and leverages the state's tradition of strong health outcomes, innovation, and provision of high quality health care. Specifically, Wisconsin's overall goals for the Medicaid program are to:

- Ensure that every Wisconsin resident has access to affordable health insurance to reduce the state's uninsured rate.
- Create a medical assistance program that is sustainable so a health care safety net is available to those who need it most.
- Help more Wisconsin citizens become independent so as to rely less on government-sponsored health insurance.
- Empower members to become active consumers of health care services to help improve their health outcomes.
- Design a medical assistance program that aligns with commercial health insurance design to support members' transition from public to commercial health care coverage.
- Establish greater accountability for improved health care value.
- Expand the use of integrated health care for all individuals.

3.2 Demonstration Project Overview

This amendment is prompted by the Wisconsin 2015-2017 Biennial Budget (Act 55), which requires the Wisconsin Department of Health Services (DHS) to submit an amendment to the BadgerCare Reform Demonstration Project in order to apply a number of new policies to the childless adult population. Wisconsin seeks to demonstrate that building on private sector health care models and implementing innovative initiatives will lead to better quality care at a sustainable cost for the childless adult population while promoting individual responsibility. The amendment policies align with what the majority of citizens experience in the private market and aim to improve health outcomes for the demonstration population by providing members and their health care providers with tools and practices that promote healthy lifestyles. The following dialogue outlines specific strategies to implement for the childless adult population to meet these goals. All of the innovations will be monitored to determine their impact.

Build on Private Sector Health Care Models
This amendment aims to more closely align the program for childless adults with private health insurance by requiring members to pay premiums toward their health care coverage. These out-of-pocket requirements are designed to prepare members for the norms of the private marketplace and ease transitions from public to private insurance.

Wisconsin believes that in addition to the long-term value to members aligning with the private system, establishing premiums will encourage members to place increased value on their health care and utilize it more effectively. Preventive care service utilization is expected to increase as members seek to utilize appropriate health care services. As a result, high costs related to emergency department usage may decline since health care needs will be met before conditions reach the level that require an emergency department visit.

In parallel to familiarizing childless adults with private sector health care practices, Wisconsin encourages Medicaid as a temporary solution rather than a replacement for employer-sponsored and private health insurance as a long-term coverage source. The amendment seeks to implement time-limited eligibility to meet this objective. However, Wisconsin also aims to provide members with the support and tools needed to obtain a full-time job that offers employer-sponsored insurance. Accordingly, the time that a member is working or participating in an employment training program for at least 80 hours a month will not count toward their 48-month time limit.

As a hallmark of the current waiver, Wisconsin implemented benefit reform to align with commercial insurance and the Affordable Care Act (ACA). In that same spirit, Wisconsin is proposing to add comprehensive substance use disorder residential treatment to align with commercial coverage.

Promote Healthy Behaviors
Promoting and incentivizing healthier lifestyles is a main focus of this demonstration. Under the amendment, a health risk assessment (HRA) will be created and utilized. The HRA will identify the health needs of the population and provide an opportunity for members to reduce their monthly premiums. Those assessed as having no health risk behaviors will see their monthly premiums reduced by half while members identified as engaging in a health risk behavior will pay the standard premium according to what income tier they fall within. This practice will incentivize members to proactively invest in their health care and promote healthier lifestyle choices. Furthermore, identifying members engaging in health risk behaviors allows the member, health plan, and provider to focus on managing these behaviors and their associated health effects. Members who practice healthy behaviors will not only be rewarded by paying lower premiums for their health care, but they will also be supported in developing those life skills needed to maintain employment or to utilize the employment and training programs also offered under this proposal.

Similarly, to promote appropriate use of health care services and behavior that is mindful of health care value, members who utilize the emergency room will be responsible for a graduated copay. Wisconsin believes this will help members understand the importance of choosing the appropriate care in the appropriate setting.

Support Behavioral Health and Substance Use Disorder Treatment Needs
Wisconsin has made, and continues to make, strides in addressing the substance use epidemic in the state. To make further inroads in helping residents recover from substance use, Wisconsin will institute a drug screening/testing program for the childless adult population. The goal of this proposal is to identify members with unmet substance use disorder treatment needs and connect those individuals to appropriate resources. Several benefits of drug screening are expected. Identifying drug use will allow the State to better provide treatment to those who may need it. Successful treatment will further enable members to live healthier lives, succeed in society, recognize gainful employment, and may lower overall program costs.

A key component in implementing this initiative is gaining approval to receive federal funds for the creation of a new residential substance use disorder treatment benefit. Wisconsin is seeking a waiver of the federal institution for mental disease (IMD) exclusion to allow coverage of medically necessary residential substance use disorder treatment services for up to 90 days for all BadgerCare Plus and Medicaid members. Appropriate and accessible care is critical to helping members receive timely and sufficient care to achieve and maintain recovery.

3.3 Demonstration Population

The amendment request pertains to non-pregnant, childless adults, ages 19 through 64 years old, who have countable income that does not exceed 100 percent of the FPL.

The amendment request also pertains to all BadgerCare Plus and Medicaid members only as it relates to residential treatment for a substance use disorder.

3.4 Demonstration Project Descriptions

The approved demonstration's special terms and conditions allow Wisconsin to submit an application for an amendment to the current waiver. Under 2015 Wisconsin Act 55 (biennial budget), DHS is required to submit to the U.S. Department of Health and Human Services (HHS) an amendment to the existing demonstration waiver that authorizes DHS to implement policies specific to the childless adult population. The proposed policy changes include:

1. Establish monthly premiums.
2. Establish lower premiums for members engaged in healthy behaviors.
3. Require completion of an HRA.
4. Limit a member's eligibility to no more than 48 months.
5. Require, as a condition of eligibility, that an applicant or member complete a drug screening and, if indicated, a drug test.

Policies that are not required by Act 55 and that are also included in the waiver amendment application include:

1. Charge an increased copayment for emergency department utilization for childless adults.
2. Establish a work component for childless adults.
3. Provide full coverage of residential substance use disorder treatment for all BadgerCare Plus and Medicaid members.

Wisconsin is committed to ensuring that the childless adult population has access to affordable health care coverage, encouraging behaviors that will improve health outcomes and promoting practices designed to help individuals successfully transition from public assistance to private health care coverage.

Current Waiver
Under the authority of a Section 1115(a) Demonstration Waiver, Wisconsin's BadgerCare Reform Demonstration Project covers two demonstration populations: non-pregnant childless adults between ages 19 and 64 years old, and the Transitional Medical Assistance (TMA) eligibility group.

The waiver demonstration allows Wisconsin to provide state plan benefits other than family planning services and tuberculosis-related services to childless adults who have household income up to 100 percent of the FPL. Cost sharing for the childless adult population is the same as that indicated in the Medicaid State Plan. The focus for this population is to improve health outcomes, reduce unnecessary services, and improve the cost-effectiveness of Medicaid services.

Additionally, Wisconsin has the authority to charge premiums to TMA adults with incomes above 133 percent of the FPL starting from the first day of enrollment, and to TMA adults from 100 to 133 percent of the FPL after the first six calendar months of TMA coverage.

All approved provisions in the BadgerCare Reform Demonstration project will be maintained.

Amendment Proposals
Wisconsin proposes to amend the current waiver with the following policies that will only apply to the childless adult population.

3.4.1 Monthly Premiums

In an effort to better align member experience with that of private health care in the state, Wisconsin proposes to implement a premium payment for the childless adult population with household income from 51 to 100 percent of the FPL. Wisconsin has structured the payment model so that no household is required to contribute more than 2 percent of their income. This structure follows recent CMS approvals that allow states to establish premiums for childless adults up to this limit. Additionally, members with the lowest or no income will be exempt from paying monthly premiums so that this population segment can maintain health care coverage and without further financial burden.

Monthly premium amounts will be divided into the following two income tiers:

Table 1. Monthly Premiums by Household Income

Household Income	Monthly Premium Amount
0 to 50 percent of the FPL	No premium
51 to 100 percent of the FPL	$8 per household

The proposed monthly premium requirement will not affect the current copayment policies, which will remain in place. Cost-sharing exemptions from copays for the American Indian and Alaska Native (AI/AN) population will extend to exemption from the monthly premiums.

Wisconsin will notify members who do not pay billed premiums, thus providing opportunities for members to pay before these provisions are applied. Once members are no longer eligible for this reason, they may not be eligible for health care benefits again for up to six (6) months. Reenrollment during those six-months will not be allowed until all outstanding premiums are paid. Members may reenroll at any time prior to the end of the six months by paying owed premiums. After the six-month period, individuals may gain eligibility for health care benefits again if they meet all program rules, even if they have unpaid premiums. Premiums will be calculated when a member reports a change in income or at annual eligibility redetermination.

Requiring payments directly from members is important to actively engage members in appropriate health care utilization and value. However, Wisconsin understands that there may be times when a member is unable to make monthly payments. Therefore, in such instances, third-party contributors will be permitted to make payments on a member's behalf. Third-party contributors may include, but are not limited to, nonprofit organizations, hospitals, provider groups, and employers.

3.4.2 Healthy Behavior Incentives

In an effort to encourage a healthy lifestyle, improve accountability, and lower health care costs, Wisconsin proposes to implement a healthy behaviors incentive program. This approach to health care also follows wellness programs adopted in the private market by linking healthy lifestyle choices with financial benefits. Wisconsin believes this program will empower members to be actively engaged in their health care. Accordingly, Wisconsin seeks to provide members with the opportunity to reduce their premium payment if they demonstrate healthy habits. Members who do not engage in behaviors that increase health risks will have their premiums reduced by 50 percent. For members who demonstrate a health risk behavior but attest to actively managing their behavior and/or have a condition beyond their control, the premium may also be reduced by half. For members who demonstrate a health risk behavior and are not actively managing their behavior(s), the standard premium will apply. This incentive model rewards members who demonstrate healthy behaviors while ensuring that cost-sharing for all members does not exceed federal limitations. Members will have the opportunity to update and self-attest to any changed health risk behavior on an annual basis when eligibility is re-determined.

Following a review of potential health risk behaviors in the Behavioral Risk Factor Surveillance System, National Health Interview Survey, and the National Center for Health Statistics annual report on national health trends, it has been determined the following behaviors increase health risks: alcohol consumption, body weight, illicit drug use, seatbelt use, and tobacco use. Wisconsin will follow the target measurements set by national health organizations, such as the Centers for Disease Prevention and Control, to determine the threshold of when engaging in these behaviors are considered to increase health risk. To identify members who are engaging in these behaviors,

Wisconsin will require members to complete an HRA, which is described in the section that follows.

Table 2. Reward for Healthy Behaviors

Reduced Premium (by half)	Standard Premium
• For members identified as not engaging in any health risk behavior(s) • For members identified as engaging in health risk behavior(s) but who attest to actively managing their behavior • For members identified as engaging in health risk behaviors(s) but who attest to having a condition beyond their control impacting the health risk measurement	For members identified as engaging in health risk behavior(s) and not actively managing their behavior(s)

Table 3. Identification of Health Risk Behaviors

Health Risk Behaviors	Risk Measurement	Identification Tool
Alcohol consumption, body weight, illicit drug use, seatbelt use, and tobacco use	Threshold of when a behavior is determined as posing a health risk will follow national health organizations standards (as described above)	Health risk assessment

3.4.2.1 Copays for Emergency Department Utilization

Additionally, to promote appropriate use of health care services and behavior that is mindful of health care value, members who use the emergency department will be responsible for an $8 copay. Wisconsin encourages members to use the emergency department appropriately as this service is costly, and non-emergent use of the emergency department decreases resources available for those truly in need of emergency care. Members will be educated on seeking preventive services and other care at the appropriate setting. They will also understand the direct cost of health care services, which will drive responsible health care decision-making. Providers will be responsible for collecting copayments from members but cannot refuse treatment for nonpayment of the copay. Cost-sharing exemptions from copays for the American Indian and Alaska Native (AI/AN) population will be applied to this policy.

3.4.3 Health Risk Assessment (HRA)

Wisconsin proposes to require the childless adult population to complete an annual HRA. In alignment with recent federal Medicaid managed care regulations, this information will be used to identify and document the health risk for all members, which will allow for more efficient management and understanding of the health needs of the demonstration population.

In an effort to encourage completion of the HRA and provide an opportunity for members to have their premiums reduced as previously described, the HRA will be the tool used to identify whether a member is engaging in or abstaining from health risk behaviors. Members may 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 affects a health risk measure. Members who fail to complete the HRA will be subject to the standard premium.

Members will complete an HRA at enrollment and again at annual renewal and will allow Wisconsin to monitor continued, discontinued, and new health risk behaviors. The health risk behaviors defined under this proposal include: alcohol consumption, body weight, illicit drug use, seatbelt use, and tobacco use. The HRA will ask members to identify whether they are engaging in any of the behaviors listed above and will self-attest on their management of the behavior.

3.4.4 Time Limit on Medicaid Eligibility

Wisconsin's goals include keeping health care costs at sustainable levels, ensuring continued assistance is available to individuals most in need, and promoting employer-sponsored insurance as the preferred means for health care coverage. As such, Wisconsin proposes to limit an individual's enrollment to 48 months. The count of the 48-month period will begin on the first month the policy goes into effect. For individuals who enroll after the implementation of the policy, the calculation will begin on initial program enrollment. After 48 months of enrollment, a member will not be eligible for health care benefits for six months. The 48-month time limit will start again when a member reenrolls after the six-month restrictive reenrollment period. Members over age 49 years old will not be subject to the 48-month eligibility limit. The 48-month time limit applies only to members who meet Medicaid eligibility requirements as childless adults. For example, if an individual loses Medicaid eligibility as a childless adult but gains Medicaid eligibility through a different eligibility category, the 48-month time limit will no longer apply unless the individual becomes a childless adult again.

3.4.4.1 Employment and Training

As part of a broader effort to encourage members to seek work and reach self-sufficiency, those who meet specified work requirements while receiving Medicaid benefits will not accrue time in their 48-month eligibility time limit. This policy aligns with Wisconsin's initiative across public assistance programs to empower residents to obtain the skills and training to secure full-time employment while still receiving support to lead healthy lives. Wisconsin's FoodShare Employment and Training (FSET) program is the model the BadgerCare work component will follow. The work component applies to members ages 19 through 49 years old. The 48-month count will stop during the time a member works and/or receives job training for at least 80 hours per month. Wisconsin will leverage the FSET resources to connect members with opportunities to participate in employment training. We anticipate that a majority of members are already familiar with employment and training programs as there is significant overlap between members enrolled in both FoodShare and BadgerCare.

Wisconsin understands there are circumstances that limit or prevent a member from being able to work or receive employment training; therefore, a member will be exempt from the work requirement and associated eligibility time limit if any of the following is true:

- The member is diagnosed with a mental illness.
- The member receives Social Security Disability Insurance (SSDI).
- The member is a primary caregiver for a person who cannot care for himself or herself.
- The member is physically or mentally unable to work.
- The member is receiving or has applied for unemployment insurance.
- The member is taking part in an alcohol or other drug abuse (AODA) treatment program.
- The member is enrolled in an institution of higher learning at least half-time.
- The member is a high school student age 19 or older, attending high school at least half-time.

3.4.5 Substance Abuse Identification and Treatment

Wisconsin recognizes that substance use disorder is a significant public health risk and a barrier to the health, welfare, and economic achievement of residents. As drug abuse is an issue of state and national concern, Wisconsin seeks to proactively address this growing problem to help all residents through focusing on medical, criminal, and treatment efforts. Wisconsin is committed to ensuring those participating in public assistance programs get help for behaviors that increase health risks and further burden public health. Wisconsin Medicaid, the state's largest health care program, must play a key role in identifying individuals affected by this disorder and assist these individuals in receiving treatment.

Accordingly, Wisconsin requests approval to require, as a condition of eligibility, that an applicant or member submit to a drug screening assessment and, if indicated, a drug test. A positive indication on the drug screening or test would not result in an individual losing eligibility or being disqualified from receiving benefits. The goal of the drug screening and drug test is to identify individuals with unmet substance use disorder treatment needs and connect them with appropriate treatment.

Individuals will be required to complete a screening questionnaire, as determined by DHS, regarding their current and prior use of controlled substances. Individuals who fail to complete a screening questionnaire will be ineligible for program benefits until they complete the screening questionnaire. Individuals whose answers to the screening questionnaire do not indicate possible abuse of a controlled substance will be deemed eligible for program benefits without further screening, testing, or treatment. Individuals whose answers on the screening questionnaire indicate possible abuse of a controlled substance shall be required to undergo a test for the use of a controlled substance. Individuals who refuse to submit to a drug test shall be ineligible for program benefits until they submit to a test, and test results have been reported. Results of a drug test performed by another state program can be used to determine whether an individual will be referred to drug treatment. Additionally, members will be allowed to forego a drug test if they indicate in their drug screening questionnaire that they are ready to enter treatment. Wisconsin is offering this option that promotes a member's choice to positively address their substance use disorder without subjecting the member to an unnecessary test.

An individual who tests negative for the use of a controlled substance will be eligible for program benefits without further screening, testing, or treatment. For individuals who test positive for a controlled substance without evidence of a valid prescription, program eligibility will go into effect under the condition that the individual enters into a substance abuse treatment program. In the event that treatment is not immediately available, a member will continue to be eligible for all health care services. Refusal to participate in a substance abuse treatment program will lead to program ineligibility; however, a dis-enrolled individual may reapply for benefits at any time the individual agrees to seek treatment. Wisconsin will follow evidence-based practice to allow members multiple opportunities to enter treatment. Evidence supports that members are much more likely to complete treatment when they enter it voluntarily rather than as a condition of eligibility, and when they are given multiple opportunities to attempt, fail, and re-enter treatment.

The table that follows summarizes the requirements and consequences of the substance abuse identification and treatment program.

Table 4. Substance Abuse Identification and Treatment Program

Requirement	Impacted Population	Impact of Requirement Results	Consequence for Refusal to Meet Requirement
Drug Screening Assessment	Individuals at time of application and members at time of annual redetermination	*Negative Result*: Eligible for BadgerCare benefits with no further action required *Positive Result*: Eligible for BadgerCare benefits ***and*** required to submit to a drug test	Ineligible for BadgerCare benefits until the assessment is completed
Drug Test	Only individuals/ members for which a positive answer is indicated in the drug screening assessment and for whom no valid prescription can be verified*	*Negative Result*: Eligible for BadgerCare benefits with no further action required *Positive Result*: Eligible for BadgerCare benefits ***and*** required to participate in substance abuse treatment	Ineligible for BadgerCare benefits until the drug test is submitted
Substance Abuse Treatment	Only members who test positive on the drug test and for whom no valid prescription can be verified	Enter into a substance abuse treatment program	Ineligible for BadgerCare benefits but may reapply for benefits at any time the member consents to treatment

**Members who express a desire to enter treatment on their screening questionnaire will be allowed to skip the drug test and enter treatment.*

3.4.5.1 Addressing Substance Abuse in Wisconsin

Wisconsin has made, and continues to make, broad efforts across the state to address the drug abuse epidemic in our communities. Initiatives include Medicaid program coverage revisions as well as broader community initiatives to address opioid addiction. The Wisconsin legislature has also enacted 17 bills for system improvements directly related to drug abuse and addiction. As the Medicaid program seeks to build on these efforts, a gap has been identified in care due to the IMD exclusion under Section 1905(a)(29)(B) of the Social Security Act creating a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services. Although the Medicaid managed care rule published in May 2016 permits states to make a monthly capitation payment to a managed care organization for a member, ages 21 through 64 years old, who is receiving inpatient treatment in an IMD for a stay of no more than 15 days, this provision is insufficient to fully address the substance use disorder treatment needs of the Wisconsin Medicaid population. Previously, on July 27, 2015, CMS published a State Medicaid Director's letter[1] indicating an openness to provide limited authority to cover short-term IMD-related expenses as part of a waiver request to comprehensively redesign the substance use disorder service delivery. Through this waiver and Wisconsin's ongoing initiatives, this would meet the state's expectations set forth in the letter on the Section 1115 Demonstration Waiver substance use disorder program.

In September 2016, Governor Scott Walker created the Task Force on Opioid Abuse to address challenges the state is facing with drug abuse and provide recommendations on legislation and statutes, funding and programs, executive actions, and best practices that would increase the effectiveness of drug abuse education, prevention, and treatment. One of the results of this task force was a report on combating opioid abuse. This report highlights the crisis Wisconsin currently faces in that the number of citizens who die due to a drug overdose exceeds the number of those who die from motor vehicle crashes, suicide, firearms, or HIV. The growing challenge of drug overdose is exemplified by the threefold increase in opioid-related overdose deaths from 194 deaths in 2003, to 622 in 2014. Prescription opioid pain relievers contributed to half of the total drug overdose deaths, while heroin contributed to one-third of the total. There is a close link between heroin abuse and prescription drug abuse as individuals are 40 times more likely to be addicted to heroin if they are addicted to painkillers. From 2008 to 2014, the Wisconsin State Crime Laboratory observed a 419-percent increase in cases involving heroin. Furthermore, over the past decade, the state has experienced a 200-percent increase in drugged driving deaths.

Thus far, to address the opioid abuse epidemic, Wisconsin's efforts include several pieces of legislation, which are collectively referred to as the Heroin, Opioid, Prevention and Education (HOPE) Agenda. The HOPE Agenda policies range from requiring individuals to show proper identification when picking up Schedule II or III opioid prescription medication to address prescription fraud and diversion, increasing funding by $1.5 million annually to expand treatment alternatives and diversion programs, to giving DHS oversight of the operation of pain management clinics across the state. Legislation passed from the 2013-2014 and 2015-2016 legislative sessions has led to improvements in opioid management through the Medicaid program. From quarter one of 2015 to the end of quarter three of 2016, the volume of Medicaid members with an opioid

[1] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, SMD #15-003, *New Service Delivery Opportunities for Individuals with Substance Use Disorder*, https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf, July 27, 2015.

prescription has dropped by 12 percent. Wisconsin Medicaid continues to implement efforts advancing the goals of the state to combat drug abuse. Stemming from the task force recommendations, Medicaid is leading the path to improvement with current efforts, which include the following directives:

1. Reduce methadone/opioid use for pain management.
2. Improve provider understanding of best practices for opioid prescribing and dispensing.
3. Implement controls for high-risk opioid painkillers.
4. Increase use of the patient delivered partner medication.
5. Establish patient review and restriction programs.
6. Increase access to naloxone.
7. Expand treatment of substance use disorders.

Expanding treatment for substance use disorders is critical to combating the statewide drug abuse epidemic and is a key element in this amendment request. As the goal of the drug screening and testing requirement is to identify individuals with unmet substance use disorder treatment needs and connect these individuals to the appropriate treatment, Wisconsin aims to provide accessible and affordable treatment services for the BadgerCare Plus and Medicaid populations.

Accordingly, Wisconsin is requesting an amendment to the existing Section 1115 Research and Demonstration Waiver to seek a waiver of the IMD exclusion for all Medicaid beneficiaries ages 21 through 64 years old, including managed care members and members who participate in a fee-for-service program. The objective of this amendment is to maintain and enhance beneficiary access to behavioral health services in appropriate settings and ensure that individuals receive care in the facility most appropriate to their needs. Specifically, the waiver of the IMD exclusion would allow the Medicaid program to develop a residential substance use disorder treatment benefit that reimburses psychiatric facilities (for example, hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services) for medically necessary residential substance use disorder treatment for up to 90 days. Wisconsin requests that expenditures related to providing services in an IMD be regarded as expenditures under the state's Medicaid Title XIX State Plan. Wisconsin's request to waive the IMD exclusion for the childless adult population would result in a significant increase in access to residential substance use disorder treatment.

3.4.6 Expanding Substance Use Disorder Treatment

Wisconsin Medicaid's current substance use disorder treatment services are described below. By expanding substance use disorder treatment to include access to alternative providers and full coverage of residential treatment, Wisconsin would be able to provide the full continuum of care to members.

Medicaid-covered services include:

- Outpatient Substance Use Disorder Treatment – Includes assessment and counseling provided by substance abuse counselors and qualified mental health professionals.

- Substance Abuse Day Treatment – A structured program of assessment/planning and counseling provided under physician supervision. Includes at least 12 hours of counseling per week.
- Psychosocial Rehabilitation – Medicaid covers wraparound psychosocial rehabilitative services to address an individual's substance use disorder and support independent living in the community.
- Medication-Assisted Treatment – Includes assessment, drug screening, prescription and administration of opioid dependency agents, and substance abuse counseling.
- Inpatient Treatment – Includes medically necessary acute care in a hospital for individuals with substance use disorder.

Although Wisconsin covers a robust set of services for individuals with substance use disorder, some gaps remain in the availability of clinically appropriate, evidence-based treatment. To address this concern, Wisconsin will develop coverage for residential substance use disorder treatment, which allows for individuals receiving treatment and recovering from substance use disorder to spend an adequate period of time to fully recover and prepare to live independently. In Wisconsin, access and availability to residential treatment for members is currently limited due to the IMD designation.

An IMD is defined in federal statute as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis and treatment of care of persons with mental diseases, including medical attention, nursing care, and related services. CMS has published sub-regulatory guidance in the State Medicaid Manual that interprets an IMD to include any institution that by its overall character is a facility that is established and maintained for the care and treatment of individuals with mental diseases, even if it is not licensed as an IMD. The manual further states that an IMD assessment must be made to the extent any of the following guidelines are met:

- The facility is licensed or accredited as a psychiatric facility.
- The facility is under the jurisdiction of the state's mental health authority.
- The facility specializes in providing psychiatric/psychological care and treatment.
- The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

In Wisconsin, there are approximately 60 certified facilities that provide residential treatment. At least 33 percent of these facilities have a capacity of 16 or more treatment beds, meeting the definition of an IMD. Although only one-third of facilities are IMDs, these facilities represent two-thirds of the treatment capacity in Wisconsin with approximately 600 of the total 900 beds in the state. Accordingly, covering services for an individual's duration at an IMD will significantly increase residential substance use disorder treatment.

DHS intends to create a benefit to cover medically necessary residential substance use disorder treatment benefit, up to 90 days, for all BadgerCare Plus and Medicaid members. Benefit design includes provider certification, maximum fee schedule, and detailed coverage policy to define parameters for the benefit. The benefit would be available under both fee-for-service and managed care delivery systems. Prior authorization would be required. DHS would seek federal funding for medically necessary services covered under the residential substance use disorder treatment

benefit, including residential substance use disorder treatment for individuals in facilities that are considered IMDs.

In order to create this benefit, DHS is requesting waiver of the federal exclusion of payments for services delivered to certain patients in IMDs, SSA 1905(a)(29)(B), and the federal funding limitation of 15 days for short-term IMD stays covered under managed care, 42 CFR 438.6(e).

As this is an amendment to a demonstration waiver, the table below shows historical enrollment and expenditures for the first three years of the demonstration and projects enrollment and expenditures for the remaining two years.

Table 5. Historical and Estimated Waiver Population Enrollment and Expenditures

				Estimated	
	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
Enrollment	99,967	154,561	150,050	147,483	146,407
Expenditures	$424,170,522	$775,836,538	$825,120,447	$923,979,859	$1,045,005,614

3.5 Implementation

Wisconsin plans to implement any approved provisions at least one year after CMS approval. This time period allows sufficient time to communicate with members the changes in the BadgerCare program and for the state to prepare and implement operational and administrative changes. Immediately after CMS approval, DHS will work on communication and implementation plans that outlines the timing, content, and methodology in which childless adults will be notified of program changes. Internally, employees will be educated and systems updated to ensure a smooth transition to the new waiver amendments.

4.0 Requested Waivers and Expenditure Authorities

Wisconsin seeks waiver of the following requirements of the Social Security Act:

1. **Cost-Sharing – Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**
   To the extent necessary to enable Wisconsin to charge premiums to the childless adult population with household income from 51 through 100 percent of the FPL.
2. **Comparability – Section 1902(a)(17)/Section 1902(a)(10)(B)**
   - To the extent necessary to enable Wisconsin to vary monthly premiums for the childless adult population based on health behaviors and HRA completion.
   - To the extent necessary to enable Wisconsin to establish a time limit on eligibility for able-bodied childless adults between the ages of 19 and 49 years old while exempting other populations.
3. **Eligibility – Section 1902(a)(10)(A)**
   - To the extent necessary to enable Wisconsin to require the childless adult population, as a condition of eligibility, to complete a drug screening assessment and, if indicated, a drug test.

- To the extent necessary to enable Wisconsin to deem a childless adult ineligible for six months after 48-months of enrollment.

4. **Reasonable Promptness – Section 1902(a)(3)/Section 1902(a)(8)**
   To the extent necessary to enable Wisconsin to establish a restrictive re-enrollment period of six months for childless adults who are dis-enrolled for failure to pay premiums within the state-determined grace period
5. **Cost-sharing for Emergency Department (ED) Utilization – Section 1916(f)**
   To the extent necessary to enable Wisconsin to establish an emergency department copay of $8 for the childless adult population.
6. **Costs Not Otherwise Matchable – Section 1905(a)(29)(B)**
   - Wisconsin requests that expenditures for providing residential substance use disorder treatment in an IMD be regarded as expenditures under the state's Medicaid Title XIX State Plan.
   - Wisconsin requests that expenditures for providing residential substance use disorder treatment in an IMD for members enrolled in managed care are allowable to the same extent as those for Medicaid members covered through fee-for-service.
   - Wisconsin requests that expenditures related to costs associated with employment training as a covered benefit for the childless adults population be regarded as expenditures under the State's Medicaid Title XIX State Plan.

5.0 Budget Neutrality

Federal policy requires Section 1115 waiver demonstrations be budget neutral to the federal government. This means that a demonstration should not cost the federal government more than what would have otherwise been spent absent the demonstration. Determination of federal budget neutrality for purposes of a Section 1115 demonstration application must follow a unique process that is distinct from federal and state budgeting and health plan rate setting. The processes, methods, and calculations required to appropriately demonstrate federal budget neutrality are for that express purpose only. Therefore, the budget neutrality model shown here should not be construed as a substitute for budgeting and rate setting or imply any guarantee of any specific payment.

To ensure budget neutrality for each federal fiscal year of this amendment through the current five-year BadgerCare Demonstration, Wisconsin will continue to use a per-member per-month (PMPM) methodology specific to the Wisconsin childless adult population. This calculation has been established in the context of current federal and state law and with the appropriate, analytically sound baselines and adjustments. The demonstration will measure the financial impact to the program. The following calculations are extended beyond the remaining waiver period for demonstration purposes.

5.1 Budget Neutrality for the Childless Adults Population Not Exceeding 100% FPL

5.1.1 Methodology for Without Waiver Amendment Calculation:

The Without Waiver Amendment (WOWA) historical amount and future projections were

determined using the following process:

Overall PMPM and Enrollment
The initial baseline PMPM and enrollment figures for the Wisconsin childless adult enrollee were determined by:

a. Reviewing historical PMPM and enrollment figures for childless adults under the current waiver from April 2014 through December 2016
b. Trending the historical data for both PMPM and enrollment into the waiver amendment periods through December 2023.
c. Multiplying PMPM by enrollment to determine an annual spend under the current waiver terms and conditions through December 2023.

Using nearly three years' historical data provides an accurate figure for the historical cost of this population that can be trended forward as a baseline through 2023. The PMPM growth rate is an average across the demonstration years, individual years may fluctuate.

5.1.2 Methodology for With Waiver Amendment (WWA) Calculation:

Calculating With Waiver Amendment (WWA) PMPM and enrollment requires analyzing WWA policy areas that impact PMPM and enrollment. The following areas were determined to impact PMPM and enrollment:

- Introduction of Premiums and Health Risk Assessments (HRA)
- Introduction of Emergency Room (ER) Copayments
- 48-month time limit on eligibility

5.2 Introduction of Premiums and Health Risk Assessments (HRA)

Introducing premiums coupled with Health Risk Assessments (HRA) will impact both PMPM and enrollment. Each area is included in the budget neutrality calculation and was molded using the following methodology:

1. Establish baseline WOWA Enrollment
    a. Historical data for enrollment from April 2014 through December 2016 was collected
    b. Historical data for enrollment by FPL from April 2014 through December 2016 was collected
    c. An average percentage of enrollment by FPL was established
    d. A trend rate for enrollment was established
    e. Historical data was trended into WWA years to create the baseline WOWA enrollment then split by the appropriate FPL percentage

2. Establish Baseline WWA Enrollment
    a. Research demonstrated a 4 percent and a 2 percent reduction in enrollment due to the introduction of premiums for households making full and reduced payments respectively
    b. Additional research indicated a 23.5 percent health risk response rate for required HRAs
    c. WWA enrollment was split by 76.5 percent non-health risk and 23.5 health risk responses
    d. An assumed 50 percent of health risk responders will manage their health risk and are subject to reduced monthly premium payments

e. WWA yearly enrollment was calculated by reducing WOWA enrollment by 4 percent for households subject to full payments and 2 percent for households subject to reduced premiums respectively this only applies to households in the 51-100% FPL range
f. The total number of households making full payments based on health risk response in the 51-100 percent FPL range is multiplied by the appropriate premium amount
g. The total number of households making reduced payments based on non-health risk response and health risk management in the 51-100 percent FPL range is multiplied by the appropriate premium amount
h. Research demonstrated a 5 percent rate of non-payment
i. The total value of premiums collected was reduced by 5 percent to create the projected monthly premium collection by year

3. Compare WOWA and WWA to determine the impact of premiums on enrollment and cost
   a. WWA total enrollment was subtracted from WOWA enrollment
   b. The difference in enrollment between WOWA and WWA was multiplied by WOWA PMPM for each year to determine projected savings from the enrollment change
   c. Decreased enrollment coupled with premium collection results in reduced overall spend in this cost center, projecting savings WWA

5.3 Introduction of Emergency Department (ED) Copayments

Collecting Emergency Department (ED) copayments will impact PMPM in two ways. First, copayment money collected will defray the cost of care. Second, research indicates that utilization of the ER declines once copayments are introduced. The following methodology was used to model how ER copayments will impact PMPM:

1. Establish baseline utilization of the ER WOWA:
   a. Historical data for yearly ER utilization and average cost of unique visits for childless adults under the current waiver provisions from 2015 through 2016 was collected and assumed constant through 2023
   b. The WOWA average ER visit cost was multiplied by the WOWA number of visits to create a WOWA ER utilization total cost figure
2. Establish baseline utilization of the ER WWA:
   a. Research was conducted that showed a 5 percent reduction in ER utilization based on the introduction of copayments
   b. WOWA utilization was reduced in WWA years by 5 percent creating a WWA yearly utilization number for each year
   c. The WOWA average ER visit cost was multiplied by the reduced WWA number of visits to create a WWA ER utilization total cost figure
   d. The copayment amount was multiplied by the WWA number of visits to create a WWA ER copayment collections total
   e. The total amount of copayments projected to be collected was subtracted by the WWA ER utilization total cost figure to create a total cost for WWA ER copayments
3. Compare WOWA and WWA figures to determine cost impact of introduction of ER copayments
   a. WWA total ER utilization costs, including copayments, were subtracted from WOWA total ER utilization costs.

b. Decreased utilization coupled with copayment collections were found to reduce overall spend in this cost center, projecting savings WWA.

5.4 48-month Time Limit on Eligibility

Introducing a 48-month time limit on eligibility will affect enrollment after the first 48 months of the waiver amendment. The methodology for determining enrollment impact is as follows:

1. Establish baseline WOWA enrollment:
   Trended enrollment based on historical data from April 2014 to December 2016 is used as the baseline WOWA enrollment
2. Establish baseline WWA enrollment:
   a. Historical data for age group and earned income was collected as of March 1, 2017, along with eligibility history from April 2014 through March 2017
   b. Percentage of households ages 19-49 with earned income, and thus considered employed were determined and thus removed from the 48-month time limit calculation
   c. The number of households staying on the program was determined at six-month intervals
   d. A six-month trend for households staying on the program continuously for 36 months was used to establish the percentage of households projected to reach 48 months of enrollment
   e. Research indicated 31 percent of households will qualify for an exemption (e.g., half-time student, on SSDI benefits). Such households were removed from the 48-month time limit calculation
   f. Research illustrated that 42 percent of FoodShare Employment and Training beneficiaries met the work or work training requirement. It was assumed childless adults would follow this same percentage. These households were removed from the 48-month time limit calculation.
   g. The 2023 WOWA trended enrollment was reduced by the number of households remaining

Compare total enrollment WOWA and WWA to determine the impact of 48 Month Eligibility on enrollment and cost:

1. WWA total enrollment post household removal was subtracted from WOWA trended enrollment
2. The difference in enrollment WOWA and WWA was multiplied by WOWA PMPM
3. The 48-month time limit results in decreased enrollment starting in 2023 and a cost savings WWA

5.5 Institute for Mental Disease Benefit (IMD) Adjustment

Wisconsin will develop coverage for residential SUD treatment in an IMD, which allows for individuals receiving treatment and recovering from SUD to spend an adequate period of time to fully recover and prepare to live independently. The methodology for determining cost impact is as follows:

1. Establish WOWA average cost per member for coverage in a non-IMD environment by using historical 2015-2016 utilization and cost data for SUD treatment in an inpatient facility.
2. Establish WWA average cost per member for coverage in an IMD environment by using historical 2015-2016 utilization data in the non-IMD environment and cost data for SUD coverage in an IMD environment.

Compare WOWA and WWA figures to determine cost impact of moving services from an inpatient environment to an IMD environment.

5.6 Budget Neutrality Table for Childless Adults

For each year of the demonstration, the following tables show the PMPM budget neutrality figures.

Overall Demonstration Chart					
Without Waiver Amendment Total Cost Demonstration					
	DY 1	DY 2	DY 3	DY 4	DY 5
Enrollment	148,962	149,706	150,455	151,207	151,963
PMPM	$560.54	$599.48	$641.13	$685.67	$733.30
Expenditures	**$1,001,989,214.05**	**$1,076,956,871.92**	**$1,157,533,522.02**	**$1,244,138,822.59**	**$1,337,223,830.17**
With Waiver Amendment Total Cost Demonstration					
	DY 1	DY 2	DY 3	DY 4	DY 5
Enrollment Increase (Decrease)	(824)	(828)	(832)	(836)	(5,102)
Enrollment	148,138	148,878	149,623	150,371	146,861
PMPM Increase (Decrease)	($2.81)	($2.80)	($2.80)	($2.79)	($2.78)
PMPM	$557.73	$596.68	$638.33	$682.88	$730.53
Total Waiver Expenditures	**$991,446,944.04**	**$1,065,990,836.61**	**$1,146,112,656.53**	**$1,232,229,740.99**	**$1,287,430,911.33**

With Waiver Amendment Enrollment and PMPM					
Enrollment Change Summary Chart					
	2019	2020	2021	2022	2023
Premium Introduction Increase (Decrease)	*(824)*	*(828)*	*(832)*	*(836)*	*(840)*
Time Limit Increase (Decrease)	*0*	*0*	*0*	*0*	*(4,262)*
Total Decrease	(824)	(828)	(832)	(836)	(5,102)
Cost (Savings) of Premium Introduction on Enrollment	*($5,541,228.72)*	*($5,955,816.95)*	*($6,401,424.19)*	*($6,880,371.24)*	*($7,395,152.55)*
Cost (Savings) of Time Limit Introduction on Enrollment	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*($37,501,815.31)*
Total Cost (Savings) of Enrollment Adjustment	**($5,541,228.72)**	**($5,955,816.95)**	**($6,401,424.19)**	**($6,880,371.24)**	**($44,896,967.86)**
PMPM Adjustment Summary Chart					
	2019	2020	2021	2022	2023
Premium PMPM Adjustment	*($1.03)*	*($1.03)*	*($1.03)*	*($1.03)*	*($1.03)*
Emergency Room PMPM Adjustment	*($1.78)*	*($1.77)*	*($1.76)*	*($1.75)*	*($1.75)*
Job Training PMPM Adjustment	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
IMD Benefit Adjustment	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
Total PMPM Adjustment	($2.81)	($2.80)	($2.80)	($2.79)	($2.78)
Cost (Savings) of Premium PMPM Adjustment	*($1,835,411.48)*	*($1,844,588.54)*	*($1,853,811.48)*	*($1,863,080.54)*	*($1,819,593.47)*
Cost (Savings) of Emergency Room PMPM Adjustment	*($3,165,629.81)*	*($3,165,629.81)*	*($3,165,629.81)*	*($3,165,629.81)*	*($3,076,357.51)*
Cost (Savings) of Job Training PMPM Adjustment	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
Cost (Savings) of IMD Benefit Adjustment	*$0.00*	*$0.00*	*$0.00*	*$0.00*	*$0.00*
Total Cost (Savings) of PMPM Adjustment	**($5,001,041.29)**	**($5,010,218.35)**	**($5,019,441.29)**	**($5,028,710.35)**	**($4,895,950.98)**
Total Savings for PMPM and Enrollment Reduction	**($10,542,270.01)**	**($10,966,035.31)**	**($11,420,865.49)**	**($11,909,081.60)**	**($49,792,918.84)**

6.0 Evaluation Design

Wisconsin will accordingly update the BadgerCare Reform Demonstration Project evaluation design to account for the amendment provisions.

The amended demonstration evaluation will include an assessment of the following hypotheses related to members' personal responsibility in their health care:

- Completion of an HRA and paying a premium will increase members' level of engagement in their health care choices.
- Increased emergency department copayments will motivate members to use the health care system more appropriately.
- Incentivizing employment and training will support members' transition to self-sufficiency.

- Access to full coverage of residential substance use disorder treatment will lead to improved health and employment outcomes.
- Drug screening and testing will lead to improved health and employment outcomes.

The evaluation will analyze how the demonstration impacts access, outcomes, and costs. Comparisons will be examined between the covered childless adult population, prior waiver programs, and other BadgerCare populations. As with the existing demonstration, this amendment will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid and subsidized health insurance offered through the federally facilitated marketplace.

A detailed evaluation design will be developed for review and approval by CMS. The evaluator will use relevant data from the BadgerCare program and its managed care organizations. This may include eligibility, enrollment, claims, payment, encounter/utilization, chart reviews, and other administrative data. The evaluator may also conduct surveys and focus groups of beneficiaries and providers and other original data collection, as appropriate.

Both interim and final evaluations will be conducted to help inform the state, CMS, stakeholders, and the general public about the performance of the demonstration. All evaluation reports will be made public and posted on the DHS website.

7.0 Public Involvement and Public Comment

Wisconsin State Budget for SFY 2015-2017: The policies and state finances underlying this amendment for Medicaid coverage of childless adults under 100 percent of the FPL were proposed, considered, debated, and enacted as part of the public process for Wisconsin's biennial State Budget for SFY 2015-17. The public documents provided with web links below provide considerable background information related to this amendment, including state policy and budget development:

- Governor Walker's Executive Budget for 2015-2017 included recommendations on the childless adult health care reforms. On February 3, 2015, Governor Walker delivered his budget address. The complete budget document is available on the web at http://www.doa.state.wi.us/Documents/DEBF/Budget/Biennial%20Budget/2015-17%20Executive%20Budget/2015-17_Executive_Budget.pdf.
- Analysis by the Wisconsin Legislative Fiscal Bureau (LFB), a nonpartisan service agency of the Wisconsin Legislature, resulted in two public reports posted on the LFB website at http://legis.wisconsin.gov/lfb/. LFB reports with detailed information related to Medicaid coverage of childless adults and policy and budget information related to this amendment include:
  - BadgerCare Plus Coverage for Childless Adults Paper #354, (May 21, 2015): https://docs.legis.wisconsin.gov/misc/lfb/budget/2015_17_biennial_budget/102_budget_papers/354_health_services_badgercare_plus_coverage_for_childless_adults.pdf

  - Drug Screening and Testing for Adults Without Dependent Children Enrolled in BadgerCare Plus, Paper #355 (May 19, 2015): https://docs.legis.wisconsin.gov/misc/lfb/budget/2015_17_biennial_budget/102_budget_papers/355_health_services_drug_screening_and_testing_for_adults_without_dependent_children_enrolled_in_badgercare_plus.pdf
- The 2015 Senate Bill 21 was introduced by the Joint Committee on Finance, by request of Governor Walker, on February 3, 2015, and was passed on July 7, 2015. Senate Bill 21 text is available at https://docs.legis.wisconsin.gov/misc/lfb/budget/2015_17_biennial_budget/102_budget_papers/355_health_services_drug_screening_and_testing_for_adults_without_dependent_children_enrolled_in_badgercare_plus.pdf.
- The 2015-2017 biennium budget was enacted as the 2015 Wisconsin Act 55 on July 12, 2015, and can be found at https://docs.legis.wisconsin.gov/2015/related/acts/55.

7. 1 Public Notice Requirements

DHS followed requirements set forth in the Special Terms and Conditions (STC) for the currently approved waiver, the Wisconsin BadgerCare Reform Demonstration Project. STC 6 instructs the State on the amendment process and DHS has accordingly included the requirements in Public Notice 42 CFR 431.408. The following describes the actions taken by DHS to ensure the public was informed and had the opportunity to provide input on the proposed waiver amendment.

Public Notice: On April 17, 2017, DHS published an abbreviated public notice to the Wisconsin Administrative Register: https://docs.legis.wisconsin.gov/code/register/2017/736A3/register/public_notices/public_notice_badgercare_reform_demonstration_waiver/public_notice_badgercare_reform_demonstration_waiver.

Additionally, DHS employed several other modes of communication to inform the public of the abbreviated notice:

- Email to the Medicaid Distribution list, including BadgerCare Plus and ForwardHealth Partners, for a total of 11,477 recipients notified.
- Posting in different forums, including:
  - DHS BadgerCare Plus webpage
  - 1 W. Wilson Street (DHS Building)
  - ForwardHealth Community Partners announcement
  - Milwaukee Journal Sentinel
  - Wisconsin State Journal
  - Wausau Daily Herald

On April 19, 2017, DHS published a press release made available to all Wisconsin media outlets, https://www.dhs.wisconsin.gov/news/releases/041917.htm, and posted a full public notice seeking input on the draft amendment to the BadgerCare Reform Demonstration Project. This press release officially started the public comment period. Copies of the abbreviated and full public notice are available starting on page 34.

The 30-day public comment period thus began on April 19, 2017, and ended on May 19, 2017. However, DHS accepted and reviewed comments that came in through May 22, 2017, in consideration of technicalities, such as faxing errors and mailing delays.

Webpage: DHS created a public webpage that includes the public notice, the public input process, scheduled public hearings, the draft amendment application, and a link to the Medicaid webpage on Section 1115 demonstrations. Additionally, DHS published a Frequently Asked Questions (FAQs) webpage to further provide the public with clarity on the proposed amendments and provided presentations in English, Spanish, and Hmong. The webpage, which is updated as the amendment process moves forward, can be found at https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm.

Public Hearings: Listed below, DHS conducted two public hearings in geographically distinct areas of the state and included live webcast and teleconference capabilities for both hearings. An announcement regarding the hearings was provided to media outlets in Wisconsin via a press release: https://www.dhs.wisconsin.gov/news/releases/041917.htm. The press release, the public notice, and the webpage announce that the public can review the official waiver amendment request and provide comments for a 30-day period, as well as through written or verbal statements made at the public hearings listed below. Comments from the two public hearings relevant to this waiver amendment request are summarized in the following subsection, and a copy of the presentation provided during the public hearings is also available on the webpage and is included and starts on page 47.

- **Wausau**: Wednesday, April 26, 2017, 11:00 a.m. – 2:00 p.m.
  Northcentral Technical College, Auditorium 1004, 1000 W. Campus Dr., Wausau, WI 54401
- **Milwaukee**: Monday, May 1, 2017, 4:00 p.m. – 7:00 p.m.
  Milwaukee Center for Independence, MCFI Main Campus, Harry and Jeanette Weinberg Building, 2020 W. Wells St., Milwaukee, WI 53233

Tribal Consultation: Following 42 CFR 431.408, DHS consulted with representatives of the federally recognized tribes located in Wisconsin during the regularly scheduled Wisconsin DHS/Tribal Health Directors Meeting. That meeting was held on May 1, 2017, from 9:00 am to 1:00 pm at the Jefferson Street Inn at 201 Jefferson Street, Wausau, WI 54403. The proposed amendment to the BadgerCare Reform Demonstration Project was one of the topics on the meeting agenda. This meeting was also available via webinar and telephone for tribal representatives not on-site. A copy of the presentation as provided during the consultation is included and starts on page 68. A comment summary is provided in the following subsection.

Availability of Waiver Materials and Comment Mechanisms: The webpage and public notice stated clearly that a copy of the waiver amendment documents, including the final waiver amendment application once complete, could be obtained from DHS at no charge by downloading the documents from https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm or by contacting DHS via regular mail, telephone, fax, or email. The webpage and public notice further explained that public comments were welcome and were accepted for 30 days (from April 19, 2017, to May 19, 2017). Written comments on the changes could be sent by fax, email, or regular

mail to the Division of Medicaid Services. The fax number listed was 608-266-1096, and the email address was wisconsin1115clawaiver@dhs.wisconsin.gov.

Public Comment Availability: A summary of the comments received through the various modes are available on the webpage for public view. In summary, DHS received 1,043 comments through email, fax, voicemail, mail, public hearings, and tribal consultation. The majority came in through email (391) and through mailings (657). Many emails and mailings contained duplicative petition language, but individuals also personalized their comments. Formal letters were also received by a number of organizations. The subsection that follows provides a summary of comments received from all comment mechanisms.

7.2 Summary of Public Comments and Wisconsin DHS Response

As stated in public hearings and documents, DHS gave all comments received through the various mechanisms the same consideration. To comprehensively address public input, comments are summarized by amendment topic and are followed by a DHS response. Of note, a significant number of comments addressed multiple or all proposed provisions in the waiver amendment. A portion of the comments made substantive comments and specific requests and recommendations. Additionally, there were a number of other comments that were either wholly in opposition or approval of the proposed waiver amendment. A summary of comments categorized by sections, along with a response from DHS, follows.

1. **Monthly Premiums**

   Comment Summary: Many comments stated that the individual or organization shares DHS's goal of encouraging members to engage in their health care. There are concerns that those with incomes starting at 21 percent of the FPL will not be able to afford paying the monthly premiums despite the seemingly nominal amount. Commenters noted that for members living at or near poverty, even one dollar a month is unaffordable given the need to pay for other basic needs, such as food and housing. Additionally, many living at or near poverty do not hold credit cards or bank accounts to be able to make payments to the State. These issues raise the concern that members will lose coverage due to nonpayment of premiums, or nonenrollment due to unaffordability and that it may be more administratively burdensome to collect premiums than to not have them exist at all. To alleviate these concerns, suggestions from many commenters included simplifying the proposed premium tiers and providing an extensive grace period for nonpayment. A number of comments also stated that there are certain populations for whom monthly premiums would be especially unaffordable, and therefore, exemption for these populations should be included in the proposed amendment. These populations include the homeless; individuals with multiple chronic conditions; individuals with cancer, HIV/AIDS, or terminal illness; and domestic violence victims. Comments also acknowledged that the listed exemptions to the 48-month time limit/work component is appreciated and should be extended to the monthly premium requirement as well. Overall, commenters noted that losing coverage for any period of time due to nonpayment should be revised. Alternative consequences suggested include enrolling members into a lesser benefit plan or having members participate in educational programs/case management.

Wisconsin DHS Response: Many comments focused on the unaffordability of the proposed premiums for households with incomes starting above 20 percent of the FPL. Federal regulations do allow cost-sharing of up to 5 percent of household income, and the proposed household premiums are within this capped amount. Additionally, CMS has approved several other states, including Indiana, Iowa, and Montana, to collect monthly premiums from childless adults with incomes below 100 percent of FPL. Approved premium amounts have been up to 2 percent of income. DHS understands these states are Medicaid expansion states covering childless adults with incomes up to 133 percent of the FPL under the Affordable Care Act (ACA). However, Wisconsin is proud to be the only state that did not expand Medicaid under ACA and still has no gaps in coverage for any income population. This is an achievement unmatched by most, if not all, of the expansion states.

DHS has considered commenters' concerns that starting premium requirements could be difficult for those near poverty and that the proposed four premium tiers may be too complex due to frequent changes in income, challenges with collecting premiums at varying amounts, and comprehension of the policy by members. DHS appreciates these concerns and suggestions to simplify the premium tiers. For the reasons mentioned above, DHS restructured the premium tiers. The amendment request now proposes two premiums tiers: members with a household income from 0 to 50 percent of FPL will have no monthly premium, and members with a household income from 51 to 100 percent of FPL will have an $8 monthly premium.

Regarding other common comments, DHS will continue to consider the operational suggestions we have received. These items include identifying allowable payment methods, particularly for members who may not have a bank account. Also, DHS agrees with commenters who expressed that a significant grace period should be in place. In our discussions with CMS and in finalizing operational protocols, DHS intends to consider a grace period of up to 12 months. DHS expects at least a yearlong implementation that will allow time to work further with stakeholders across the state and educate members on any approved policy.

Lastly, DHS would like to clarify that a member will start receiving benefits upon enrollment regardless of a first payment being made.

2. Health Risk Assessment

Comment Summary: Many commenters expressed that a health risk assessment (HRA), which allows providers and health maintenance organizations (HMOs) to better help patients with their health care needs, is overall a good idea. Suggestions for improvement include having members complete the HRA with their providers. Commenters indicated they believe this would help the parties work together to develop an appropriate care plan. Comments also stated that if HMOs are responsible for HRA administration, then this information should be readily available and accessible to members' providers. Some comments also recommended that premiums be completely reduced for members who complete the HRA, regardless of whether they engage in health risk behaviors or not. Lastly, a number of comments raised the concern that the HRA may be duplicative of other types of assessments members are expected to complete, such as the health needs assessment (HNA).

Wisconsin DHS Response: In regard to the duplicative assessments, the HRA will replace the HNA for the childless adults population enrolled in BadgerCare Plus. As processes are in place for the HNA, DHS intends to use these same processes in administering the HRA.

DHS encourages and will continue to encourage members to meet with a provider upon enrollment so a care plan can be developed to address their health risks and so they may receive preventative care.

3. Healthy Behaviors Incentives

a. Lower premiums for members engaging in healthy behaviors

Comment Summary: Comments expressed general acknowledgement that promoting healthy behaviors is a shared goal that individuals and organizations have with DHS. Concerns were raised that paying a higher premium due to engaging in health risk behaviors will result in a barrier for members in enrolling and receiving treatment or medical assistance for their health risk behaviors. As health risk behaviors will be identified based on the HRA, many comments suggested that the HRA should be completed by members and their provider. Comments also suggested that instead of eliminating higher premiums for those who engage in health risk behaviors, members could be required to develop a care plan or receive health education from providers. Moreover, a number of comments also mentioned that health risk behaviors are sometimes a result of an underlying condition and are not easily managed.

Wisconsin DHS Response: DHS respects the concerns and suggestions raised in the submitted comments. The policy provides members with the option of indicating whether or not they are managing their health risk or if an underlying condition exists that impacts a health risk. We encourage members to be honest and to see their provider to address health risks.

Furthermore, DHS has restructured premium tiers after reviewing comments and believes this will also be beneficial to the proposed healthy behavior incentive. The revised requested premium requirement starts at above 50 percent of the FPL. Accordingly, those with incomes at or below 50 percent of the FPL will not be subject to the healthy behavior incentive. The revised premium structure promotes affordability across all incomes, and the healthy behavior incentive further provides an opportunity for members to reduce their required monthly premium by half.

b. Emergency Department (ED) Utilization Graduated Copays

Comment Summary: Comments for this proposed provision included uncertainty on how a member's first and second ED visit would be determined and how this will be done in a timely manner, a perceived high amount of the copays from $8 to $25, the methodology for collection of the copay, and worry that members may avoid ED utilization even in cases when that level of care is appropriate. Suggestions submitted include only charging

members for non-emergent use of the ED and, accordingly, clearly defining the definition of non-emergent ED utilization, lowering the cost of copays, and developing a collection mechanism that will not burden ED providers in providing care or prevent members from receiving care at the time they are at the ED. Many advocates shared that there are certain populations who are more likely to need necessary ED care due to their conditions and that therefore, they should be exempt from this copay requirement. Populations mentioned often include individuals with multiple chronic conditions, cancer, HIV/AIDS, and those with low or no income. Many comments also stated that they encourage DHS to educate members on the appropriate use of medical facilities.

Wisconsin DHS Response: The majority of comments regarding ED utilization addressed the difficulty in identifying a member's first and subsequent visits. DHS has revised this request and is now proposing an $8 copay for each ED visit. One amount will be a clearer policy for all stakeholders to understand and administer. Additionally, this change in policy still provides an opportunity for members to understand health care value and seek care in the appropriate setting. DHS maintains the collection of this copay will appropriately follow federal regulations that cost-sharing not exceed 5 percent of household income.

In regard to providing treatment, DHS would like to clarify that payment is not a requirement for service.

4. 48-month Time Limit with a Work Component

Comment Summary: Commenters expressed concern over posing a time limit on eligibility and disrupting continuity of care for members. Particularly, comments mentioned how certain populations, such as individuals with mental health conditions and those with cancer or terminal illnesses, will not be able to meet the work requirement and therefore will reach the time limit and lose coverage for a period of time. Advocates also note that although members receiving Social Security Disability Insurance (SSDI) are exempt from this proposed policy, the definition of the disability to receive SSDI is much narrower than that found under Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. These individuals with disabilities may not qualify as "unable to work" and therefore will lose BadgerCare coverage for some time. It was noted that obtaining SSDI is a process that can take years. Losing coverage, even for six months, is detrimental to the health of the stated populations and will increase ED utilization and uncompensated care in the view of multiple commenters. Overall, commenters argued that losing coverage for any period of time due to nonpayment should be revised. Alternative consequences suggested include enrolling members into a lesser benefit plan or having members participate in educational programs/case management.

Many comments also addressed the work component and whether such a policy is effective, citing national and Wisconsin data. Also, commenters indicated that allowing individuals to maintain health care coverage better allows them to obtain and maintain employment. While some comments suggested completely removing the 48-month time limit and work component, other comments suggested reducing the 80-hour-per-month requirement. Many comments stated an appreciation of the exemption list from the work component and, accordingly, the time limit. However, there were a number of commenters who requested clarification on

whether those exempt from the work component are also exempt from the proposed time limit. Additionally, commenters suggested more exemptions, including for individuals who are homeless, have multiple chronic conditions, have cancer, HIV/AIDS, and are domestic violence victims. Furthermore, commenters suggested additions to fulfilling the work component and the inclusion of those actively seeking work and time volunteering.

Wisconsin DHS Response: A significant number of comments addressed this proposed policy and the implications it would have on members. DHS is required to submit a 48-month time limit request as directed by Act 55. The work component has been added in consideration of members who are working but whose income remains below 100 percent of FPL and who do not have access to health care coverage. DHS has also included exemptions to this policy as we understand there are populations where working may not be feasible. Lastly, DHS included a request with this policy that allows members to regain benefits after six months.

As some commenters noted, a substantial percentage of members work or go to school, and another portion meet the listed exemptions. This leaves a small percentage of members who naturally churn in and out of BadgerCare or who remain on BadgerCare for a longer period of time and are unable to find work. For the latter population, DHS aims to offer support in not only providing health care coverage for these members, but also encouraging them to engage in their communities. With this in consideration, the work requirement can be satisfied through not only actively working, but also job training. Additionally, comments include suggestions to add performing community service and actively seeking work as qualified activities. DHS will consider these items in our discussions with CMS and when developing an operational protocol.

5. Substance Abuse Identification and Treatment

Comment Summary: The majority of commenters acknowledged the addiction crisis in the state and the need to treat individuals with substance use disorder (SUD). A number of commenters expressed that drug screening and testing are unlawful and ineffective ways to identify individuals with substance use disorder. They stated that implementing this requirement as a condition of eligibility further stigmatizes SUD and will be a barrier to individuals obtaining health care coverage and receiving treatment not only for substance abuse, but other medical conditions.

In regard to the methodology used to screen and test individuals, providers and advocates recommend that screening should occur in a provider setting using an established tool, such as the Screening, Brief Intervention, and Referral to Treatment (SBIRT). Some commenters stated that having a provider administer drug screening using an established screening tool creates a safe setting for individuals and will lead to a higher likelihood of identifying those with SUD. As for drug testing, other than opposition to the requirement, suggestions include allowing individuals to use results from other state-mandated testing to avoid duplication of resources and additional burden on individuals.

In regard to treatment, many commenters expressed concern that requiring treatment for individuals who test positive for a drug is a matter of medical ethics and that forcing treatment

is an ineffective method to help individuals participate and complete a treatment program. Additionally, advocates and providers indicated that SUD should be treated as a chronic condition and that DHS should not expect an individual who completes one treatment program to be drug free or result in long-term recovery. Similarly, many commenters shared that treatment should be allowed the same priority for individuals who do not screen or test positive but who feel that they need treatment.

A larger issue of treatment capacity in the state was widely mentioned in comments. Commenters noted capacity issues throughout the state and that this needs to be addressed to fulfill the goal that members will be given treatment and not be disenrolled. Often, individuals must wait to receive treatment, and it would be unfair if this waiting time results in a member losing coverage.

Wisconsin DHS Response: DHS received substantive feedback on this proposed policy. General opposition to drug screening and testing as a condition of eligibility and specific suggestions for improvement were heard. DHS will consider the proposed policy implementation options should the policy be approved.

Advocates and providers stressed that if members lose benefits for six months for refusal to complete a treatment program, this may create a barrier to access care when they may become ready to enter treatment during those six months. In response, DHS has removed the six-month restrictive reenrollment period to address these concerns. This will allow individuals to receive timely treatment when they are ready. Additionally, DHS will follow evidence-based practice and allow members multiple opportunities to enter treatment. Evidence supports that members are much more likely to complete treatment when they enter voluntarily rather than as a condition of eligibility and when they are given multiple opportunities to attempt, fail, and reenter treatment.

Commenters also voiced that those who express a desire to enter treatment should be able to do so regardless of if they screen or test positive. In response, DHS has revised the amendment and is now proposing to allow members who indicate they are ready for treatment on their screening questionnaire to skip the drug test and access treatment. We believe doing so will promote the member's choice to positively address their substance use disorder without subjecting them to an unnecessary test.

6. Expansion of Residential Treatment

Comment Summary: Overall, comments were in support of the amendment's request to expand access to residential services at an IMD. Some advocates, providers, and other stakeholders did note that DHS must continue to invest in behavioral health in the community and address capacity issues through sufficient reimbursement, workforce development, and minimization of administrative burdens. Some comments stated that the IMD waiver should be expanded while others expressed a desire for a narrow focus.

Wisconsin DHS Response: DHS appreciates the support for this proposed waiver expenditure and will continue to work on initiatives to address substance use disorder and behavioral health services in the state.

7. 2.1 Tribal Consultation Comment Summary

Comments received during the Tribal Consultation on May 1, 2017, along with comments received throughout the 30-day public comment period from Tribal Governments, are summarized below.

Tribal Government Comment Summary: Comments from tribes were expressive of concerns relating to whether tribal members are exempt from the proposals included in the draft amendment application and the perceived negative impact that the proposals would have on American Indians/Alaska Natives (AI/AN) Medicaid beneficiaries if there is no exemption. Commenters expressed concern that the proposed amendments will result in tribal members being disenrolled from Medicaid or not applying for Medicaid coverage. Concerns were raised that this will increase reliance on Indian Health Services, which has insufficient funding and relies on Medicaid and Medicare.

Concern was noted regarding the 48-month time limit and work component. Members of the tribes generally live in areas of high unemployment and poor access to state employment programs. It will be especially difficult for tribal members to meet work requirements or demonstrate they meet requirements in the eyes of some commenters. Additionally, tribal governments state that enforcing the work component is inconsistent with federal trust responsibility to provide health care access.

In regard to substance abuse identification and treatment, the tribal governments express that this additional eligibility requirement will steer tribal members from getting Medicaid coverage. The tribal governments agree that substance abuse is an important issue to address and offered a suggestion that the tribes could work with DHS on screening their citizens to identify individuals needing SUD treatment. This process would be voluntary for members and administered by the tribes.

For the proposed policies that impact cost-sharing (monthly premiums and ED copays), the tribes noted that Congress has exempted AI/ANs from cost-sharing and that this amendment proposal should state this exemption as well.

Unrelated to any particular proposed policy in the amendment, tribes that submitted formal letters referenced the CMS State Health Official Letter (SHO) and would like to consult with DHS on ways to increase reimbursement at 100 FMAP for services received through the HIS and tribal health care providers. There were also requests for tribal consultation before the waiver amendment application is submitted.

Wisconsin DHS Response: DHS appreciates all comments from tribes received at the tribal consultation meeting and through other communication modes. DHS will work with tribes to address concerns as discussions occur with CMS and details are worked out for any approved policies.

DHS would like to clarify that current copayment policies for BadgerCare will remain in place, and therefore, tribal members will be exempt from the following proposed cost-sharing policies: monthly premiums and ED copays.

Additionally, a tribal consultation was conducted on May 1, 2017, at Wausau, Wisconsin. The proposed waiver amendment was an agenda item during the quarterly scheduled meetings with tribal health directors. This process follows requirements found in the Section 1115 waiver submission regulations and Wisconsin's approved Medicaid State Plan regarding tribal consultation.

7.2.2 Consideration of Public Comments in Final Waiver

As stated in the previous subsection, each comment that was submitted to DHS through either public hearings, the waiver amendment webpage, mail, or voicemail was reviewed as the final waiver amendment submission was developed. Embedded in our response to the comment summaries, DHS has stated where revisions have been made in the final application as a result of consideration of comments and suggestions received from the public. Below is the list of changes/clarifications that have been made to the final waiver amendment application:

Policy Changes

Table 6. Changes Made in the Final Application

Policy Area	Draft Application	Changes made in the Final Application
Monthly Premiums	Four premium tiers (on household basis): 0-20% FPL: No premium 21-20% FPL: $1 51-80% FPL: $5 81-100% FPL: $10	Two premium tiers (on household basis): 0-50% FPL: No premium 51-100% FPL: $8
ER Utilization Copay	Graduated copay: $8 for first ER visit and $25 for subsequent ER visits within a 12-month period	$8 copay for any ER visit
Substance Abuse Identification and Treatment	The consequence for refusal to complete drug treatment is the member is ineligible for BadgerCare benefits and may reapply for benefits after a six-month period. Individuals whose answers on the screening questionnaire indicate possible abuse of a controlled	The consequence for refusal to complete drug treatment is the member is ineligible for BadgerCare benefits but may reapply for benefits at any time the member consents to treatment. Allow members multiple opportunities to enter treatment and remove the six-month lockout

Policy Area	Draft Application	Changes made in the Final Application
	substance shall be required to undergo a test for the use of a controlled substance.	period. Allow individuals who express a desire to enter treatment on the screening questionnaire to skip the drug test and enter treatment.

Policy Clarifications

- Forty-eight-month time limit with work component: Those individuals exempt from the work requirement per the list provided in the application are also exempt from the 48-month time limit.
- Cost-sharing: In following current policy, the AI/AN population is exempt from monthly premiums and ER utilization copays.

8.0 Demonstration Administration

Wisconsin's point of contact for this demonstration waiver amendment is as follows:

Name and Title: Michael Heifetz, Medicaid Director
Phone Number: 608-266-5151
Email Address: michaelg.heifetz@dhs.wisconsin.gov

Wisconsin Department of Health Services
Section 1115 BadgerCare Reform Demonstration Project Waiver Amendment

Overview
The Department of Health Services (DHS) intends to submit an application to the Centers for Medicare and Medicaid Services (CMS) on May 26, 2017, requesting an amendment to certain provisions of its Section 1115 Demonstration Waiver, known as the BadgerCare Reform Demonstration Waiver. DHS is requesting the amendment based on changes in state law under 2015 Wisconsin Act 55. DHS must obtain approval from CMS before these changes can take effect.

Specific proposed changes to the childless adult (CLA) population include:

1. Monthly Premiums: Establishing monthly premiums help to increase the sustainability and value of health care in the state. Monthly premiums will range from $1 to $10 per household according to household income. Members with household incomes of 0 to 20 percent of the federal poverty level will not have a monthly premium.

2. Healthy Behavior Incentives: Members will have the opportunity to have their monthly premiums reduced by 50 percent if they engage in healthy behaviors. Those engaged in behaviors that increase their health risk will owe the full standard premium. Additionally, to promote appropriate use of health care services and behavior that is mindful of health care value, members who utilize the emergency room (ER) will be responsible for an $8 copay for the first visit and a $25 copay for subsequent visits over a 12-month period.

3. Health Risk Assessment (HRA): The HRA is a questionnaire that will be used to identify healthy behavior and health risks for improved understanding of the health needs of members. HRA completion is not a condition of eligibility; however, members will pay the full standard premium until they complete the HRA.

4. Time Limit on Medicaid Eligibility: This policy is a 48-month eligibility limit for members using a cumulative formula. After 48 months of enrollment, a member will not be eligible for health care benefits for six months. The time in which a member is working or participating in an employment and training program for at least 80 hours a month will not be included in their 48-month eligibility limit. This work component applies to members ages 19-49. Exemptions from the work component and time limit will align with the FoodShare Employment and Training (FSET) program (for example, individuals with mental illness, disabilities, and full-time student). Members over age 49 will not be subject to the 48-month eligibility limit.

5. Substance Abuse Identification and Treatment: Substance Use Disorder (SUD) is a significant public health risk and a barrier to health, welfare, and economic achievement of residents. The policy requires individuals to complete a drug screening assessment and, if indicated, a drug test, but individuals will not be ineligible for benefits for testing positive. Individuals who do test positive for a drug will be referred to a SUD treatment program. Members who fail to complete a drug screening assessment or drug test will be ineligible for benefits until

the requirement is completed. Refusal to participate in a SUD treatment program will result in ineligibility for benefits for six months.

Proposed benefit change for all BadgerCare Plus and Medicaid members:

6. Residential Treatment Coverage: Expanding treatment for SUD is critical to combating a statewide drug abuse epidemic. Under current policy, WI Medicaid does not provide full coverage of residential SUD treatment. DHS recognizes the barrier this presents for individuals who require SUD treatment and is designing a benefit to provide full coverage of residential treatment. In order to effectively implement this benefit, however, federal Medicaid funding must be made available to reimburse residential SUD treatment for individuals in facilities that qualify as institutions for mental diseases (IMD). As such, DHS is requesting a residential SUD treatment waiver of the federal exclusion for IMD reimbursement. Additionally, DHS is requesting a waiver of the 15-day limit for IMD coverage found in Medicaid managed care regulations.

Public Comment
Providing information and obtaining input on changes from the public is of high importance for DHS as we prepare to submit the amendment request. By law, you have the opportunity to review the official waiver amendment application and provide comments for 30 days starting on April 19, 2017, and ending on May 19, 2017. You may also provide comments through written or verbal statements made during public hearings (see below). Public comments will be included in the waiver request submitted to CMS on May 26, 2017, and will be available on DHS's website at the address listed below.

Public Hearings
Wednesday, April 26, 2017
11:00 a.m. – 2:00 p.m.
Northcentral Technical College
Auditorium 1004
1000 W. Campus Dr.
Wausau, WI 54401

Monday, May 1, 2017
4:00 p.m. – 7:00 p.m.
Milwaukee Center for Independence
MCFI Main Campus, Harry and Jeanette Weinberg Building
2020 W. Wells St.
Milwaukee, WI 53233

Copies of Waiver Documents
Copies of waiver documents, including the full public notice, which will posted on April 19, 2017, and the final waiver amendment application once complete, may be obtained from DHS at no charge by downloading the documents at https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm or by contacting Al Matano at:

Mail: Al Matano
Division of Medicaid Services
P.O. Box 309
Madison, WI 53707-0309
Phone: 608-267-6848
Fax: 608-266-3205
Email: alfred.matano@dhs.wisconsin.gov

Written Comments
Written comments on the proposed changes are welcome and will be accepted from April 19, 2017, through May 19, 2017. Written comments may be sent to the Division of Medicaid Services at:

Fax: 608-266-1096
Email: wisconsin1115clawaiver@dhs.wisconsin.gov
Mail: P.O. Box 309, Madison, WI 53707-0309

Public Notice
Wisconsin Department of Health Services
BadgerCare Reform Demonstration Project Waiver Amendment

I. Overview

In accordance with federal law, the Wisconsin Department of Health Services (DHS) must notify the public of its intent to submit to the Centers for Medicare and Medicaid Services (CMS) any new 1115 demonstration waiver project, extension, or amendment of any previously approved demonstration waiver project or the ending of any previously approved expiring demonstration waiver projects. DHS must provide an appropriate public comment period prior to submitting to CMS the new, extended, or amended 1115 demonstration waiver application.

This notice meets the federal requirement to notify the public that DHS intends to submit a request for amendments to the BadgerCare Reform Demonstration Project Waiver to CMS on May 26, 2017. The public can review the official waiver amendment request and provide comments for 30 days through written or verbal statements made at the following public hearings:

Wednesday, April 26, 2017
11:00 a.m. – 2:00 p.m.
Northcentral Technical College
Auditorium 1004
1000 W. Campus Dr., Wausau, WI 54401

Monday, May 1, 2017
4:00 p.m. – 7:00 p.m.
Milwaukee Center for Independence
MCFI Main Campus, Harry and Jeanette Weinberg Building
2020 W. Wells St., Milwaukee, WI 53233

Comments will be considered to determine if changes should be made to the waiver request but will not impact proposed or enacted state and federal law. In addition, all public comments will be communicated to the U.S. Department of Health and Human Services (HHS) as part of the final waiver amendment application.

Accessibility

English
DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability or need an interpreter or translator, or if you need this material in another language or in an alternate format, you may request assistance to participate by contacting Al Matano at 608-267-6848. You must make your request at least seven days before the activity.

Spanish

DHS es una agencia que ofrece igualdad en las oportunidades de empleo y servicios. Si necesita algún tipo de acomodaciones debido a incapacidad o si necesita un interprete, traductor o esta información en su propio idioma o en un formato alterno, usted puede pedir asistencia para participar en los programas comunicándose con Kim Reniero al número 608-267-7939. Debe someter su petición por lo menos 7 días de antes de la actividad.

Hmong
DHS yog ib tus tswv hauj lwm thiab yog ib qhov chaw pab cuam uas muab vaj huam sib luag rau sawv daws. Yog koj xav tau kev pab vim muaj mob xiam oob qhab los yog xav tau ib tus neeg pab txhais lus los yog txhais ntaub ntawv, los yog koj xav tau cov ntaub ntawv no ua lwm hom lus los yog lwm hom ntawv, koj yuav tau thov kev pab uas yog hu rau Al Matano ntawm 608-267-6848. Koj yuav tsum thov qhov kev pab yam tsawg kawg 7 hnub ua ntej qhov hauj lwm ntawd.

II. Background

The State of Wisconsin reimburses providers for services provided to Medical Assistance recipients under the authority of Title XIX of the Social Security Act and Chapter 49 of the Wisconsin Statutes. This program, administered by DHS, is called Medical Assistance (MA) or Medicaid. In addition, Wisconsin has expanded this program to create the BadgerCare Plus program under the authority of Title XIX and Title XXI of the Social Security Act and Chapter 49 of the Wisconsin Statutes. Federal statutes and regulations require that a state plan be developed that provides the methods and standards for reimbursement of covered services. A plan that describes the reimbursement system for the services (methods and standards for reimbursement) is now in effect.

Section 1115 of the Social Security Act provides the Secretary of HHS broad authority to authorize research and demonstration projects, which are experimental or pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. In 2013, Wisconsin requested and received approval of the BadgerCare Reform Demonstration Project Waiver from the HHS Secretary. Effective January 1, 2014, Wisconsin was authorized to provide coverage to adults without dependent children who have attained the age of 19 years old and have not yet attained the age of 65 years old with Medicaid coverage so long as their family income does not exceed 100 percent of the federal poverty level (FPL). Additionally, Wisconsin began requiring a monthly premium for parents and caretakers' relatives who qualify for transitional medical assistance.

The approved demonstration's special terms and conditions allow Wisconsin to submit an application for an amendment to the current waiver. Under 2015 Wisconsin Act 55 (biennial budget), DHS is required to submit to HHS an amendment to the existing demonstration waiver that authorizes DHS to implement policies specific to the childless adult population. The proposed policy changes include:

1. Establish monthly premiums.
2. Establish lower premiums for members engaged in healthy behaviors.

3. Require completion of a health risk assessment.
4. Limit a member's eligibility to no more than 48 months.
5. Require, as a condition of eligibility, that an applicant or member complete a drug screening, and if indicated, a drug test.

Policies that are not required by Act 55 and that are also included in the waiver amendment application include:

1. Charge an increased copayment for emergency department utilization for childless adults.
2. Establish a work component for childless adults.
3. Provide full coverage of residential Substance Use Disorder (SUD) treatment for all BadgerCare Plus and Medicaid members.

III. Project Goals

- Ensure that every Wisconsin resident has access to affordable health insurance and reduce the state's uninsured rate.
- Create a medical assistance program that is sustainable so a health care safety net is available to those who need it most.
- Help more Wisconsin citizens become independent and rely less on government-sponsored health insurance.
- Increase members' responsibility and investment in their health care choices.
- Empower members to become active consumers of health care services to help improve their health outcomes.
- Design a medical assistance program that aligns with commercial health insurance design to support members' transition from public to commercial health care coverage.
- Establish greater accountability and improved health care value.
- Expand the use of integrated health care for all individuals.

IV. Project Description

This amendment is a result of the Wisconsin 2015-2017 Biennial Budget (Act 55), which requires DHS to amend the BadgerCare Reform Demonstration Project in order to apply new policies to the childless adult population. Wisconsin seeks to demonstrate that building on private sector health care models and implementing innovative initiatives will lead to better quality health care at a sustainable cost for the childless adult population while promoting individual responsibility. The amendment policies align with what the majority of citizens experience in the private market and aim to improve health outcomes for the demonstration population by providing members and their health care providers with tools and practices that promote healthy lifestyles. The following dialogue outlines specific strategies that will be implemented for the childless adult population to meet these goals. All of the strategies will be monitored to determine their impact.

Build on Private Sector Health Care Models
This amendment aims to more closely align the program for childless adults with the private health insurance marketplace by requiring members to pay premiums toward their health care coverage. These out-of-pocket requirements are designed to prepare members for the norms of the private marketplace and ease transitions from public to private insurance.

Wisconsin believes that in addition to the long-term value to members of aligning with the private system, establishing premiums will encourage members to place increased value on their health care and utilize it more effectively. Preventive care service utilization is expected to increase as members seek to utilize appropriate health care services. High costs related to emergency department usage may decline since health care needs will be met before conditions reach the level that require an emergency department visit.

In parallel to familiarizing childless adults with private sector health care practices, Wisconsin encourages Medicaid as a temporary solution rather than a replacement for employer-sponsored and private health insurance as a long-term coverage source. The amendment seeks to implement time-limited eligibility to meet this objective. However, Wisconsin also aims to provide members with the support and tools needed to obtain a full-time job that offers employer-sponsored insurance. Accordingly, the time that a member is working or participating in an employment training program for at least 80 hours a month will not count toward his or her 48-month time limit.

Promote Healthy Behaviors
Promoting and incentivizing healthier lifestyles is a main focus of this demonstration. Under the amendment, a health risk assessment will be created and utilized. The health risk assessment will identify the health needs of the population and provide an opportunity for members to reduce their monthly premiums. Those assessed as having healthy behaviors will see their monthly premiums reduced by half, while members identified as engaging in a health risk behavior will pay the standard premium according to what income tier they fall within. This practice will incentivize members to proactively invest in their health care and promote healthier lifestyle choices. Furthermore, identifying members engaging in health risk behaviors allows the member, health plan, and provider to focus on managing these behaviors and their associated health effects.

Similarly, to promote appropriate use of health care services and behavior that is mindful of health care value, members who utilize the emergency department will be responsible for a graduated copay. We believe this will help members understand the importance of choosing the appropriate care in the appropriate setting.

Support and SUD and Treatment Needs
Wisconsin has and continues to make strides in addressing the substance use epidemic in the state. To make further inroads in helping our residents recover from substance use, Wisconsin will institute a drug screening/testing program for the childless adult population. The goal of this proposal is to identify members with unmet SUD treatment needs and connect those individuals to appropriate resources. Several benefits of drug screening are expected. Identifying drug use will allow Wisconsin to provide treatment to those who may need it. Successful treatment will

further enable members to live healthier lives, succeed in society, recognize gainful employment, and may lower overall program costs.

A key component in implementing this initiative is gaining approval to receive federal funds for the creation of a new residential SUD treatment benefit. Wisconsin is seeking a waiver of the federal institution for mental disease (IMD) exclusion to allow coverage of medically necessary residential SUD treatment services for up to 90 days for all BadgerCare Plus and Medicaid members. Appropriate and accessible care is critical to helping members receive timely and sufficient care to achieve and maintain recovery.

V. Childless Adults Eligibility and Coverage

Outlined below are the current Medicaid eligibility and coverage standards for childless adults that describe the specific proposed changes sought for this demonstration population through this waiver amendment request.

Current Program: Under the authority of an 1115(a) demonstration waiver, Wisconsin's BadgerCare Reform Demonstration Project covers non-pregnant, childless adults, between ages 19 and 64, with income that does not exceed 100 percent of the FPL. These individuals are not pregnant or qualified for any other Medicaid, Medicare, or Children's Health Insurance Program (CHIP).

The waiver demonstration allows Wisconsin to provide state plan benefits, other than family planning services and tuberculosis-related services, to childless adults who have household income that does not exceed 100 percent of the FPL. Cost sharing for the childless adult population is the same as that indicated in the Medicaid state plan. The focus for this population is to improve health outcomes, reduce unnecessary services, and improve the cost effectiveness of Medicaid services.

Amendment Proposal: Through a waiver amendment, Wisconsin would establish new policies for the childless adult population. The benefit package and delivery system for the demonstration population would remain the same.

Policy 1: Monthly Premiums
Establishing monthly premiums help to increase the sustainability and value of health care in the state. The amount of the premium will be divided into four income tiers:

	Household Income	Monthly Premium Amount
Tier 1	0 to 20 percent of the FPL	No premium
Tier 2	21 to 50 percent of the FPL	$1 per household
Tier 3	51 to 80 percent of the FPL	$5 per household
Tier 4	81 to 100 percent of the FPL	$10 per household

The proposed monthly premium requirement will not affect the current copayment policies, which will remain in place. Wisconsin will notify members who do not pay billed premiums,

thus providing opportunities for members to pay before these provisions are applied. Once members are no longer eligible for this reason, they may not be eligible for health care benefits again for up to six (6) months. Re-enrollment during those six-months will not be allowed until all outstanding premiums are paid. Members may reenroll at any time prior to the end of the six months by paying owed premiums. After the six-month period, individuals may gain eligibility for health care benefits again if they meet all program rules, even if they have unpaid premiums. Premiums will be calculated when a member reports a change in income or at annual eligibility redetermination. Third-party contributors will be permitted to make payments on a member's behalf.

Policy 2: Healthy Behavior Incentives
This policy includes using a healthy behaviors incentive model. For members who are engaging in healthy behaviors, premiums will be reduced by half. For members who are found as having a health risk behavior but who are actively managing their behavior and/or have a condition beyond their control, the premium will be reduced by half. For members found as having a health risk behavior who are not actively managing their behavior(s), the standard premium will be applied. Health risk behavior measures include alcohol consumption, body weight, illicit drug use, seatbelt use, and tobacco use. There will be a threshold identified that determines when these behaviors are health risks.

Additionally, to promote appropriate use of health care services and behavior that is mindful of health care value, members who utilize the emergency department will be responsible for an $8 copay for the first visit and a $25 copay for subsequent visits during a 12-month period. Providers will be responsible for collecting copayments from members but cannot refuse treatment for nonpayment of the copay.

Policy 3: Health Risk Assessment
This policy includes a health risk assessment (HRA) that will be used to identify healthy behavior and health risks for improved understanding of the health needs of these members. The HRA is expected to be completed at enrollment and again at annual renewal, and it will be the tool used to determine if a member is eligible for rewards for engaging in healthy behavior. HRA completion is not a condition of eligibility; however, members will pay the full standard premium until they complete the HRA.

Policy 4: Time Limit on Medicaid Eligibility
This policy is a 48-month eligibility limit for members using a cumulative formula. After 48 months of enrollment, a member will not be eligible for health care benefits for six months. The time a member is working or taking part in an employment and training program for at least 80 hours a month will not be included in their 48-month eligibility limit. This work component applies to members ages 19-49. Exemptions from the work component and time limit will align with the FoodShare Employment and Training (FSET) program (for example, individuals with mental illness, disabilities, and full-time students). Members who are over age 49 will not be subject to the 48-month eligibility limit.

Policy 5: Substance Abuse Identification and Treatment
This policy addresses the issues of SUD, which is a significant public health risk and a barrier to health, welfare, and economic achievement of residents. The goal of the drug screening and drug test is to identify individuals with unmet SUD treatment needs and connect them with appropriate treatment. The policy requires these individuals to submit to a drug screening assessment and, if indicated, a drug test. Individuals who do test positive for a drug without evidence of a valid prescription will be referred to a SUD treatment program and will continue to be eligible for all program benefits. Members who fail to complete a drug screening assessment or drug test will be ineligible for benefits until the requirement is completed. Refusal to participate in a SUD treatment program will result in ineligibility for benefits for six months.

Proposed Benefit Change for all BadgerCare Plus and Medicaid Members

Policy 6: Residential Treatment Coverage
Under current policy, residential substance abuse treatment is not fully covered, presenting a barrier to continuity of care and limiting access to appropriate levels of care for individuals with SUDs. Expanding treatment for SUD is critical to combating a statewide drug abuse epidemic. DHS recognizes the barrier this presents for individuals who require SUD treatment and is designing a benefit to provide full coverage of residential treatment. In order to effectively implement this benefit, however, federal Medicaid funding must be made available to reimburse residential SUD treatment for individuals in facilities that qualify as IMDs. As such, DHS is requesting a residential SUD treatment waiver of the federal exclusion for IMD reimbursement. Additionally, DHS is requesting a waiver of the 15-day limit for IMD coverage found in Medicaid managed care regulations. These waivers will ensure that appropriate treatment options are available for individuals with SUD.

VI. Budget and Cost Effectiveness Analysis

Waiver Population Enrollment and Expenditures

				Estimated	
	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
Enrollment	99,967	154,561	150,050	147,483	146,407
Expenditures	$424,170,522	$775,836,538	$825,120,447	$923,979,859	$1,045,005,614

Approach to Ensuring Federal Budget Neutrality
Federal policy requires section 1115 waiver demonstrations be budget neutral to the federal government. This means that a demonstration should not cost the federal government more than what would have otherwise been spent absent the demonstration. Particulars, including methodologies, are subject to negotiation between DHS submitting the demonstration application and CMS.

To ensure budget neutrality for each federal fiscal year of this amendment to the current five-year BadgerCare demonstration, Wisconsin will continue to use a per-member per-month (PMPM) methodology specific to the Wisconsin childless adult population with income under

100 percent of the FPL, in the context of current federal and state law and with the appropriate, analytically sound baselines and adjustments. The demonstration will measure the financial impact to the program independent of enrollment fluctuations.

In establishing the baseline PMPM, historic enrollment and expenditure experience related to childless adults (managed care and fee-for-service) will be evaluated. This evaluation will accurately represent the primary baseline costs associated with this population and will include payments made under the actuarially sound, CMS-approved capitation rates.

Adjustments to reflect, as appropriate:

- Financial impact of collecting premiums coupled with healthy behavior incentives.
- Financial impact of collecting higher emergency department copays.
- Financial impact of 48-month eligibility. This may include estimated costs related to job training.
- Substance abuse identification and treatment will include modeled costs of treatment, including potential agreements with the federal government around residential SUD treatment at IMDs.
- Use of an analytically appropriate per capita trend factor. When demonstrating federal budget neutrality under a PMPM-based methodology, states typically use the national Medicaid-specific per trends reflected in the President's most recent proposed federal budget.
- Multiplying aggregate average annual PMPM figures by the State's applicable Federal Medical Assistance Percentage for benefits.
- Conversion of figures from state fiscal year or calendar year to a federal fiscal year.

VII. Hypothesis and Evaluation Parameters

Wisconsin will accordingly update the BadgerCare Reform Demonstration Project evaluation design to account for the amendment provisions.

The amended demonstration evaluation will include an assessment of the following hypotheses related to members' personal responsibility in their health care:

- Completion of an HRA and paying a premium will increase members' level of engagement in their health care choices.
- Increased emergency department copayments will motivate members to use the health care system more appropriately.
- Incentivizing employment and training will support members' transition to self-sufficiency.
- Access to full coverage of residential SUD treatment will lead to improved health and employment outcomes.
- Drug screening and testing will lead to improved health and employment outcomes.

The evaluation will analyze how the demonstration impacts access, outcomes, and costs. Comparisons will be examined between the covered childless adult population, prior waiver programs, and other BadgerCare populations.

A detailed evaluation design will be developed for review and approval by CMS. The evaluator will use relevant data from the BadgerCare program and its managed care organizations. This

may include eligibility, enrollment, claims, payment, encounter/utilization, chart reviews, and other administrative data. The evaluator may also conduct surveys and focus groups of beneficiaries and providers and other original data collection, as appropriate.

Both interim and final evaluations will be conducted to help inform DHS, CMS, stakeholders, and the general public about the performance of the demonstration. All evaluation reports will be made public and posted on the DHS website.

VIII. Specific Waiver and Expenditure Authorities

Wisconsin seeks waiver of the following requirements of the Social Security Act:

1. **Cost Sharing – Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**
   To the extent necessary to enable Wisconsin to charge premiums to the childless adult population with household incomes from 21 through 100 percent of the FPL.

2. **Comparability – Section 1902(a)(17)/Section 1902(a)(10)(B)**
   - To the extent necessary to enable Wisconsin to vary monthly premiums based on health behaviors and HRA completion.
   - To the extent necessary to enable Wisconsin to establish a time limit on eligibility for able-bodied childless adults between the ages of 19-49, while exempting other populations.

3. **Eligibility – Section 1902(a)(10)(A)**
   - To the extent necessary to enable Wisconsin to require the childless adult population, as a condition of eligibility, to complete a drug screening assessment and, if indicated, a drug test.
   - To the extent necessary to enable Wisconsin to limit a childless adult's eligibility to 48 cumulative months with exceptions as described in this waiver application.

4. **Reasonable Promptness – Section 1902(a)(3)/Section 1902(a)(8)**
   - To the extent necessary to enable Wisconsin to establish a restrictive re-enrollment period of six months for childless adults who are disenrolled for failure to pay premiums prior to annual re-enrollment, for exceeding the 48-month enrollment time limit, or for refusal to participate in a substance abuse treatment program if required.

5. **Cost Sharing for Emergency Department Utilization – Section 1916(f)**
   - To the extent necessary to enable Wisconsin to establish an emergency department copay of $8 and subsequently $25 over a 12-month period for the childless adult population.

6. **Costs Not Otherwise Matchable - Section 1905(a)(29)(B)**
   - Wisconsin requests that expenditures for providing residential SUD treatment in an IMD be regarded as expenditures under the State's Medicaid Title XIX State Plan.
   - Wisconsin requests that expenditures for providing residential SUD treatment in an IMD for members enrolled in managed care are allowable to the same extent as those for Medicaid members covered through fee-for-service.

- Wisconsin requests that expenditures related to costs associated with employment training as a covered benefit for the childless adults population be regarded as expenditures under the State's Medicaid Title XIX State Plan.

IX. Copies of Demonstration Project Waiver Documents

Copies of waiver documents, including the final waiver amendment application once complete, may be obtained from DHS at no charge by downloading the documents at https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm or by contacting Al Matano at:

Division of Medicaid Services
P.O. Box 309
Madison, WI 53707-0309
Phone: 608-267-6848
Fax: 608-266-3205
Email: Alfred.Matano@dhs.wisconsin.gov

X. Written Comments

Written comments on the proposed changes are welcome and will be accepted from April 19, 2017, through May 19, 2017. Written comments may be sent to the Division of Medicaid Services at:

P.O. Box 309
Madison, WI 53707-0309
Fax: 608-266-1096
Email: Wisconsin1115CLAWaiver@dhs.wisconsin.gov

Public comments will be included in the waiver request submitted to CMS on May 26, 2017, and will be available on DHS's website at the address listed above.

Section 1115 BadgerCare Reform Demonstration Project Waiver Amendment

Public Hearing

April 26, 2017

May 1, 2017

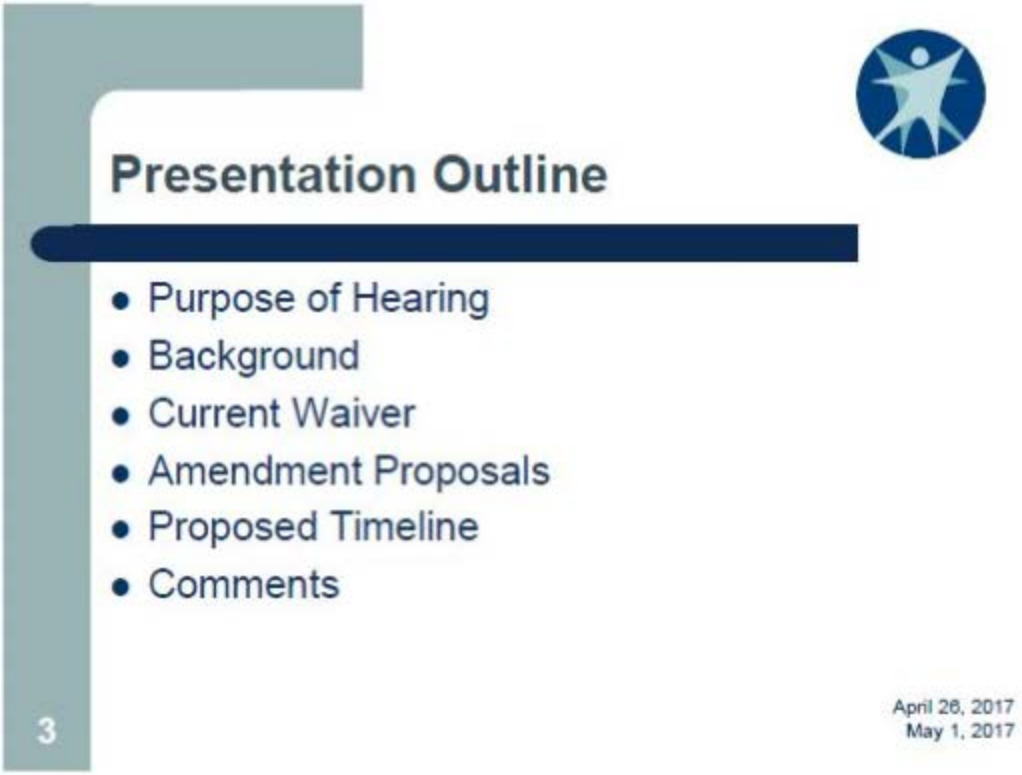
Wisconsin Department of Health Services

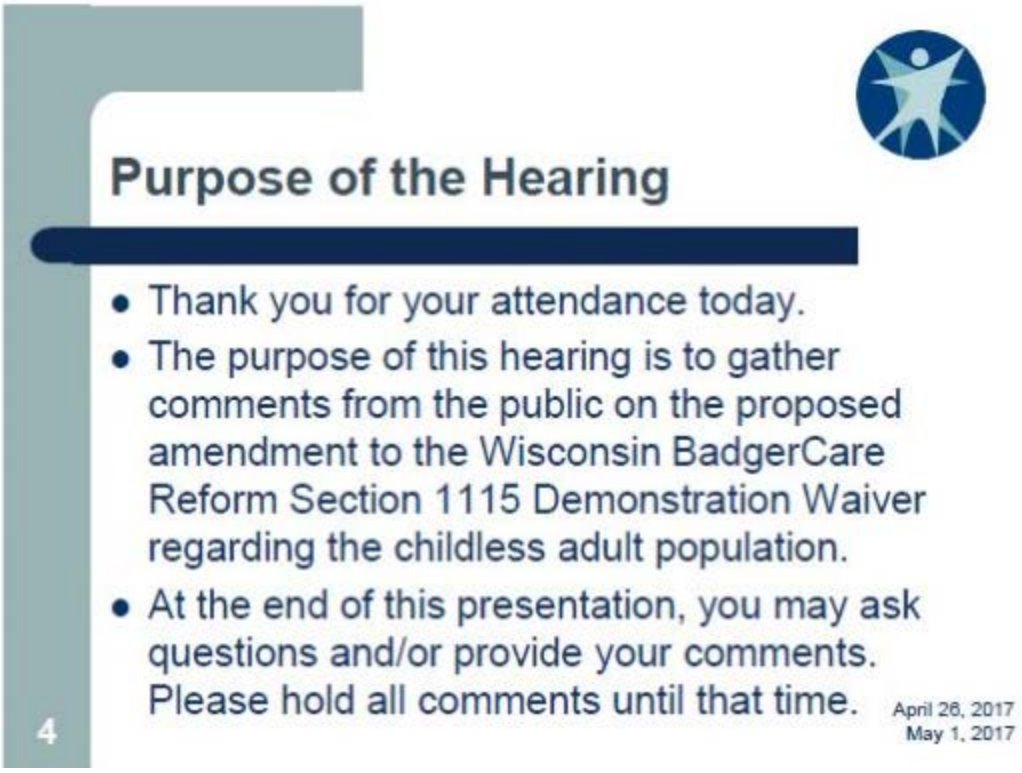
Join the Public Hearing Remotely (live)

- Webcast link available at:
  - https://livestream.com/accounts/14059632/events/7313758 (Wausau, April 26, 2017)
  - https://livestream.com/DHSWebcast/events/7314990 (Milwaukee, May 1, 2016)
- Dial in to the webcast for listening only:
  - 1-877-820-7831
  - Enter 907179 (participant passcode)
- Leave comments by voicemail until midnight at: 1-888-258-8997

2

April 26, 2017
May 1, 2017


Presentation Outline
• Purpose of Hearing
• Background
• Current Waiver
• Amendment Proposals
• Proposed Timeline
• Comments
3
April 26, 2017
May 1, 2017


Purpose of the Hearing
• Thank you for your attendance today.
• The purpose of this hearing is to gather comments from the public on the proposed amendment to the Wisconsin BadgerCare Reform Section 1115 Demonstration Waiver regarding the childless adult population.
• At the end of this presentation, you may ask questions and/or provide your comments. Please hold all comments until that time.
4
April 26, 2017
May 1, 2017

Current Waiver – Background

Starting January 1, 2014, the Center for Medicare and Medicaid Services (CMS) granted Wisconsin approval to:

- Cover the childless adult population with no waitlist for the first time in state history.
- Test the impact of providing Transitional Medical Assistance (TMA) to individuals who are paying premiums that align with Marketplace insurance.

5

April 26, 2017
May 1, 2017

Current Waiver – Childless Adult Population

- Defined as non-pregnant adults without dependent children ages 19 to 64.
- Household income limit up to 100 percent federal poverty level (FPL).
- Standard benefit plan coverage.
- Enrollment is not capped and is currently approximately 148,000.

6

April 26, 2017
May 1, 2017

State Legislation

- The Wisconsin 2015-2017 biennial budget (Act 55) requires the Wisconsin Department of Health Services (DHS) to submit to the federal Department of Health and Human Services an amendment to the BadgerCare Reform Demonstration Waiver.
- There are five policy changes pertaining only to the childless adult population that must be included in the amendment request.

7

April 26, 2017
May 1, 2017

Act 55 Amendment Proposals

- Establish monthly premiums.
- Establish lower premiums for members engaged in healthy behaviors.
- Require completion of a health risk assessment.
- Limit a member's eligibility to no more than 48 months.
- Require, as a condition of eligibility, that an applicant or member complete a drug screening, and, if indicated, a drug test.

8

April 26, 2017
May 1, 2017

Non-Act 55 Amendment Proposals

- Charge an increased copayment for emergency department utilization for childless adults.
- Establish a work component for childless adults.
- Provide full coverage of residential substance use disorder treatment for all BadgerCare Plus and Medicaid members.

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April 26, 2017
May 1, 2017

Project Objectives

- Ensure that every Wisconsin resident has access to affordable health insurance to reduce the state's uninsured rate.
- Create a medical assistance program that is sustainable so a health care safety net is available to those who need it most.
- Expand the use of integrated health care for all individuals.
- Establish greater accountability for improved health care value.

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April 26, 2017
May 1, 2017

Project Objectives

- Empower members to become active consumers of health care services to help improve their health outcomes.
- Help more Wisconsin citizens become independent and be able to rely less on government-sponsored health insurance.
- Design a medical assistance program that aligns with commercial health insurance design to support members' transition from public to commercial health care coverage.

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April 26, 2017
May 1, 2017

Monthly Premiums

- Premiums will help better align the member experience with that of private health care in Wisconsin.
- Requiring payments directly from members will help to actively engage members in appropriate health care utilization and value.
- If approved, the following premium policy will apply to the childless adult population:

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April 26, 2017
May 1, 2017

Monthly Premiums

Household Income	Monthly Premium Amount
0 to 20 percent of FPL	No premium
21 to 50 percent of FPL	$1 per household
51 to 80 percent of FPL	$5 per household
81 to 100 percent of FPL	$10 per household

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April 26, 2017
May 1, 2017

Premium Payment Requirements

- Members with outstanding premiums will not be eligible for annual re-enrollment for six months or until all premiums are paid in full.
- Premiums can be paid at anytime during the six-month period to regain eligibility.
- After the six-month period, individuals may regain eligibility even if they have unpaid premiums.
- Premiums may be paid by third parties, including nonprofits, etc.

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April 26, 2017
May 1, 2017

Healthy Behavior Incentives

- Members will be provided the opportunity to reduce their premiums by choosing healthy behaviors.
- Rewarding members' healthy behavior will empower them to be actively engaged in their health care.
- It will also improve accountability and lower health care costs and follow similar programs adopted in the private market.
- Those engaging in healthy behavior would have the standard premium reduced by 50%.

15

April 26, 2017
May 1, 2017

Health Risk Assessment (HRA)

An HRA will be required on an annual basis.

- Members will self-attest to their behaviors.
- If a member does not complete the HRA, then the member would be subject to the standard premium.
- Members can self-attest to their active management of a health risk behavior.
- Members can self-attest to an underlying health condition that affects a health risk measure.

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April 26, 2017
May 1, 2017

Healthy Behavior Incentives

Health Risk Behaviors	Risk Measurement	Identification Tool
• Alcohol consumption • Body weight • Illicit drug use • Seatbelt use • Tobacco use	Threshold of when a behavior is determined as posing a health risk will follow national health organizations standards.	HRA

17

April 26, 2017
May 1, 2017

Healthy Behavior Incentives

Reduced Premium (by half)	Standard Premium
• Members not engaging in any health risk behaviors. • Members engaging in health risk behavior(s) but who attest to actively managing their behavior. • Members engaging in health risk behaviors(s) but who attest to having a condition beyond their control impacting the health risk measurement.	Members engaging in health risk behavior(s) and not actively managing their behavior(s).

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Emergency Department Copay

- To promote appropriate use of health care services and behavior that is mindful of health care value.
- Members who use the emergency department will pay an $8 copay for the first visit and a $25 copay for subsequent visits during a 12-month period.

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Time Limit on Medicaid Eligibility

Aligns with program goals:

- Provides assistance to individuals most in need.
- Promotes employer-sponsored insurance.
- Helps people move from dependence to independence.
- Promotes work and training to move to nongovernment programs.

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48-Month Eligibility Time Limit
• Members enrollment is limited to 48 months.
• The 48-month count will begin on the effective date of policy implementation for all childless adults currently enrolled in BadgerCare.
• For members who enroll in BadgerCare after the 48-month limit has been implemented, the time limit count will begin on the date of initial program enrollment.
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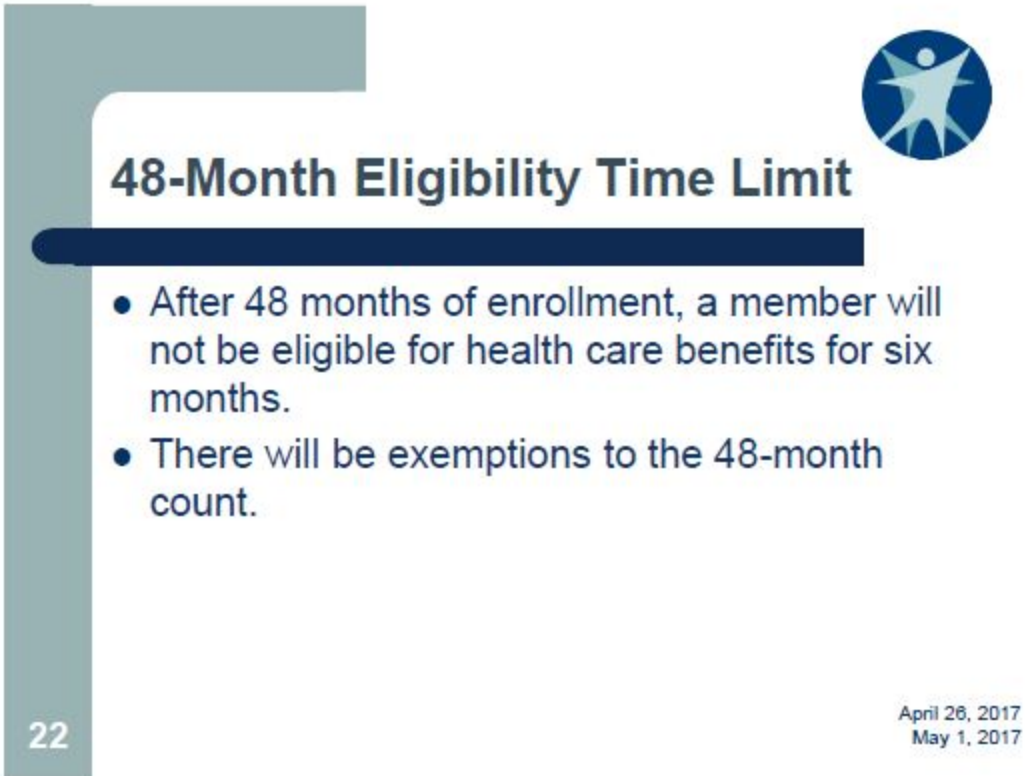
48-Month Eligibility Time Limit
• After 48 months of enrollment, a member will not be eligible for health care benefits for six months.
• There will be exemptions to the 48-month count.
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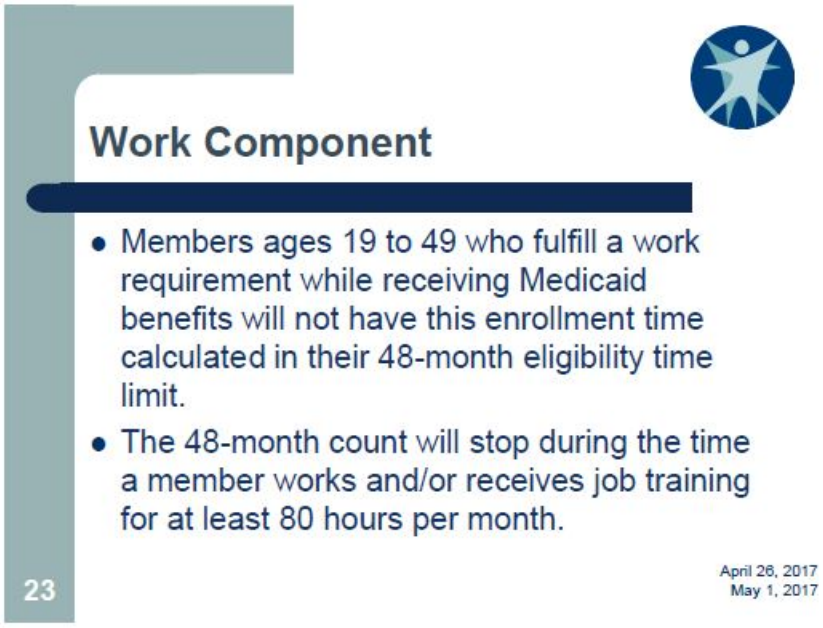
Work Component
• Members ages 19 to 49 who fulfill a work requirement while receiving Medicaid benefits will not have this enrollment time calculated in their 48-month eligibility time limit.
• The 48-month count will stop during the time a member works and/or receives job training for at least 80 hours per month.
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Work Component
Aligns with program goals:
• Encourages members to seek work and reach self-sufficiency.
• Empowers citizens to obtain skills and training to secure full-time employment.
• Aligns with Wisconsin's FoodShare Employment and Training (FSET) program.
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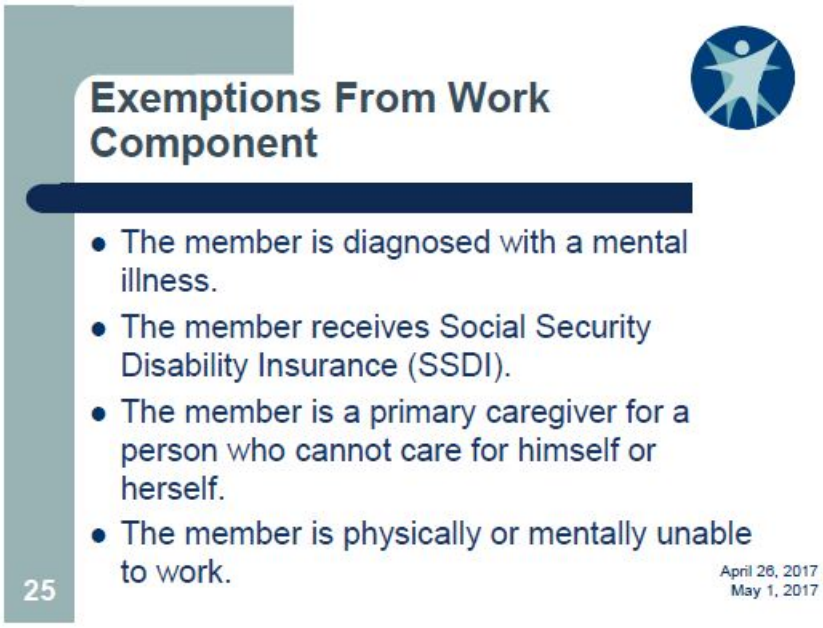
Exemptions From Work Component
• The member is diagnosed with a mental illness.
• The member receives Social Security Disability Insurance (SSDI).
• The member is a primary caregiver for a person who cannot care for himself or herself.
• The member is physically or mentally unable to work.
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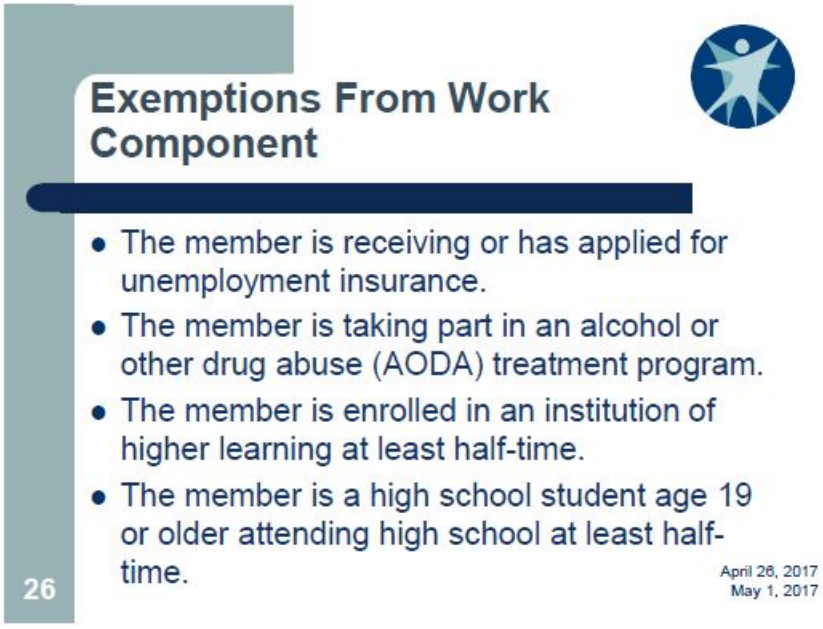
Exemptions From Work Component
• The member is receiving or has applied for unemployment insurance.
• The member is taking part in an alcohol or other drug abuse (AODA) treatment program.
• The member is enrolled in an institution of higher learning at least half-time.
• The member is a high school student age 19 or older attending high school at least half-time.
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Substance Abuse Identification and Treatment
• Substance abuse is a major public health issue in Wisconsin and across the nation.
• Since 2013, 17 bills have been passed in Wisconsin that address substance abuse.
• In 2016, the Governor created the Task Force on Opioid Abuse to address these challenges.
• In 2017, 9 bills on substance abuse have passed the Assembly.
• Medicaid is Wisconsin's largest health care program and plays a key role in identifying affected individuals and assisting them with treatment.
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Substance Abuse Identification and Treatment
Requires, as a condition of eligibility, that an applicant or member submit to a drug screening assessment and, if indicated, a drug test.
• Individuals will not lose coverage or eligibility if they test positive, as the policy goal is to connect those with substance use disorder to treatment.
• The drug screening assessment will be a questionnaire regarding members current and prior use of controlled substances.
• Screening will be completed at the time of application and annual redetermination.
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Substance Abuse Identification and Treatment

Requirement	Impact of Requirement Results	Consequence for Refusal to Complete Requirement
Drug Screening Assessment	Negative Result: Eligible for health care benefits with no further action required Positive Result: Eligible for health care benefits AND required to submit to a drug test	Ineligible for heath care benefits until the assessment is completed
Drug Test	Negative Result: Eligible for health care benefits with no further action required Positive Result: Eligible for health care benefits AND required to participate in substance abuse treatment	Ineligible for health care benefits until the drug test is submitted
Substance Abuse Treatment	Full completion of substance abuse treatment program	Ineligible for health care benefits and may reapply for benefits after a six-month period

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Substance Use Disorder Residential Treatment

Under current federal policy, residential substance abuse treatment is not fully covered, presenting a barrier to continuity of care and limiting access to appropriate levels of care for individuals with substance use disorders.

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Substance Use Disorder Residential Treatment

DHS is requesting the following for all BadgerCare Plus and Medicaid members:

- Residential substance use disorder treatment waiver of the federal exclusion for institution for mental disease (IMD) reimbursement.
- A waiver of the 15-day limit for IMD coverage found in Medicaid managed care regulations.

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Budget Neutrality

- Federal policy requires Section 1115 demonstration waivers be budget neutral to the federal government.
- Wisconsin proposes to use a per-member per-month (PMPM) methodology to determine and achieve budget neutrality.

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Proposed Timeline

Major Milestone	Tentative Date
Public Notice Issued	April 19, 2017
Public Hearings	April 26, 2017 May 1, 2017
Tribal Consultation	May 1, 2017
Public Comment Period Closed	May 19, 2017
Review Public Comments/Edit Draft Waiver Amendment Application	May 19 – May 26, 2017
Waiver Amendment Application Submitted to CMS	May 26, 2017
CMS Approval	By end of 2017
Amendment Effective Date	At least a year from CMS Approval

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Providing Comments

To ensure an orderly and efficient process:

- Sign in if you would like to provide a comment during the meeting today.
- You will be given a number that will be called when it is your turn to speak.
- Speak into the microphone so you can be heard.
- Keep your comments to the topic at hand – the BadgerCare Reform Section 1115 Demonstration Waiver Amendment.
- You will have two minutes to speak.
- If you have written comments, leave them with the designated individual.

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Comments

- All comments that are properly submitted will be given equal weight regardless of the method in which they are submitted.
- Comments may be submitted through May 19, 2017
  - Online: https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm
  - Email: Wisconsin1115CLAWaiver@dhs.wisconsin.gov
- Phone number for voicemail: 1-888-258-8997 (available until midnight tonight).

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Comments

Comments may also be submitted by:

- Fax: 608-266-1096
- Mail:

  Al Matano
  Division of Medicaid Services
  P.O. Box 309
  Madison, WI 53707-0309

Note: You may provide comments in your desired language.

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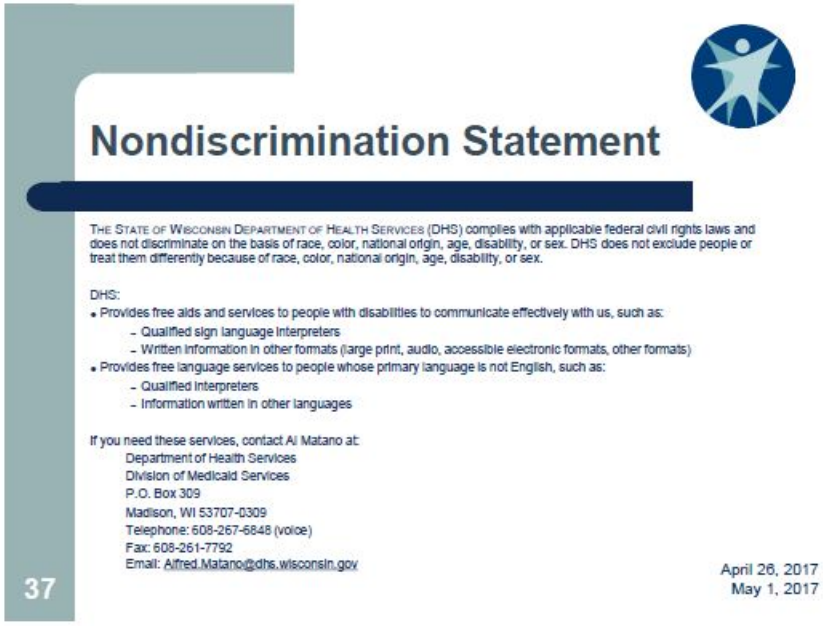

Nondiscrimination Statement

THE STATE OF WISCONSIN DEPARTMENT OF HEALTH SERVICES (DHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DHS:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Al Matano at:

Department of Health Services
Division of Medicaid Services
P.O. Box 309
Madison, WI 53707-0309
Telephone: 608-267-6848 (voice)
Fax: 608-261-7792
Email: Alfred.Matano@dhs.wisconsin.gov

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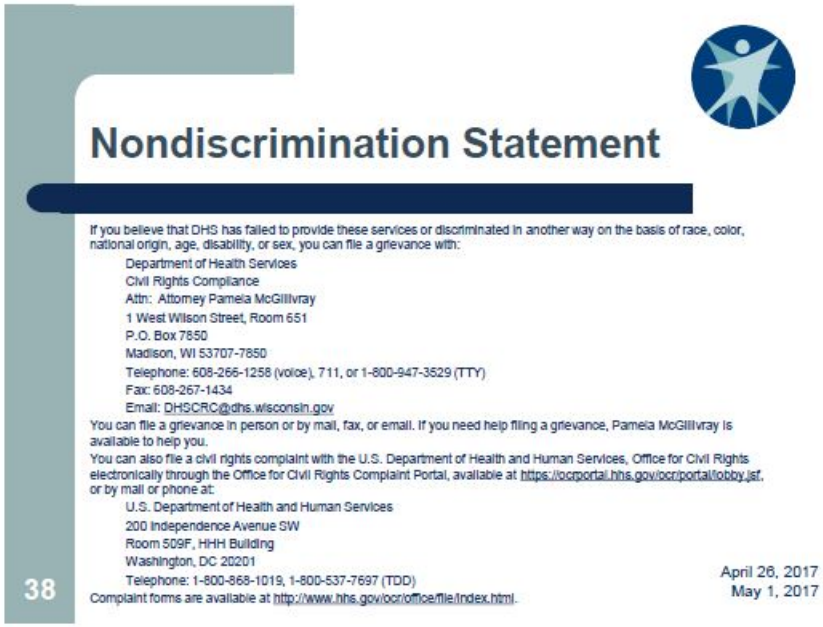

Nondiscrimination Statement

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Department of Health Services
Civil Rights Compliance
Attn: Attorney Pamela McGillivray
1 West Wilson Street, Room 651
P.O. Box 7850
Madison, WI 53707-7850
Telephone: 608-266-1258 (voice), 711, or 1-800-947-3529 (TTY)
Fax: 608-267-1434
Email: DHSCRC@dhs.wisconsin.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pamela McGillivray is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Telephone: 1-800-868-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Language Assistance

- This presentation will be posted in English, Spanish, and Hmong at: https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm.
- If you would like to see this presentation in your desired language, email Alfred.Matano@dhs.wisconsin.gov.

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Language Assistance

- ATTENTION: Language assistance services, free of charge, are available to you. Call 1-608-267-6848.
- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-267-6848.
- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-608-267-6848.
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-608-267-6848.
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-608-267-6848.
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-608-267-6848.
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-608-267-6848 번으로 전화해 주십시오.
- ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-608-267-6848 पर कॉल करें।

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Language Assistance
اذا كنت تتحدث اكرا اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-608-267-6848 (رقم هاتف الصم و البكم/الحركة:
ໃບຄວາມ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ວິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-608-267-6848.
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-608-267-6848.
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-608-267-6848.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-608-267-6848.
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-608-267-6848.
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-608-267-6848.
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-608-267-6848.
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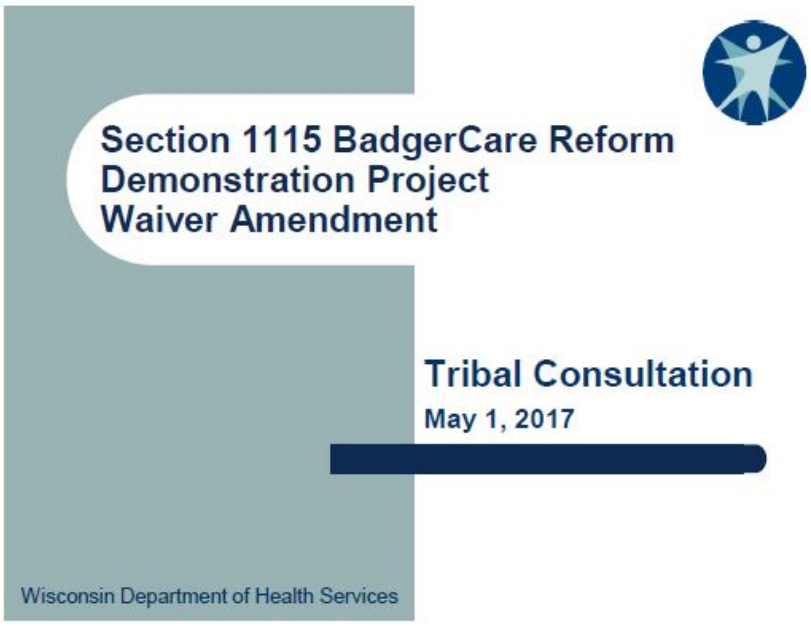
Section 1115 BadgerCare Reform Demonstration Project Waiver Amendment
Tribal Consultation
May 1, 2017
Wisconsin Department of Health Services


Join the Public Hearing Remotely (live)
Webcast link available at:
https://livestream.com/accounts/14059632/events/7313758 (Wausau, April 26, 2017)
https://livestream.com/DHSWebcast/events/7314990 (Milwaukee, May 1, 2016)
Dial in to the webcast for listening only:
1-877-820-7831
Enter 907179 (participant passcode)
Leave comments by voicemail until midnight at: 1-888-258-8997
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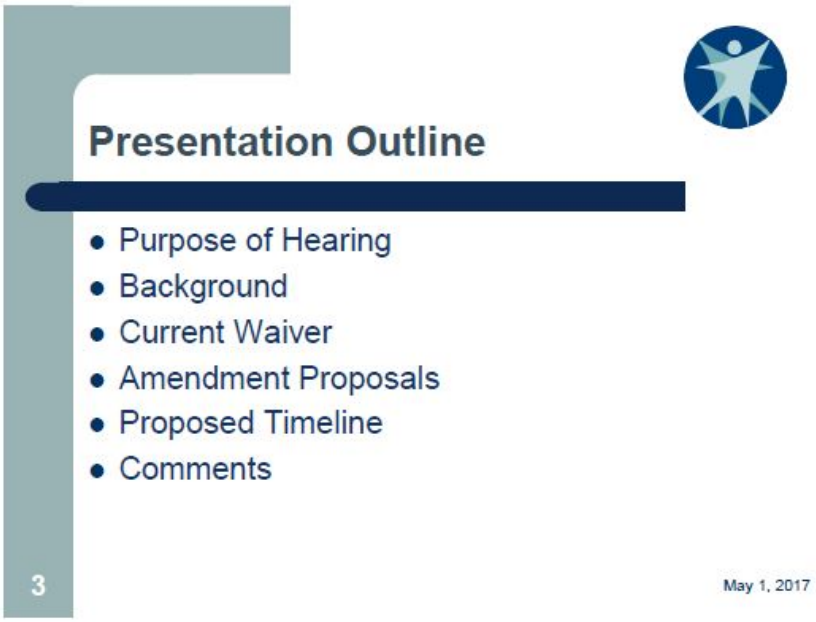
Presentation Outline
Purpose of Hearing
Background
Current Waiver
Amendment Proposals
Proposed Timeline
Comments
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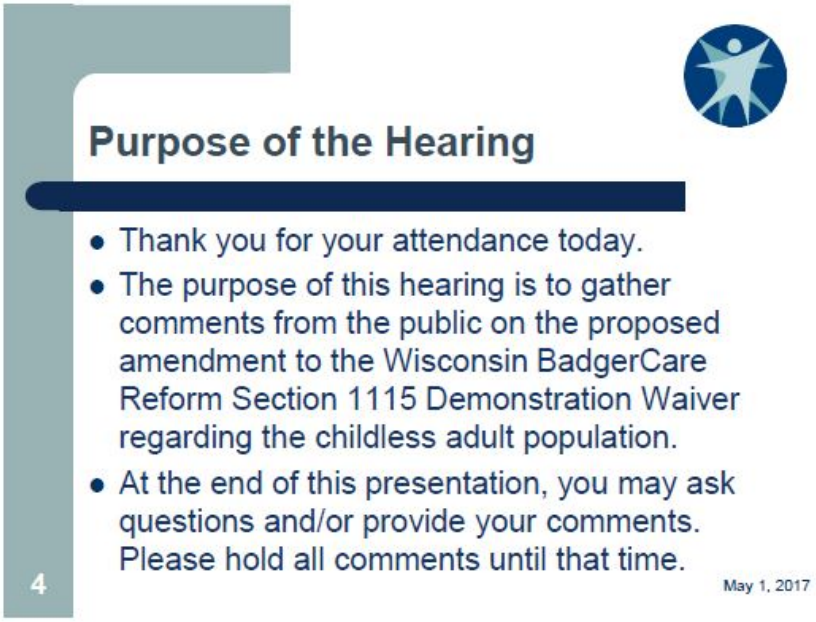
Purpose of the Hearing
Thank you for your attendance today.
The purpose of this hearing is to gather comments from the public on the proposed amendment to the Wisconsin BadgerCare Reform Section 1115 Demonstration Waiver regarding the childless adult population.
At the end of this presentation, you may ask questions and/or provide your comments. Please hold all comments until that time.
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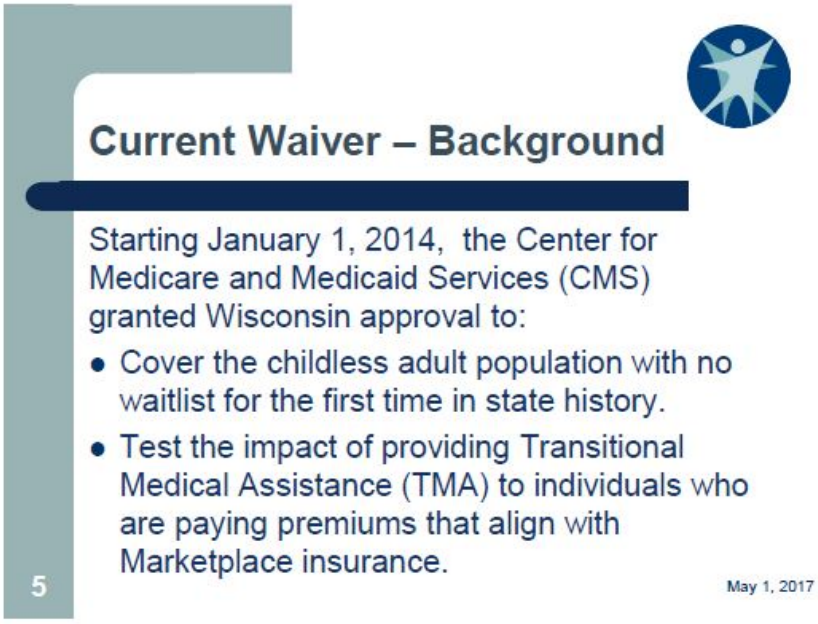
Current Waiver – Background
Starting January 1, 2014, the Center for Medicare and Medicaid Services (CMS) granted Wisconsin approval to:
• Cover the childless adult population with no waitlist for the first time in state history.
• Test the impact of providing Transitional Medical Assistance (TMA) to individuals who are paying premiums that align with Marketplace insurance.
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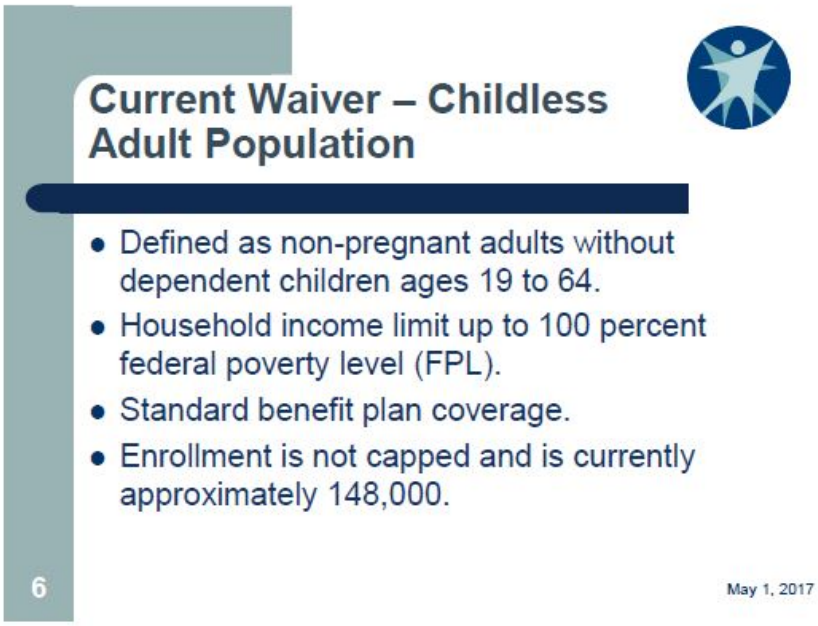
Current Waiver – Childless Adult Population
• Defined as non-pregnant adults without dependent children ages 19 to 64.
• Household income limit up to 100 percent federal poverty level (FPL).
• Standard benefit plan coverage.
• Enrollment is not capped and is currently approximately 148,000.
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State Legislation

- The Wisconsin 2015-2017 biennial budget (Act 55) requires the Wisconsin Department of Health Services (DHS) to submit to the federal Department of Health and Human Services an amendment to the BadgerCare Reform Demonstration Waiver.
- There are five policy changes pertaining only to the childless adult population that must be included in the amendment request.

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Act 55 Amendment Proposals

- Establish monthly premiums.
- Establish lower premiums for members engaged in healthy behaviors.
- Require completion of a health risk assessment.
- Limit a member's eligibility to no more than 48 months.
- Require, as a condition of eligibility, that an applicant or member complete a drug screening, and, if indicated, a drug test.

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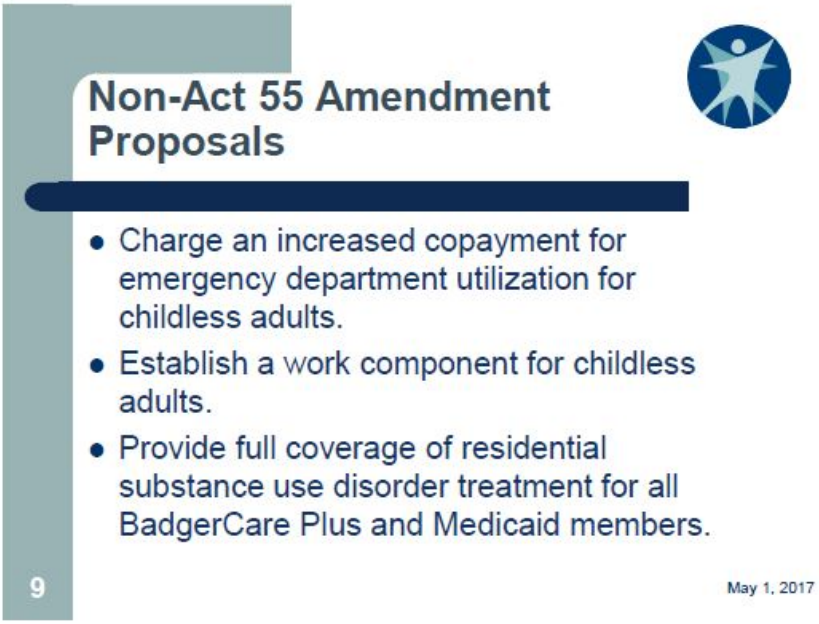
Non-Act 55 Amendment Proposals
Charge an increased copayment for emergency department utilization for childless adults.
Establish a work component for childless adults.
Provide full coverage of residential substance use disorder treatment for all BadgerCare Plus and Medicaid members.
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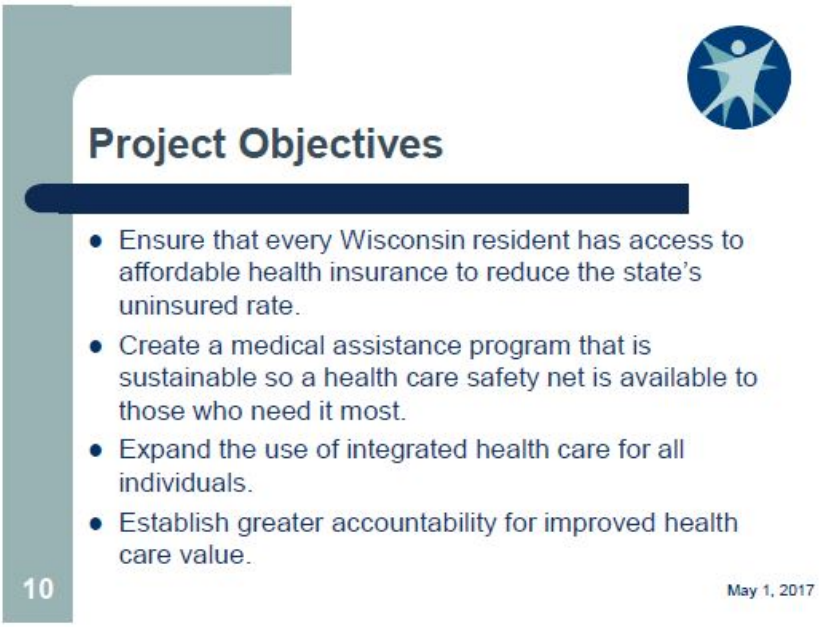
Project Objectives
Ensure that every Wisconsin resident has access to affordable health insurance to reduce the state's uninsured rate.
Create a medical assistance program that is sustainable so a health care safety net is available to those who need it most.
Expand the use of integrated health care for all individuals.
Establish greater accountability for improved health care value.
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Project Objectives
• Empower members to become active consumers of health care services to help improve their health outcomes.
• Help more Wisconsin citizens become independent and be able to rely less on government-sponsored health insurance.
• Design a medical assistance program that aligns with commercial health insurance design to support members' transition from public to commercial health care coverage.
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Monthly Premiums
• Premiums will help better align the member experience with that of private health care in Wisconsin.
• Requiring payments directly from members will help to actively engage members in appropriate health care utilization and value.
• If approved, the following premium policy will apply to the childless adult population:
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Monthly Premiums

Household Income	Monthly Premium Amount
0 to 20 percent of FPL	No premium
21 to 50 percent of FPL	$1 per household
51 to 80 percent of FPL	$5 per household
81 to 100 percent of FPL	$10 per household

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Premium Payment Requirements

- Members with outstanding premiums will not be eligible for annual re-enrollment for six months or until all premiums are paid in full.
- Premiums can be paid at anytime during the six-month period to regain eligibility.
- After the six-month period, individuals may regain eligibility even if they have unpaid premiums.
- Premiums may be paid by third parties, including nonprofits, etc.

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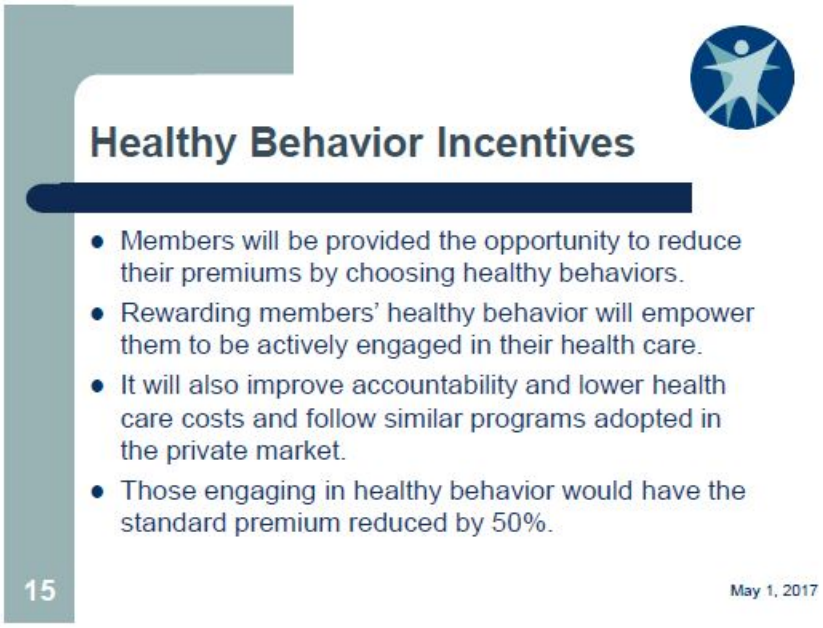
Healthy Behavior Incentives
• Members will be provided the opportunity to reduce their premiums by choosing healthy behaviors.
• Rewarding members' healthy behavior will empower them to be actively engaged in their health care.
• It will also improve accountability and lower health care costs and follow similar programs adopted in the private market.
• Those engaging in healthy behavior would have the standard premium reduced by 50%.
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Health Risk Assessment (HRA)
An HRA will be required on an annual basis.
• Members will self-attest to their behaviors.
• If a member does not complete the HRA, then the member would be subject to the standard premium.
• Members can self-attest to their active management of a health risk behavior.
• Members can self-attest to an underlying health condition that affects a health risk measure.
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Healthy Behavior Incentives

Health Risk Behaviors	Risk Measurement	Identification Tool
• Alcohol consumption • Body weight • Illicit drug use • Seatbelt use • Tobacco use	Threshold of when a behavior is determined as posing a health risk will follow national health organizations standards.	HRA

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Healthy Behavior Incentives

Reduced Premium (by half)	Standard Premium
• Members not engaging in any health risk behaviors. • Members engaging in health risk behavior(s) but who attest to actively managing their behavior. • Members engaging in health risk behaviors(s) but who attest to having a condition beyond their control impacting the health risk measurement.	Members engaging in health risk behavior(s) and not actively managing their behavior(s).

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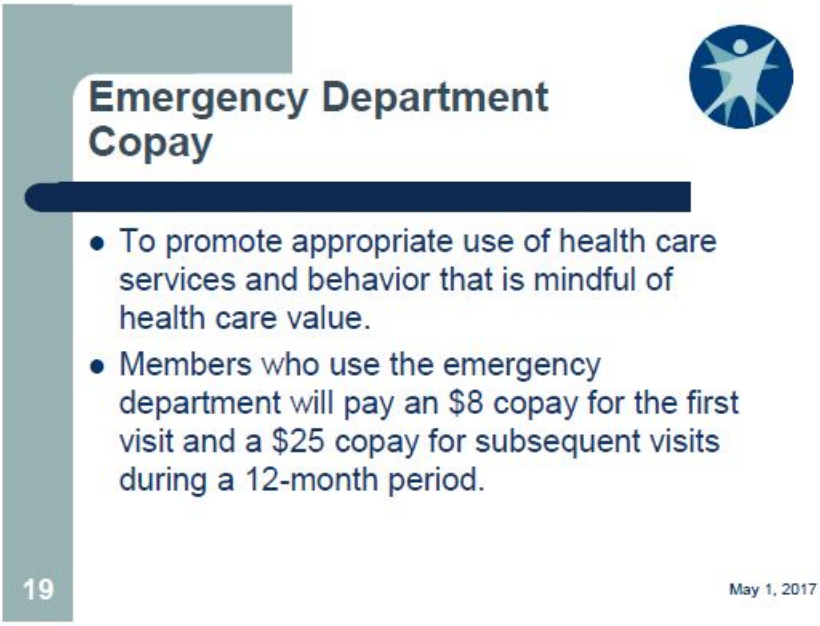
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19
May 1, 2017


Time Limit on Medicaid Eligibility
Aligns with program goals:
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May 1, 2017


48-Month Eligibility Time Limit
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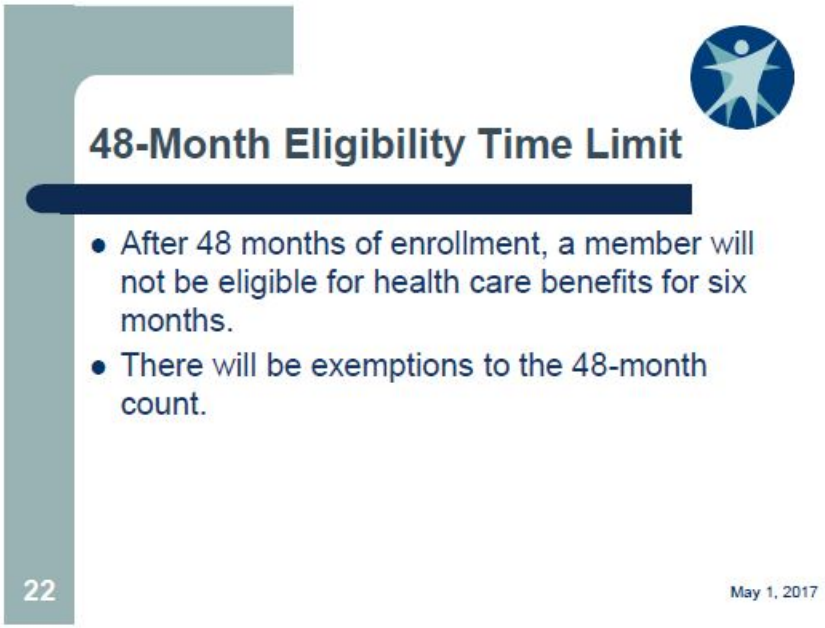
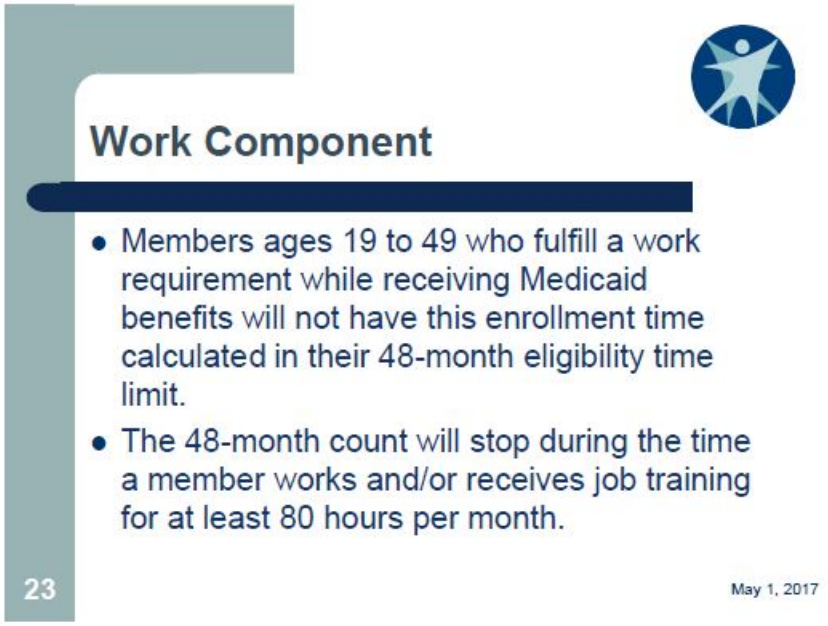
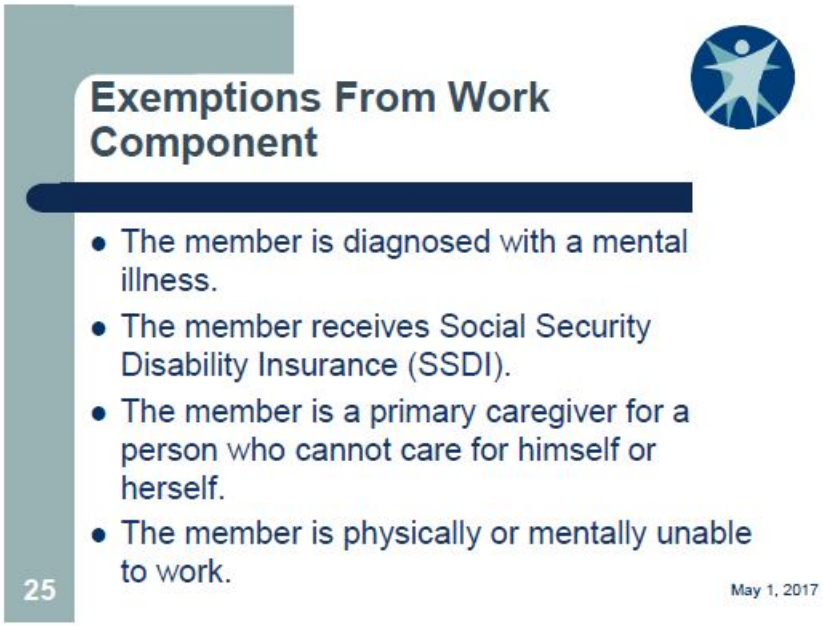
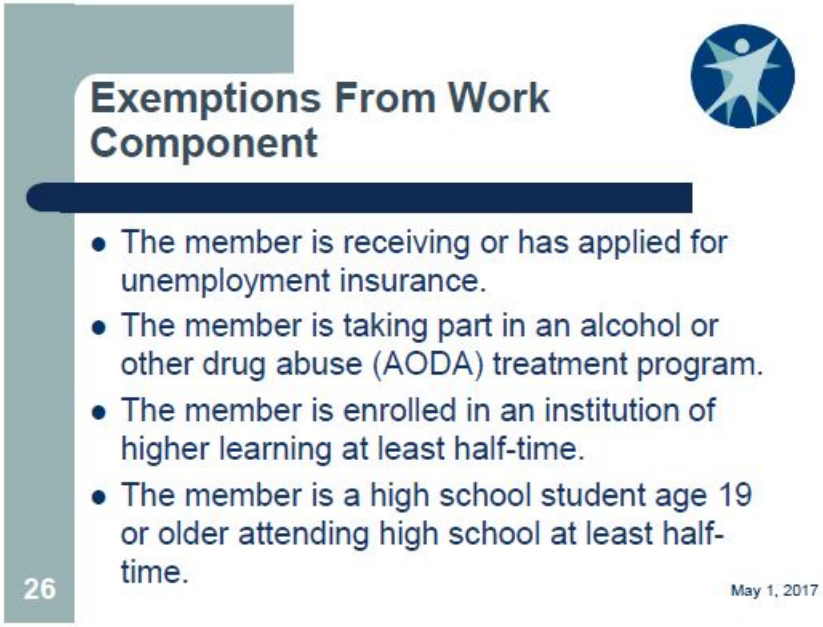
21
May 1, 2017


48-Month Eligibility Time Limit
• After 48 months of enrollment, a member will not be eligible for health care benefits for six months.
• There will be exemptions to the 48-month count.
22
May 1, 2017


Work Component
• Members ages 19 to 49 who fulfill a work requirement while receiving Medicaid benefits will not have this enrollment time calculated in their 48-month eligibility time limit.
• The 48-month count will stop during the time a member works and/or receives job training for at least 80 hours per month.
23
May 1, 2017


Work Component
Aligns with program goals:
• Encourages members to seek work and reach self-sufficiency.
• Empowers citizens to obtain skills and training to secure full-time employment.
• Aligns with Wisconsin's FoodShare Employment and Training (FSET) program.
24
May 1, 2017


Exemptions From Work Component
• The member is diagnosed with a mental illness.
• The member receives Social Security Disability Insurance (SSDI).
• The member is a primary caregiver for a person who cannot care for himself or herself.
• The member is physically or mentally unable to work.
25
May 1, 2017


Exemptions From Work Component
• The member is receiving or has applied for unemployment insurance.
• The member is taking part in an alcohol or other drug abuse (AODA) treatment program.
• The member is enrolled in an institution of higher learning at least half-time.
• The member is a high school student age 19 or older attending high school at least half-time.
26
May 1, 2017


Substance Abuse Identification and Treatment
• Substance abuse is a major public health issue in Wisconsin and across the nation.
• Since 2013, 17 bills have been passed in Wisconsin that address substance abuse.
• In 2016, the Governor created the Task Force on Opioid Abuse to address these challenges.
• In 2017, 9 bills on substance abuse have passed the Assembly.
• Medicaid is Wisconsin's largest health care program and plays a key role in identifying affected individuals and assisting them with treatment.
27
May 1, 2017


Substance Abuse Identification and Treatment
Requires, as a condition of eligibility, that an applicant or member submit to a drug screening assessment and, if indicated, a drug test.
• Individuals will not lose coverage or eligibility if they test positive, as the policy goal is to connect those with substance use disorder to treatment.
• The drug screening assessment will be a questionnaire regarding members current and prior use of controlled substances.
• Screening will be completed at the time of application and annual redetermination.
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May 1, 2017

Substance Abuse Identification and Treatment

Requirement	Impact of Requirement Results	Consequence for Refusal to Complete Requirement
Drug Screening Assessment	Negative Result: Eligible for health care benefits with no further action required Positive Result: Eligible for health care benefits AND required to submit to a drug test	Ineligible for heath care benefits until the assessment is completed
Drug Test	Negative Result: Eligible for health care benefits with no further action required Positive Result: Eligible for health care benefits AND required to participate in substance abuse treatment	Ineligible for health care benefits until the drug test is submitted
Substance Abuse Treatment	Full completion of substance abuse treatment program	Ineligible for health care benefits and may reapply for benefits after a six-month period

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May 1, 2017

Substance Use Disorder Residential Treatment

Under current federal policy, residential substance abuse treatment is not fully covered, presenting a barrier to continuity of care and limiting access to appropriate levels of care for individuals with substance use disorders.

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May 1, 2017

Substance Use Disorder Residential Treatment

DHS is requesting the following for all BadgerCare Plus and Medicaid members:

- Residential substance use disorder treatment waiver of the federal exclusion for institution for mental disease (IMD) reimbursement.
- A waiver of the 15-day limit for IMD coverage found in Medicaid managed care regulations.

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May 1, 2017

Budget Neutrality

- Federal policy requires Section 1115 demonstration waivers be budget neutral to the federal government.
- Wisconsin proposes to use a per-member per-month (PMPM) methodology to determine and achieve budget neutrality.

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May 1, 2017

Proposed Timeline

Major Milestone	Tentative Date
Public Notice Issued	April 19, 2017
Public Hearings	April 26, 2017 May 1, 2017
Tribal Consultation	May 1, 2017
Public Comment Period Closed	May 19, 2017
Review Public Comments/Edit Draft Waiver Amendment Application	May 19 – May 26, 2017
Waiver Amendment Application Submitted to CMS	May 26, 2017
CMS Approval	By end of 2017
Amendment Effective Date	At least a year from CMS Approval

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May 1, 2017

Providing Comments

To ensure an orderly and efficient process:

- Sign in if you would like to provide a comment during the meeting today.
- You will be given a number that will be called when it is your turn to speak.
- Speak into the microphone so you can be heard.
- Keep your comments to the topic at hand – the BadgerCare Reform Section 1115 Demonstration Waiver Amendment.
- You will have two minutes to speak.
- If you have written comments, leave them with the designated individual.

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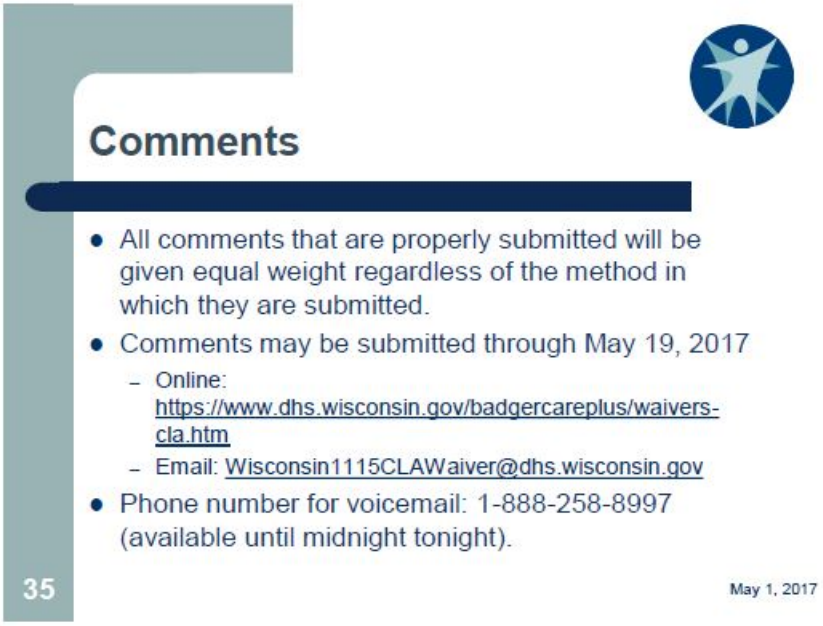
May 1, 2017


Comments
All comments that are properly submitted will be given equal weight regardless of the method in which they are submitted.
Comments may be submitted through May 19, 2017
Online: https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm
Email: Wisconsin1115CLAWaiver@dhs.wisconsin.gov
Phone number for voicemail: 1-888-258-8997 (available until midnight tonight).
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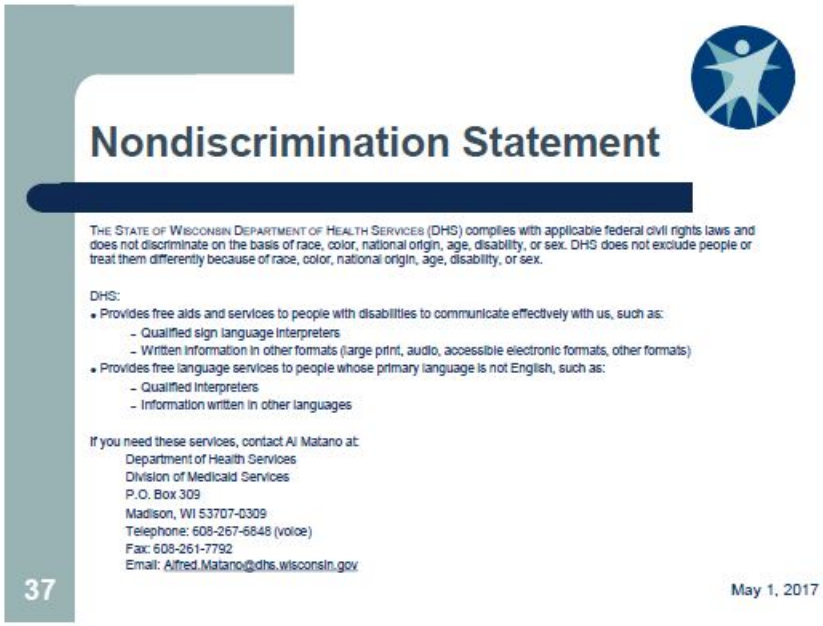
May 1, 2017


Comments
Comments may also be submitted by:
Fax: 608-266-1096
Mail:
Al Matano
Division of Medicaid Services
P.O. Box 309
Madison, WI 53707-0309
Note: You may provide comments in your desired language.
36
May 1, 2017



Nondiscrimination Statement

THE STATE OF WISCONSIN DEPARTMENT OF HEALTH SERVICES (DHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DHS:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Al Matano at:

Department of Health Services
Division of Medicaid Services
P.O. Box 309
Madison, WI 53707-0309
Telephone: 608-267-6848 (voice)
Fax: 608-261-7792
Email: Alfred.Matano@dhs.wisconsin.gov

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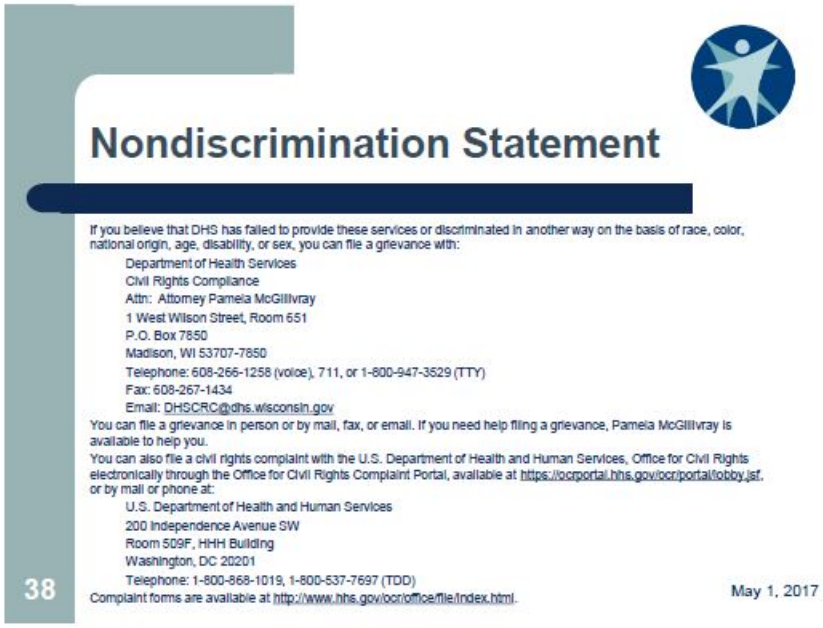
May 1, 2017



Nondiscrimination Statement

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Department of Health Services
Civil Rights Compliance
Attn: Attorney Pamela McGillivray
1 West Wilson Street, Room 651
P.O. Box 7850
Madison, WI 53707-7850
Telephone: 608-266-1258 (voice), 711, or 1-800-947-3529 (TTY)
Fax: 608-267-1434
Email: DHSCRC@dhs.wisconsin.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pamela McGillivray is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Telephone: 1-800-868-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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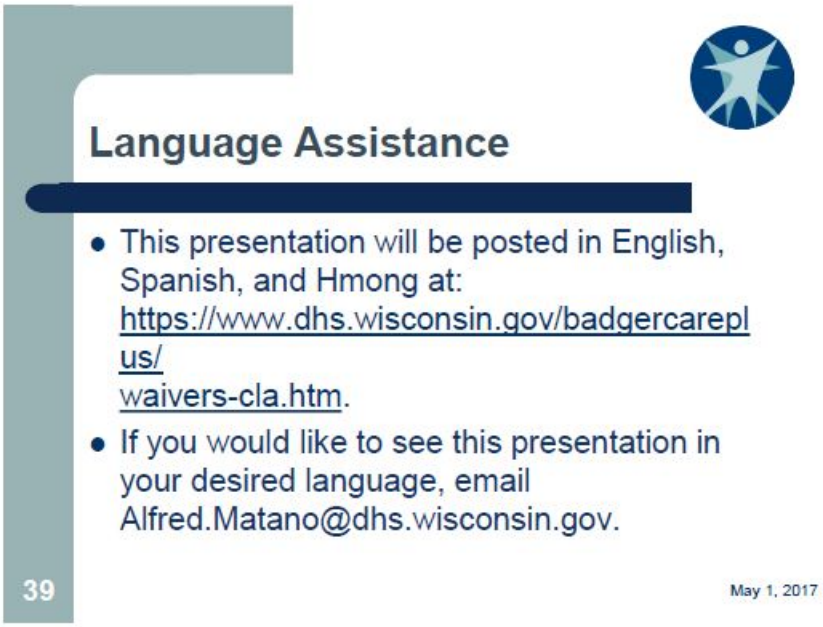
May 1, 2017


Language Assistance
This presentation will be posted in English, Spanish, and Hmong at: https://www.dhs.wisconsin.gov/badgercareplus/waivers-cla.htm.
If you would like to see this presentation in your desired language, email Alfred.Matano@dhs.wisconsin.gov.
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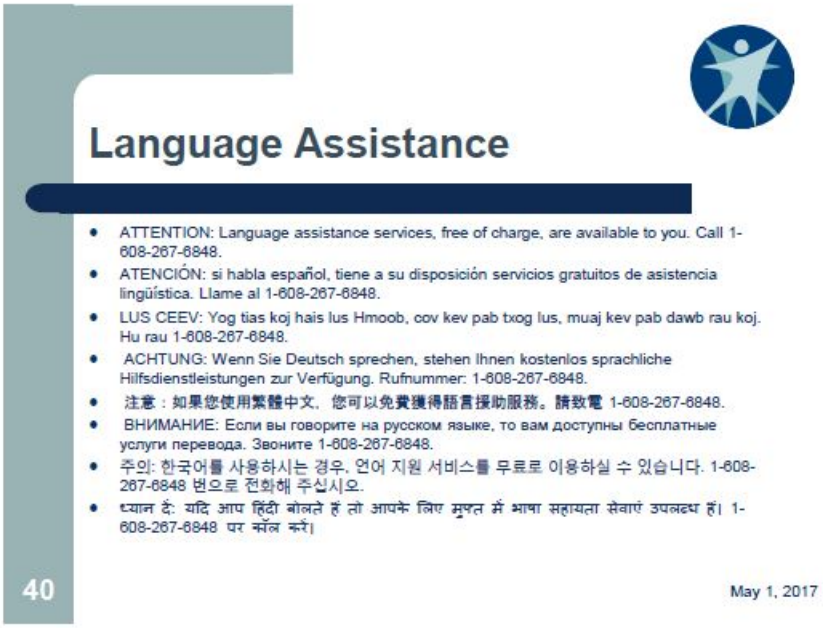
May 1, 2017


Language Assistance
ATTENTION: Language assistance services, free of charge, are available to you. Call 1-608-267-6848.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-608-267-6848.
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-608-267-6848.
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-608-267-6848.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-608-267-6848.
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-608-267-6848.
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-608-267-6848 번으로 전화해 주십시오.
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-608-267-6848 पर कॉल करें।
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May 1, 2017


Language Assistance
اذا كنت تتحدث اذكرا للغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-608-267-6848 (رقم هاتف الصم والبكم/الحولة:
ໃບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ວິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-608-267-6848.
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-608-267-6848.
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-608-267-6848.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-608-267-6848.
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-608-267-6848.
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-608-267-6848.
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-608-267-6848.
41
May 1, 2017

Scott Walker
Governor

Linda Seemeyer
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF MEDICAID SERVICES

1 WEST WILSON STREET
PO BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
Fax: 608-266-1096
TTY: 711

May 19, 2017

Victoria Wachino
Centers for Medicare and Medicaid Services
Children and Adults Health Programs Group
Mail Stop: S2-01-16
75000 Security Boulevard
Baltimore, MD 21244

Dear Ms. Wachino:

I am pleased to submit Wisconsin's Section 1115 Demonstration Waiver application for Medicaid coverage for former foster care youth from a different state.

Through this waiver, Wisconsin will continue to provide full Medicaid benefits to this population. It is anticipated that there will be no increase in costs to continue providing services to former foster care youth from a different state and that this will assist in supporting foster care youth who come from another state seeking stability, education, and workforce opportunities.

We look forward to discussions with your office to finalize the waiver.

Sincerely,

Michael Heifetz
Medicaid Director

Medicaid Coverage for Former Foster Care Youth from a Different State Section 1115 Demonstration Waiver Application

Submitted to:

Ms. Victoria Wachino
Centers for Medicare and Medicaid Services
Children and Adults Health Programs Group
Mail Stop: S2-01-16
75000 Security Boulevard
Baltimore, MD 21244

Submitted by:

Wisconsin Department of Health Services

Medicaid Coverage for Former Foster Care Youth from a Different State Section 1115 Demonstration Waiver Application

Section I – Program Description

Since January 1, 2009, Wisconsin has provided health care coverage to the optional foster care adolescents group described in Sections 1905(w)(1) and 1902(a)(10)(A)(ii)(XVII) of the Social Security Act under the State Plan. Under that optional group coverage, youths who were in foster care when they turned 18 years old are eligible for Medicaid until they turn 21 years old. Wisconsin opted to cover these individuals with no income or resource tests. These individuals are eligible for this optional group regardless of what state they were residing in when they received foster care when they turned 18 years old.

The Affordable Care Act (ACA) created a new mandatory coverage group under Section 1902(a)(10)(A)(i)(IX) of the Social Security Act for youth who were in foster care under the responsibility of the state or tribe and receiving Medicaid when they turned 18 years old, commonly referred to as former foster care youth. Former foster care youth can obtain coverage until age 26 and are not subject to income limits. In January 2013, the Centers for Medicare and Medicaid Services (CMS) issued proposed regulations that offered the option to allow states to provide Medicaid to former foster care youth who were in foster care and receiving Medicaid in another state when they turned age 18. Wisconsin decided to elect the option that coverage for disadvantaged youth include youths who were in foster care in other states and extend current coverage of out-of-state youths to those ages 21 through 25.

On January 1, 2014, Wisconsin began providing Medicaid coverage to Wisconsin residents who met the former foster care youth eligibility criteria regardless of which state the individual resided in while in foster care and receiving Medicaid. On November 21, 2016, CMS published final regulations that no longer allowed states under the State Plan authority to cover youth who were in foster care and receiving Medicaid in another state. As a result, Wisconsin is requesting to continue providing coverage to youth who were in foster care and receiving Medicaid in another state under the Section 1115 Demonstration authority.

The purpose of this demonstration is to provide statewide Medicaid coverage during the three-year duration of the waiver to former foster care youth who currently reside in a different state than the state in which they were in foster care as of age 18 or when they “aged out” of foster care. Wisconsin will cover former foster care youth ages 21 to 26 who were in foster care and receiving Medicaid in a different state under the waiver. Wisconsin would continue to cover out-of-state youths under age 21 under the optional State Plan group. This demonstration will not affect or require modifications to other components of the state’s current Medicaid program and Children’s Health Insurance Program (CHIP) outside of eligibility, benefits, cost sharing, or delivery systems.

Wisconsin proposes to test and evaluate how including former foster care youth who "aged out" in a different state increases and strengthens overall coverage for former foster care youth and improves health outcomes for these youth and expects that this hypothesis will be proven correct.

A detailed evaluation design will be developed for review and approval by CMS. Wisconsin will use relevant data, including eligibility, enrollment, claims, payment, encounter/utilization, chart reviews, and other administrative data, to evaluate overall coverage and health outcomes for this population.

Section II – Demonstration Eligibility

The population affected by this demonstration is former foster care youth who were in foster care and receiving Medicaid in a different state at age 18 or older. There is no income limit for individuals who meet these criteria. Wisconsin projects that annually, there will be about four individuals in foster care receiving Medicaid under the responsibility of a different state who will seek Medicaid coverage in Wisconsin. These individuals will be covered under the Section 1115 Demonstration.

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Former foster care youth who were in foster care and enrolled in Medicaid under the responsibility of another state when they turned 18 years old	Section 1115 Demonstration	No income Limit

Section III – Demonstration Benefits and Cost-Sharing Requirements

1. Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

   ☐ Yes ☒ No (if no, please skip questions 3-7)

2. Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

   ☐ Yes ☒ No (if no, please skip questions 8-11)

Section IV – Delivery System and Payment Rates for Services

1. Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

   ☐ Yes

   ☒ No (if no, please skip questions 2-7 and the applicable payment rate questions)

Currently, there are three former foster care youth who were in foster care and enrolled in Medicaid under the responsibility of another state. One is currently younger than 21 years old and eligible under the optional foster care adolescents group. The remaining two youths would potentially receive benefits by this waiver.

Wisconsin estimates that about 93 percent of the entire former foster care youth population will receive benefits through the same managed care delivery system described in the state's approved 1932(a) State Plan Amendment.

Section V – Implementation of Demonstration

Wisconsin is already providing coverage for former foster care youth who were in foster care and enrolled in Medicaid under the responsibility of another state at age 18 or older, under its State Plan under section S33. As it is no longer an option to provide coverage under the law, Wisconsin will continue to provide coverage to this population under authority of the Section 1115 Demonstration. While approval for the waiver application is pending, there will be no gap in coverage for this population. Wisconsin will switch to the Section 1115 Demonstration authority effective on approval from CMS of the waiver application.

Section VI – Demonstration Financing and Budget Neutrality

Wisconsin will submit an estimate of annual enrollment and annual aggregate expenditures for this population for the duration of the demonstration. A copy of Wisconsin's demonstration data and expenditures is available in Appendix A.

Section VII – List of Proposed Waivers and Expenditure Authorities

Wisconsin requests Section 1115(a)(2) expenditure authority to cover these former foster care youth individuals. The authority would be for expenditures for full Medicaid State Plan benefits for: former foster care youth who are at least 21 years old through age 26, were in foster care under the responsibility of a state or tribe from any state on the date the individual turned 18 years of age or such higher age as the state has elected, and were enrolled in Medicaid on that date while in foster care.

Section VIII – Public Notice

1. Wisconsin provided an open comment period for public comments from April 3, 2017, through May 2, 2017.

   Wisconsin published a public notice in the Wisconsin Administrative Register on April 3, 2017. The citation may be found in No. 736A1. The public notice and a draft of this Section 1115 Demonstration Waiver application was published on April 3, 2017, and information is available at https://www.dhs.wisconsin.gov/badgercareplus/waivers.htm. A copy of the public notice is available in Appendix B.

2. Wisconsin conducted public hearings on the Section 1115 Demonstration Waiver application. The public hearings were held on:

   a. Tuesday, April 18
      10:00 a.m. to 12:00 p.m.
      Gerald L. Ignace Indian Health Center
      930 West Historic Mitchell Street
      Community Room
      Milwaukee, WI 53204

   b. Friday, April 21
      10:00 a.m. to 12:00 p.m.
      Wisconsin Department of Health Services
      One West Wilson Street
      Room 630
      Madison, WI 53703

   A copy of the presentation shared at the public hearings is available in Appendix C.

3. Wisconsin certifies that it used electronic mailing lists to notify the public. The electronic mailing lists consist of individuals subscribed to receive alerts about BadgerCare Plus and Medicaid policy changes and Wisconsin's community partners. A copy of the email is available in Appendix D.

4. Wisconsin certifies that it completed the tribal consultation with the Wisconsin Tribal Health Directors on March 2, 2017.

5. Wisconsin received one comment regarding the 1115 Demonstration submission from the Wisconsin Association of Family and Children's Agency expressing support of the waiver. A copy of the comment is available in Appendix E.

   The Department reviewed the comment submitted and appreciates the support. We have determined that it is not necessary to modify the 1115 Demonstration application based on receipt of this comment.

Section IX – Demonstration Administration

Name and Title:	Michael Heifetz
Telephone Number:	(608) 266-5151
Email Address:	MichaelG.Heifetz@dhs.wisconsin.gov

Appendix A
Historical Demonstration Data and Budget Neutrality Demonstration

Former Foster Care Youth (FFCY) Historical Demonstration Data

Table I - Current Eligble Population for Demonstration- History

FFCY Out of State Actual	2015 Q1 & Q2	2015 Q3 & Q4	2016 Q1 & Q2	2016 Q3 & Q4	2017 Q1 & Q2	Total
TOTAL EXPENDITURES		$ -	$ 704	$ -	$ 1,130	$ 1,834
ELIGIBLE MEMBER MONTHS		-	3	-	5	
PMPM COST			$ 234.81	$ -	$ 225.92	
TREND RATES						
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE				-100.00%	60.36%	12.53%
ELIGIBLE MEMBER MONTHS				-100.00%	66.67%	13.62%
PMPM COST					-3.78%	-0.96%

Biannual information is used in order to best capture all of the data to date. These dates are depicted by Wisconsin State Fiscal Year (July 1-June 30). Formulas have been changed to allow for calculation of trend rates.

Table II - All Former Foster Care Youth (Includes In-State & Out-of-State

All Former Foster Care Youth	2013	2014	2015	2016	2017	Total
TOTAL EXPENDITURES		$ 241,649	$ 1,174,089	$ 1,710,460	$ 1,978,784	$ 5,104,982
ELIGIBLE MEMBER MONTHS		804	888	876	888	
PMPM COST		$ 300.56	$ 1,322.17	$ 1,952.58	$ 2,228.36	
TREND RATES						3-Year
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE			385.87%	45.68%	15.69%	13.94%
ELIGIBLE MEMBER MONTHS			10.45%	-1.35%	1.37%	0.00%
PMPM COST			339.91%	47.68%	14.12%	13.94%

The program was introduced in January 2015, so SFY 2014 is a ramp up year. Established trend rates only take into account SFY 2015-2017. SFY 2017 data utilizes actual costs from July-April plus an average monthly cost of $164,899 for the fiscal year added for the missing months of May and June.

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

WI DHS Expected Demonstration Population Expenditures Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2017	2018	2019	2020	2021	
Demonstration Population	$ 44,594	$ 71,733	$ 81,732	$ 93,126	$ 106,108	$ 397,294
TOTAL	$ 44,594	$ 71,733	$ 81,732	$ 93,126	$ 106,108	$ 397,294

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	2017	2018	2019	2020	2021	
Demonstration Population	$ 44,594	$ 71,733	$ 81,732	$ 93,126	$ 106,108	$ 397,294
TOTAL	$ 44,594	$ 71,733	$ 81,732	$ 93,126	$ 106,108	$ 397,294
HYPOTHETICALS VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR 2017	TREND RATE 2	DEMONSTRATION YEARS (DY) 2017	2018	2019	2020	2021	TOTAL WOW
FFCY Out of State Actual										
Pop Type:	Medicaid									
Eligible Member Months	13.6%	3	5	13.6%	6	7	8	9	10	
PMPM Cost	-1.0%	3	$ 225.38	-1.0%	$ 223.22	$ 221.08	$ 218.96	$ 216.86	$ 214.78	
Total Expenditure					$ 1,309	$ 1,473	$ 1,657	$ 1,865	$ 2,099	$ 8,402
All Former Foster Care Youth										
Pop Type:	Medicaid									
Eligible Member Months	0.0%	3	888	0.0%	888	888	888	888	888	
PMPM Cost	13.9%	3	$ 2,302.26	13.9%	$ 2,623.20	$ 2,988.87	$ 3,405.52	$ 3,880.25	$ 4,421.16	
Total Expenditure					$ 2,329,402	$ 2,654,117	$ 3,024,102	$ 3,445,662	$ 3,925,990	$ 15,379,272
Poulation remains flat at 2 members per year										
Pop Type:	Hypothetical									
Eligible Member Months	0.0%	3	2	100.0%	17	24	24	24	24	
PMPM Cost	13.9%	3	$ 2,302.26	13.9%	$ 2,623.20	$ 2,988.87	$ 3,405.52	$ 3,880.25	$ 4,421.16	
Total Expenditure					$ 44,594	$ 71,733	$ 81,732	$ 93,126	$ 106,108	$ 397,294

This population utilizes the PMPM cost growth trends from the total Former Foster Care Youth population. It also assumes a flat member enrollment. Wi-DHS believes that this is the most likely population outcome.

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	Base Year 2016	DEMO TREND RATE	DEMONSTRATION YEARS (DY) 2017	2018	2019	2020	2021	Total WW
Current Population Demonstration								
Pop Type:	Medicaid							
Eligible Member Months	5.16	13.6%	5.86	6.66	7.57	8.60	9.77	
PMPM Cost	$ 225.38	-1.0%	$ 223.22	$ 221.08	$ 218.96	$ 216.86	$ 214.78	
Total Expenditure			$ 1,308.69	$ 1,472.68	$ 1,657.21	$ 1,864.87	$ 2,098.54	$ 8,402.00
All Former Foster Care Youth								
Pop Type:	Medicaid							
Eligible Member Months	888	0.0%	888	888	888	888	888	
PMPM Cost	$ 2,302.26	13.9%	$ 2,623.20	$ 2,988.87	$ 3,405.52	$ 3,880.25	$ 4,421.16	
Total Expenditure			$2,329,401.60	$ 2,654,116.56	$ 3,024,101.76	$ 3,445,662.00	$ 3,925,990.08	$ 15,379,272.00

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
71																		
72	**WI DHS Expected Population Demonstration**																	
73	**Pop Type:**	**Hypothetical**																
74	Eligible Member Months	2	1.4%	17	24	24	24	24										
75	PMPM Cost	$ 2,302.26	13.9%	$ 2,623.20	$ 2,988.87	$ 3,405.52	$ 3,880.25	$ 4,421.16										
76	Total Expenditure			$ 44,594.40	$ 71,732.88	$ 81,732.48	$ 93,126.00	$ 106,107.84	$ 397,293.60									
77																		
78																		
79	NOTES																	
80	For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.																	

Appendix B

PUBLIC NOTICE
Wisconsin Department of Health Services
Public Hearings Regarding BadgerCare Plus Demonstration Project Waiver for Providing Medicaid Coverage for Certain Former Foster Care Youth

The State of Wisconsin reimburses providers for services provided to Medical Assistance recipients under the authority of Title XIX of the Social Security Act and Chapter 49 of the Wisconsin Statutes. This program, administered by the State's Department of Health Services (the Department), is called Medical Assistance (MA) or Medicaid. In addition, Wisconsin has expanded this program to create BadgerCare Plus program under the authority of Title XIX and Title XXI of the Social Security Act and Chapter 49 of the Wisconsin Statutes. Federal statutes and regulations require that a state plan be developed that provides the methods and standards for reimbursement of covered services. A plan that describes the reimbursement system for the services (methods and standards for reimbursement) is now in effect.

Section 1115 of the Social Security Act provides the federal Secretary of Health and Human Services broad authority to authorize Research & Demonstration Projects, which are experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under §1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. Wisconsin intends to submit an application for a demonstration project waiver from the Centers for Medicare and Medicaid Services (CMS) under this federal authority. CMS is an agency within the U.S. Department of Health and Human Services (DHHS).

Background

The Affordable Care Act (ACA) created a new mandatory Medicaid coverage group under Section 1902(a)(10)(A)(i)(IX) for former foster care youth who were in foster care under the responsibility of the State or Tribe and receiving Medicaid at age 18 or older. Under this group, former foster care youth can obtain coverage until age 26 of age and are not subject to income limits. Under proposed regulations in accordance with the ACA at 42 CFR 435.150, The Centers for Medicare and Medicaid Services (CMS) allowed states the option to provide coverage to individuals who were now residents of the state but were in foster care and receiving Medicaid in another state on their 18th birthday. Wisconsin decided to elect the option that coverage for disadvantaged youth should include youths who were in foster care in other States and extend our existing coverage of out-of-state youths and cover those age 21 through age 25. On January 1, 2014, Wisconsin began providing coverage to former foster care youth under its Medicaid state plan.

On November 21, 2016, CMS published final regulations that no longer allowed states to cover youth who were in foster care and receiving Medicaid in another state under State Plan authority. However, in an information bulletin to states titled “Section 1115 Demonstration Opportunity to Allow Medicaid Coverage to Former Foster Care Youth Who Have Moved to a Different State,” CMS provided the option to allow states to cover former foster care youth who were in foster care and receiving Medicaid in another state under Section 1115 Demonstration authority.

Wisconsin is already providing coverage for this category of former foster care youth. As it is no longer an option to provide coverage under the law, Wisconsin will seek to continue to provide this coverage to this population under Section 1115 Demonstration Authority. The Department of Health Services expects to submit the Section 1115 Demonstration application to CMS no

later than May 21, 2017. There will be no gap in coverage for former foster care youth from a different state while the Section 1115 application is pending.

In accordance with federal law, Section 431.408 (a) (3) of 42 CFR, the Department must conduct at least two public hearings, on separate dates and at separate locations, regarding the State's demonstration application at which members of the public throughout the State have an opportunity to provide comments. These public hearings must be conducted at least 20 days prior to submitting an application for a new demonstration project or extension of an existing demonstration project to CMS for review.

The following two public hearings will be conducted:

Tuesday, April 18
10:00 a.m. to 12:00 noon
Gerald L. Ignace Indian Health Center
930 West Historic Mitchell Street
Community Room
Milwaukee, WI 53204

Friday, April 21
10:00 a.m. to 12:00 noon
Wisconsin Department of Health Services
One West Wilson Street
Room 630
Madison, WI 53703

For the Friday, April 21 hearing, attendees may also attend from remote locations via Skype. The telephone number to call to do so is (844) 561- 6590.

Accessibility

English
DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability or need an interpreter or translator, or if you need this material in another language or in an alternate format, you may request assistance to participate by contacting Al Matano at (608)267-6848. You must make your request at least 7 days before the activity.

Spanish
DHS es una agencia que ofrece igualdad en las oportunidades de empleo y servicios. Si necesita algún tipo de acomodaciones debido a incapacidad o si necesita un interprete, traductor o esta información en su propio idioma o en un formato alterno, usted puede pedir asistencia para participar en los programas comunicándose con Al Matano al número (608)267-6848. Debe someter su petición por lo menos 7 días de antes de la actividad.

Hmong
DHS yog ib tus tswv hauj lwm thiab yog ib qhov chaw pab cuam uas muab vaj huam sib luag rau sawv daws. Yog koj xav tau kev pab vim muaj mob xiam oob qhab los yog xav tau ib tus neeg pab txhais lus los yog txhais ntaub ntawv, los yog koj xav tau cov ntaub ntawv no ua lwm hom lus los yog lwm hom ntawv, koj yuav tau thov kev pab uas yog hu rau Al Matano ntawm (608)267-6848. Koj yuav tsum thov qhov kev pab yam tsawg kawg 7 hnub ua ntej qhov hauj lwm ntawd.

Copies Of Demonstration Project Waiver

Copies of Waiver Documents

A copy of waiver documents, including the waiver application once complete, may be obtained from the department at no charge by downloading the documents from http://dhs.wisconsin.gov/badgercareplus/waivers.htm or by contacting:

Regular Mail
Al Matano
Division of Medicaid Services
P.O. Box 309
Madison, WI 53707−0309

Phone
Al Matano
(608) 267−6848

FAX
(608) 267−3205

E−Mail
Alfred.Matano@dhs.wisconsin.gov

Written Comments

Written comments are welcome and will be accepted through May 2, 2017. Written comments on the progress of the waiver to date may be sent by FAX, e-mail, or regular mail to the Division of Medicaid Services. The FAX number is (608) 266-3205. The e-mail address is Alfred.Matano@dhs.wisconsin.gov. Comments can be made on the web site at:

http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm

Regular mail can be sent to the above address.

Public comments will be considered to determine the final content of the application to be submitted to CMS. A summary of the comments received will be included in the Department's application to CMS, and will be available on the department’s web site at the address listed above.

Appendix C
Email Notification

From: DHS DHCAA Communications
Sent: Wednesday, April 12, 2017 3:57 PM
To: Medicaid Listserv (dhs-dhcaa-medicaid@lists.wi.gov); BCP HB Listserv (dhs-dhcaa-bcplus@lists.wi.gov)
Subject: Waiver for Medicaid Coverage of Former Foster Care Youth from Another State Posted for Public Comment

Public Notice

The State of Wisconsin Department of Health Services is seeking public comment on a Section 1115 Demonstration Waiver to continue providing Medicaid coverage to former foster care youth who were in foster care under the responsibility of another state when they turned 18 years old. Former foster care youth refers to individuals who were in foster care, under the responsibility of the state or tribe, and were receiving Medicaid when they turned 18 years old. There will be no changes to benefits for former foster care youth as a result of this demonstration.

Learn more about this waiver for coverage of former foster care youth. Public comments or requests for the waiver documents can be sent to Al Matano at:

Email: Alfred.Matano@dhs.wisconsin.gov

Phone: 608-267-6848

Fax: 608-267-3205

Mail:

Al Matano
Division of Medicaid Services
P.O. Box 309
Madison, WI 53707-0309

Appendix D
Demonstration Presentation for Wisconsin's Public Hearings

Section 1115 Demonstration Project Waiver
Former Foster Care Youth

Pungnou Her, Policy Analyst
April 18, 2017
April 21, 2017

Wisconsin Department of Health Services
Division of Medicaid Services

Outline

- Background
- Federal Regulations
- Waiver
- Eligibility Impact
- Proposed Timeline
- Comments and Testimonials
- Questions

Background

- Since January 1, 2009, Wisconsin Medicaid has covered youth who were in foster care when they turned 18 years old, until they turned age 21. This is part of an optional foster care adolescents group described in Sections 1905(w)(1) and 1902(a)(10)(A)(ii)(XVII) of the Social Security Act.
- Eligibility coverage for these individuals includes:
  - No income or resource tests
  - No regard for what state they were residing in when they turned age 18.

3

Background

- The Affordable Care Act (ACA) created a new mandatory coverage group under Section 1902(a)(10)(A)(i)(IX) of the Social Security Act.
  - Youth who were in foster care, under the responsibility of the state or tribe, and receiving Medicaid when they turned 18 years old.
  - This group is referred to as former foster care youth.
- Under this category, individuals can obtain coverage until age 26 and are not subject to income limits.

4

Background

- In January 2013, the Centers for Medicare and Medicaid Services (CMS) issued proposed regulations that offered states the option to provide Medicaid to former foster care youth who were in foster care in another state when they turned age 18.
- Wisconsin elected this option beginning January 1, 2014.

5

Federal Regulations

- On November 21, 2016, CMS published final regulations that no longer allow states under the State Plan authority to cover youth who were in foster care in another state when they turned age 18.
- States that want to provide Medicaid coverage for former foster care youth who were in foster care in another state when they turned 18 years old must submit a Medicaid Demonstration Waiver application under authority of Section 1115 of the Social Security Act.

6

Waiver

- Wisconsin is choosing to continue providing Medicaid coverage to former foster care youth from another state under the Section 1115 Demonstration Waiver.
- The waiver would provide statewide Medicaid coverage to former foster care youth who resided in a state other than Wisconsin when they were in foster care as of age 18.
  - The duration of the waiver is three years.

7

Waiver

- By providing coverage to former foster care youth who were in foster care in another state when they turned age 18, Wisconsin will benefit by:
  - Increasing and strengthening overall access to health care coverage for former foster care youth.
  - Improving health outcomes for former foster care youth.

8

Eligibility Impact

- Wisconsin is already providing coverage to former foster care youth who are from a different state under BadgerCare Plus.
- If this demonstration application is approved, there will be no gap in coverage and no changes to the benefits provided as part of this demonstration.
- Currently, there are three former foster care youth enrolled in BadgerCare Plus who were in foster care in another state when they turned age 18.

9

Proposed Timeline

Milestone	Date
Public Notice Issued	April 3, 2017
Comment Period Closes	May 2, 2017
Waiver Submission	May 19, 2017
CMS Approval	August 2017

10

Comments and Testimonials

Comments and testimonials will be accepted through May 2, 2017, and may be submitted using any of the following methods:

- Email: Alfred.Matano@dhs.wisconsin.gov
- Fax: 608-267-3205
- Phone: 608-267-6848
- Mail:

  Al Matano
  Division of Medicaid Services
  P.O. Box 309
  Madison, WI 53707−0309

This information is also online at dhs.wisconsin.gov/badgercareplus/waivers.htm.

Appendix E
Public Comment from the Wisconsin Association of Family and Children's Agency

TO: Alfred Mantano, Division of Medicaid Services
FROM: Linda A. Hall, Executive Director
DATE: May 2, 2017
RE: WAFCA Support for Health Coverage for Former Foster Youth from a Different State

---

Thank you for the opportunity to voice our support for the Wisconsin Department of Health Services' proposed Section 1115 Demonstration Waiver to continue providing Medicaid coverage to former foster youth who were in foster care and receiving Medicaid benefits in another state when they turned 18.

WAFCA is a statewide association that represents over fifty child and family serving agencies and leaders in the field and advocates for the more than 250,000 individuals and families that our member agencies serve each year. Our members' services include counseling; chemical dependency treatment; crisis intervention; outpatient mental health therapy; and foster care programs, among others. For many years, our member agencies have focused significant attention on the needs of the youth in their care who "age out" of the foster care system.

Youth exiting Wisconsin's foster care system without permanency face a range of challenges as they move into their adult lives. Like all young people, children in foster care need support – both financial and social – as they take their first steps toward independence. However, unlike their peers, youth aging out of the foster care system face unique obstacles that can make it more difficult as they seek to find their footing through their first tentative steps on the path to adulthood.

The *Midwest Evaluation of the Adult Functioning of Former Foster Youth*, which included a cohort of youth from Wisconsin, tracked former foster youth for nearly a decade. The study found, among other challenges, that youth who age out of the foster care system are twice as likely as their same age peers to experience depression and physical health problems. Continuation of Medicaid coverage is a critical element to sustaining access to mental health and other health services for this population.

While the number of out-of-state youth who will likely be impacted by this extension of coverage is small, this waiver is an important statement about Wisconsin's commitment to former foster youth who come into the state seeking greater stability, education and/or workforce opportunities. This waiver will extend the same benefits of coverage until age 26 that is available to their same age peers covered under parental health insurance plans.

While the system failed to achieve permanence for these young people, the state can provide some stability by sustaining their access to health coverage.

Thank you for advancing this important waiver request.

Wisconsin Association of Family & Children's Agencies
131 W Wilson Street #901 | Madison WI 53703
Office: 608.257.5939 | Fax: 608.257.6067 | wafca.org

Wisconsin BadgerCare Reform 1115 Waiver Demonstration
Section 1115 Annual Report

Section 1115 Annual Report Summary

Demonstration Year:
3 (1/1/2016 – 12/31/2016)

Table of Contents

Introduction

The Wisconsin BadgerCare Reform demonstration provides state plan benefits to childless adults who have family incomes up to 95 percent of the Federal Poverty Level (FPL) (effectively 100 percent of the FPL considering a disregard of 5 percent of income), and permits the state to charge premiums to adults who are only eligible for Medicaid through the Transitional Medical Assistance eligibility group (hereinafter referred to as "TMA Adults") with incomes above 133 percent of the FPL starting from the first day of enrollment and to TMA Adults from 100-133 percent of the FPL after the first 6 calendar months of TMA coverage.

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

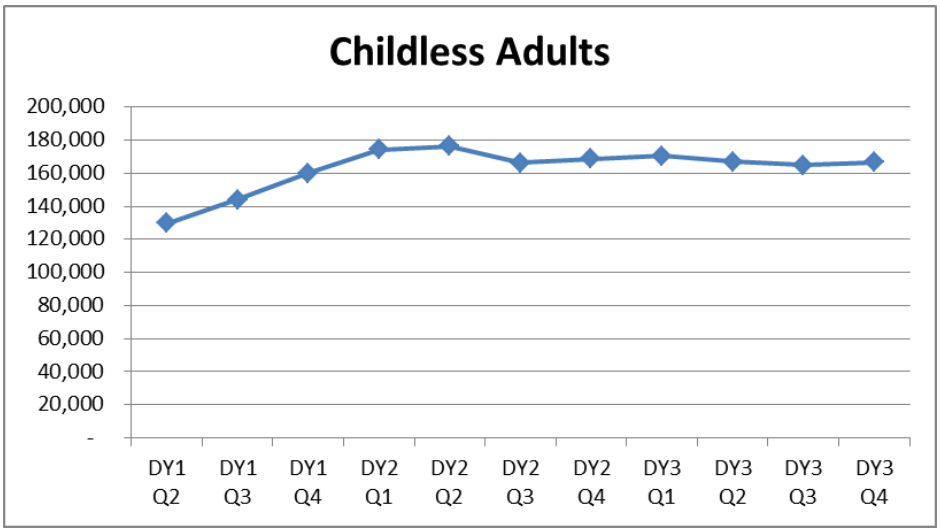
The state's goals for the program are to demonstrate whether the program will:

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

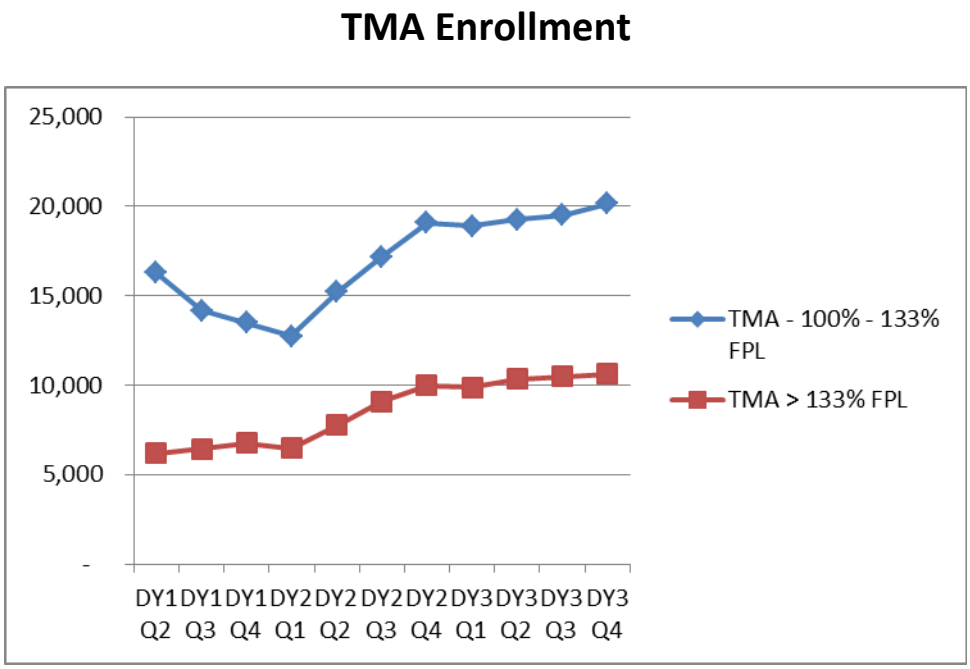
The DHS has contracted, through an interagency agreement, with the UW Population Health Institute (including the Scope of Work, Workplan, and Budget) for conducting the BadgerCare Reform Demonstration Evaluation. The DHS and UW began work starting on September 1, 2015. A copy of the demonstration evaluation scope of work and workplan are included as Attachment E.

Enrollment and Benefits Information

Childless Adults (Population Group 2) - In demonstration year 3 the number of unique program participants decreased, as did the total number of childless adults enrolled in the program. From the beginning to the end of demonstration year 3 the total number of unique program participants decreased from 170,266 to 166,740. Total monthly enrollment decreased from the start to the end of the demonstration year with 154,285 childless adults in January 2016 and 147,595 childless adults in December 2016. The following graph shows the childless adults enrollment trend over the first 3 years of the demonstration:



Transitional Medical Assistance (TMA) Adults (Population Group 1) - In demonstration year 3 the number of unique program participants increased as did the total number of TMA adults enrolled in the program. From the beginning to the end of the demonstration year the total number of unique program participants increased from 28,806 to 30,801. Total monthly enrollment also increased from during the demonstration year with 22,231 TMA adults in January 2016 and 22,839 TMA adults in December 2016. The following graph shows the TMA enrollment trends over the first 3 years of the demonstration:



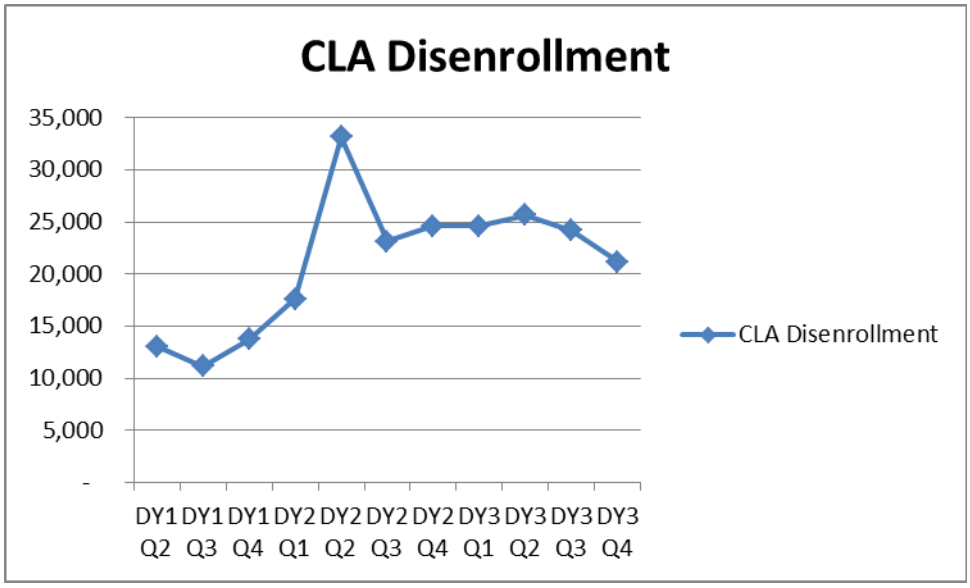
Following is an enrollment summary for the unique program participants in both demonstration groups over the first 3 years of the demonstration:

BadgerCare Reform Demonstration - Enrollment Summary*

Demonstration Year	DY1 (CY 2014)				DY2 (CY 2015)				DY3 (CY 2016)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CLA (Group 2)	N/A	129,712	144,102	160,095	174,320	176,378	166,401	168,756	170,266	166,971	164,761	166,740
TMA (Group 1)												
TMA - 100% - 133% FPL	N/A	16,311	14,170	13,508	12,741	15,214	17,173	19,082	18,903	19,261	19,517	20,164
TMA > 133% FPL	N/A	6,191	6,456	6,778	6,477	7,778	9,118	9,998	9,903	10,354	10,485	10,637
Total TMA	N/A	22,502	20,626	20,286	19,218	22,992	26,291	29,080	28,806	29,615	30,002	30,801
*Reflects total unduplicated count of members enrolled during the demonstration quarter												

The rate of disenrollment for non-payment of premiums for the TMA Adult population 100% to 133% FPL was 5%, compared to 20% for the TMA Adult population over 133% FPL, and this rate of disenrollment remained constant throughout the demonstration year. We will attempt to learn more about the reasons behind the variances between the two populations through the formal evaluation.

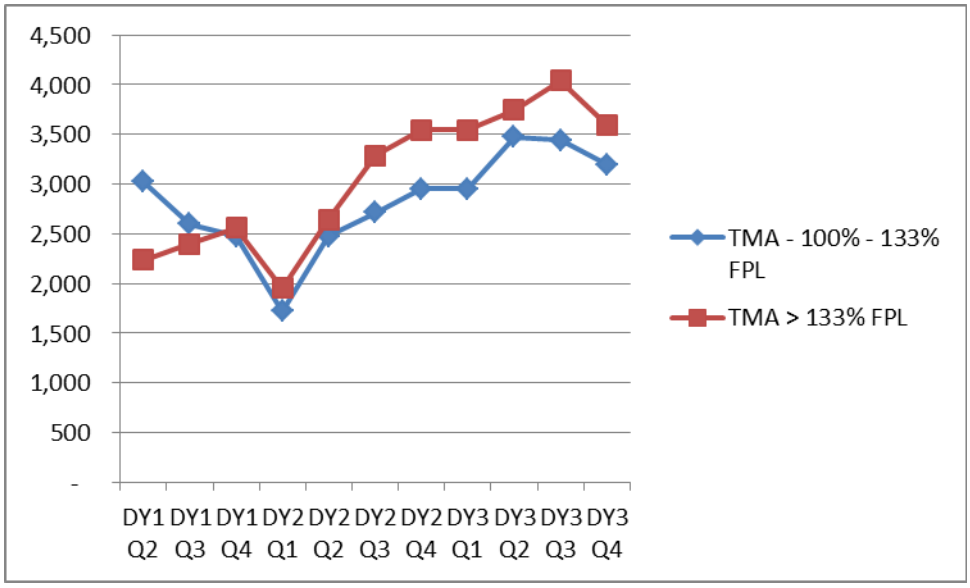
Following is the disenrollment summary for the unique program participants in both demonstration groups over the first 3 years of the demonstration:



BadgerCare Reform Demonstration - CLA Disenrollment Summary*

Demonstration Year	DY1 (CY 2014)				DY2 (CY 2015)				DY3 (CY 2016)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CLA (Group 2)	N/A	13,019	11,165	13,744	17,565	33,147	23,109	24,579	24,579	25,643	24,166	21,166
*Reflects total unduplicated count of members enrolled during the demonstration quarter												

TMA Disenrollment

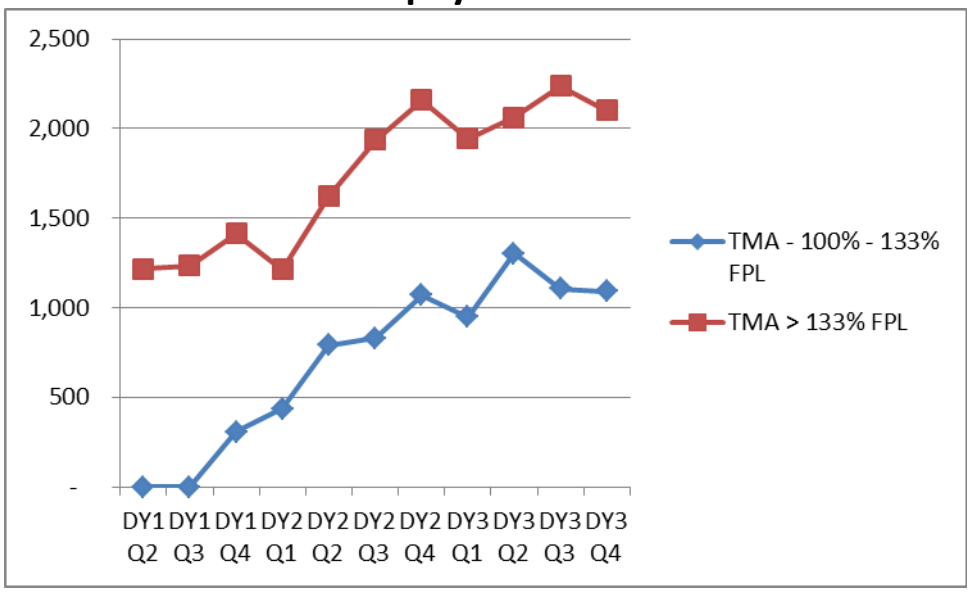


BadgerCare Reform Demonstration - TMA Disenrollment Summary*

Demonstration Year	DY1 (CY 2014)				DY2 (CY 2015)				DY3 (CY 2016)			
	Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1	DY2 Q2	DY2 Q3	DY2 Q4	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4
TMA - 100% - 133% FPL	N/A	3,021	2,595	2,475	1,724	2,473	2,713	2,955	2,955	3,474	3,443	3,195
TMA > 133% FPL	N/A	2,240	2,397	2,560	1,954	2,641	3,286	3,546	3,546	3,743	4,039	3,597

*Reflects total unduplicated count of members enrolled during the demonstration quarter

TMA Disenrollment
Due to Non-payment of Premium



BadgerCare Reform Demonstration - TMA Disenrollment Summary*; Non-payment of Premium

Demonstration Year												
	Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1	DY2 Q2	DY2 Q3	DY2 Q4	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4
TMA - 100% - 133% FPL	N/A	-	-	309	436	791	833	1,071	951	1,304	1,108	1,094
TMA > 133% FPL	N/A	1,219	1,234	1,414	1,216	1,623	1,938	2,158	1,944	2,063	2,238	2,101

*Reflects total unduplicated count of members enrolled during the demonstration quarter

The DHS has not identified any issues related to access to care or delivery of benefits given the current enrollment trends and will continue to monitor.

Enrollment Counts for Quarter and Year to Date

Demonstration Populations	Total Number of Demonstration Participants Quarter Ending – 03/31/2016*	Current Enrollees (year to date)**	Disenrolled in Current Quarter	TMA Adults Disenrolled Due to Non-Payment of Premiums (current quarter)***
BC Reform Adults	170,266	170,266	24,579	N/A
TMA Adults – 100% to 133% FPL	18,903	18,903	2,955	951
TMA Adults – Over 133% FPL	9,903	9,903	3,546	1,944

Demonstration Populations	Total Number of Demonstration Participants Quarter Ending – 06/30/2016*	Current Enrollees (year to date)**	Disenrolled in Current Quarter	TMA Adults Disenrolled Due to Non-Payment of Premiums (current quarter)***
BC Reform Adults	166,971	191,240	25,643	N/A
TMA Adults – 100% to 133% FPL	19,261	26,812	3,474	1,304
TMA Adults – Over 133% FPL	10,354	15,231	3,743	2,063

Demonstration Populations	Total Number of Demonstration Participants Quarter Ending – 09/30/2016*	Current Enrollees (year to date)**	Disenrolled in Current Quarter	TMA Adults Disenrolled Due to Non-Payment of Premiums (current quarter)***
BC Reform Adults	164,761	210,999	24,166	N/A
TMA Adults – 100% to 133% FPL	19,517	34,268	3,443	1,108
TMA Adults – Over 133% FPL	10,485	20,425	4,039	2,238

Demonstration Populations	Total Number of Demonstration Participants Quarter Ending – 12/31/2016*	Current Enrollees (year to date)**	Disenrolled in Current Quarter	TMA Adults Disenrolled Due to Non-Payment of Premiums (current quarter)***
BC Reform Adults	166,740	232,172	21,166	N/A
TMA Adults – 100% to 133% FPL	20,164	41,427	3,195	1,094
TMA Adults – Over 133% FPL	10,637	25,537	3,597	2,101

*Reflects total unduplicated count of members enrolled during the demonstration quarter
** Reflects total unduplicated count of members enrolled during the demonstration year.
***Disenrollment does not reflect those who maintained eligibility after the closure month for any benefit plan

Member Month Reporting

Eligibility Group	Month 1 (January 2016)	Month 2 (February 2016)	Month 3 (March 2016)	Total for Quarter Ending 03/2016
BC Reform Adults	154,285	153,942	153,212	461,439
TMA Adults – 100% to 133% FPL	13,961	13,708	13,451	41,120
TMA Adults – Over 133% FPL	8,270	6,290	6,364	20,924

Eligibility Group	Month 1 (April 2016)	Month 2 (May 2016)	Month 3 (June 2016)	Total for Quarter Ending 06/2016
BC Reform Adults	151,504	149,709	147,989	449,202
TMA Adults – 100% to 133% FPL	13,513	13,525	13,733	40,771
TMA Adults – Over 133% FPL	8,342	6,515	6,800	21,657

Eligibility Group	Month 1 (July 2016)	Month 2 (June 2016)	Month 3 (September 2016)	Total for Quarter Ending 09/2016
BC Reform Adults	148,128	148,116	147,281	443,525
TMA Adults – 100% to 133% FPL	13,829	13,740	13,820	41,389
TMA Adults – Over 133% FPL	8,585	6,625	6,690	21,900

Eligibility Group	Month 1 (October 2016)	Month 2 (November 2016)	Month 3 (December 2016)	Total for Quarter Ending 12/2016
BC Reform Adults	147,595	148,145	148,334	444,074
TMA Adults – 100% to 133% FPL	14,075	14,425	14,487	42,987
TMA Adults – Over 133% FPL	8,764	6,820	6,736	22,320

Childless Adult and TMA Re-Enrollment Statistics

During the second demonstration year CMS requested that Wisconsin analyze the demonstration groups to identify how many members had been disenrolled and subsequently regained program eligibility.

In providing these statistics we included those members that regained full-benefit eligibility within 12 months of the current reporting quarter. The statistics provided below include those childless adult and TMA members who were disenrolled since April 2014 (the start of the demonstration) and were enrolled through the fourth quarter of demonstration year 3.

The table below shows that the percentage of childless adults who were disenrolled in demonstration year 2 and (population group 2) regained eligibility in demonstration year 3 rose to 43%, and for TMA adults (population group 1) nearly 65% had regained eligibility by the end of demonstration year 3.

		Number re-enrolled within one year by benefit plan										
Quarter of Disenrollment	Waiver Group	BCSP	FSTMA	MAP	MAPW	MCD	MCDW	SSIMA	WWMA	All Benefit Plans	Total Disenrolled	% Re-enrolled within one year
04/14 - 06/14	CLA	4,962	1	260	16	399	97	155	8	5,898	16,291	36.20%
04/14 - 06/14	TMA	6,289	0	7	1	25	4	15	2	6,343	10,551	60.12%
07/14 - 09/14	CLA	5,686	1	229	14	386	95	142	3	6,556	14,478	45.28%
07/14 - 09/14	TMA	5,691	0	6	0	15	4	13	3	5,732	9,531	60.14%
10/14 - 12/14	CLA	6,890	1	277	13	412	101	121	2	7,817	17,310	45.16%
10/14 - 12/14	TMA	5,733	0	3	0	14	3	9	1	5,763	9,334	61.74%
01/15 - 03/15	CLA	8,346	0	261	10	470	94	146	5	9,332	20,828	44.81%
01/15 - 03/15	TMA	5,237	0	5	0	10	3	6	0	5,261	7,719	68.16%
04/15 - 06/15	CLA	13,240	2	323	16	478	108	185	1	14,353	37,233	38.55%
04/15 - 06/15	TMA	6,136	1	3	0	4	4	9	2	6,159	9,314	66.13%
07/15 - 09/15	CLA	10,843	0	270	16	425	113	149	5	11,821	27,122	43.58%
07/15 - 09/15	TMA	6,778	0	3	0	13	3	9	1	6,807	10,482	64.94%
10/15 - 12/15	CLA	11118	1	312	16	463	120	177	6	12213	28270	43.20%
10/15 - 12/15	TMA	7622	0	3		7	1	5	2	7640	11583	65.96%
CLA = Childless Adults												
TMA = Transitional Medical Assistance												

Outreach/Innovative Activities to Assure Access

All HMOs serving BadgerCare Plus members, which includes members of this demonstration waiver population, but are not limited to the demonstration population, are required to submit their member communication and outreach plans to the DHS for review. All materials are reviewed and approved by the DHS prior to distribution to members. Such materials include HMO-developed member handbooks, HMO-developed new member enrollment materials, and HMO-developed brochures.

The DHS also contracts with the City of Milwaukee Health Department to focus on outreach to current and prospective BadgerCare Plus members in Milwaukee County. As part of this agreement, staff is available at multiple locations throughout the county, including Milwaukee Health Department sites, in order to provide assistance with ACCESS applications and renewals, as well as with other enrollment and eligibility troubleshooting.

Collection and Verification of Encounter Data and Enrollment Data

Following is a summary of the demonstration year 3 annual managed care enrollment. Managed care enrollment for demonstration year 3 shows relatively stable enrollment with approximately 85% of all childless adults enrolled in managed care which is comparable with managed care enrollment for other BadgerCare Plus populations.

BadgerCare Plus Childless Adult HMO Enrollment	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Anthem Blue Cross Blue Shield	13,684	14,053	14,669	14409	14602	14415	14,414	14,481	14,590	14,541	14,533	14,486
Childrens Community Health Plan	10,537	10,740	10,997	10750	10740	10624	10,745	10,691	10,826	10,779	10,880	10,829
Compcare	3863	3932	4040	4035	4024	3996	3954	3936	3949	3853	3807	3744
Dean Health Plan	4772	4805	4879	4699	4633	4558	4559	4518	4598	4484	4537	4548
Group Health Eau Claire	6376	6500	6791	6776	6692	6665	6701	6664	6728	6658	6686	6686
Group Health South Central	2120	2138	2297	2246	2214	2149	2154	2054	2067	1998	1985	1910
Gundersen	2419	2528	2546	2524	2528	2623	2570	2551	2562	2546	2549	2473
Health Tradition	1199	1220	1281	1249	1247	1236	1253	1226	1248	1190	1183	1162
iCare	6670	6752	6854	6611	6493	6387	6359	6298	6360	6348	6267	6235
Managed Health Services	8628	8637	8753	8578	8406	8242	8263	8058	8142	7992	8023	7937
Mercy	2268	2316	2449	2423	2398	2400	2388	2318	2396	2360	2367	2324
Molina	9320	9499	9779	9511	9363	9256	9244	9196	9190	9073	9032	8860
Network	8564	8548	8551	8564	8343	8204	8166	8088	8145	7763	8084	7910
Physicians Plus	2796	2817	3003	2995	2928	2959	2939	2882	2855	2796	2769	2748
Security	8578	8838	9119	9129	9031	8859	8948	8934	9006	8870	8800	8762
Trilogy	3497	3604	3669	3630	3611	3567	3542	3508	3607	3545	3576	3551
UnitedHealthcare	28,237	28,906	29,884	29726	29631	29701	29,699	29,628	29,990	29,792	29,705	29,644
Unity	1321	1351	1347	1288	1258	1280	1270	1287	1296	1307	1307	1313
Total	**124,849**	**127,184**	**130,908**	**129,143**	**128,142**	**127,121**	**127,168**	**126,318**	**127,555**	**125,895**	**126,090**	**125,122**

Operational/Policy/Systems/Fiscal Developments/Issues

The state did not identified program developments/issues/problems that have occurred in demonstration year 3 and does not anticipate to occur in the near future that affect health care delivery, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

Financial/Budget Neutrality Development/Issues

The state has not identified any significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter.

Please see Attachment A for a copy of the budget neutrality workbook.

The chart provides monthly and quarterly enrollment and expenditure data for the BadgerCare Plus Reform Adult Waiver since its inception in April 2014 through September 2016. This data is compared to the childless adult CORE baseline from April 2013 through March 2014 for budget neutrality purposes.

The data shows waiver enrollment increasing each month from April 2014 to March 2015. From January 2016 to December 2016 waiver enrollment remains relatively stable.

The monthly managed care enrollment growth rate peaked in March 2015, reflecting the systematic transition of enrollees from FFS to managed care. Managed care enrollees also declined starting in April 2015.

Since the waiver's April 2014 inception, per-member-per-month (PMPM) costs have increased, but are well below the budget neutrality limits established with the waiver and we do not have any concerns or issues to report at this time.

Consumer Issues

Consumers have not reported any significant issues related to coverage and/or access to the program and benefits in the current quarter.

Quality Assurance/Monitoring Activity

The DHS consistently monitors activities using a systematic approach that ensures services for all BadgerCare Plus populations are reviewed for quality assurance.

Following is a summary of the activities DHS conducted in demonstration year 3 by quarter:

Quarter One

a) Health Needs Assessment Requirement for Childless Adults

The 2016-2017 BadgerCare Plus HMO contract required health plans to conduct a Health Needs Assessment (HNA) screening of newly enrolled BadgerCare Plus childless adult members within two months of HMO enrollment. The contract requires HMOs to include the following elements in the HNA screening:

- Urgent medical and behavioral symptoms (e.g., shortness of breath, rapid weight gain/loss, syncope, suicidal ideations, psychotic break);
- Members' perception of their general well-being;
- Identify usual sources of care (e.g., primary care provider, clinic, specialist, dental provider);
- Frequency in use of emergency and inpatient services;
- History of chronic physical and mental health illnesses (e.g., respiratory disease, heart disease, stroke, diabetes/pre-diabetes, back pain and musculoskeletal disorders, cancer, overweight/obesity, severe mental illness(es), substance abuse);
- Number of prescription medications used monthly;
- Socioeconomic barriers to care (e.g., stability of housing, reliable transportation, nutrition/food resources, availability of family/caregivers to provide support);
- Behavioral and medical risk factors including member's willingness to change their behavior such as:

  - Symptoms of depression
  - Alcohol consumption and substance abuse
  - Tobacco use
- Weight (e.g., using BMI or waist circumference) and blood pressure indicators.

HMOs can conduct the screening in-person, over the phone, via mail or online.

For 2016, BadgerCare Plus HMOs are required to meet the lesser of the following targets of timely HNA Screeings:

- Performance Level Target: 35% rate of timely HNA Screenings in calendar year 2016-2017; OR
- Reduction in Error Target: 10% improvement from baseline.

HMOs who do not meet the HNA target in 2016 will be subject to liquidated damages. The amount will be the lesser of either $250,000 or $40 per BadgerCare Plus Childless Adult member for whom the HMO failed to meet the target in the calendar year.

In the second quarter of 2016, DHS worked with the EQRO to develop the HNA review process and define the HNA performance measurement specifications which were included in the 2016 HNA Guide. In June 2016, DHS shared a preliminary draft of the HNA Guide and had a conference call with the 18 HMOs to discuss the HNA review process and the HNA measurement specifications.

b) External Quality Review Activities

Following were the activities for the first quarter of the demonstration completed by the External Quality Review Organization (EQRO) – MetaStar for the HMOs operating the BadgerCare+ program.

- In collaboration with DHS, developed and distributed accreditation deeming strategy document request lists for accredited HMOs. Conducted review of documents for accreditation gaps.
- Completed 2016 PIP Proposal Reviews for three HMOs who received extensions.
- Performed data abstraction for HBO initiative (medical home enrollees). Delivered records request lists to HMOs (July-December 2015 postpartum visits). Maintained OBMH registry, triaged questions as needed.
- Met with DHS and began developing HIV/AIDs health home review criteria.
- Developed and delivered to BBM, a Timeline of Activities for External Quality Reviews.

Quarter Two

a) Health Needs Assessment Requirement for Childless Adults

The 2016-2017 BadgerCare Plus HMO contract required health plans to conduct a Health Needs Assessment (HNA) screening of newly enrolled BadgerCare Plus childless adult members within two months of HMO enrollment. The contract requires HMOs to include the following elements in the HNA screening:

- Urgent medical and behavioral symptoms (e.g., shortness of breath, rapid weight gain/loss, syncope, suicidal ideations, psychotic break);
- Members' perception of their general well-being;
- Identify usual sources of care (e.g., primary care provider, clinic, specialist, dental provider);
- Frequency in use of emergency and inpatient services;
- History of chronic physical and mental health illnesses (e.g., respiratory disease, heart disease, stroke, diabetes/pre-diabetes, back pain and musculoskeletal disorders, cancer, overweight/obesity, severe mental illness(es), substance abuse);
- Number of prescription medications used monthly;
- Socioeconomic barriers to care (e.g., stability of housing, reliable transportation, nutrition/food resources, availability of family/caregivers to provide support);
- Behavioral and medical risk factors including member's willingness to change their behavior such as:
    - Symptoms of depression
    - Alcohol consumption and substance abuse
    - Tobacco use
- Weight (e.g., using BMI or waist circumference) and blood pressure indicators.

HMOs can conduct the screening in-person, over the phone, via mail or online.

For 2016, BadgerCare Plus HMOs are required to meet the lesser of the following targets of timely HNA Screeings:

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- Reduction in Error Target: 10% improvement from baseline.

HMOs who do not meet the HNA target in 2016 will be subject to liquidated damages. The amount will be the lesser of either $250,000 or $40 per BadgerCare Plus Childless Adult member for whom the HMO failed to meet the target in the calendar year.

In the second quarter of 2016, DHS worked with the EQRO to develop the HNA review process and define the HNA performance measurement specifications which were included in the 2016 HNA Guide. In June 2016, DHS shared a preliminary draft of the HNA Guide and had a conference call with the 18 HMOs to discuss the HNA review process and the HNA measurement specifications.

c) External Quality Review Activities

Following were the activities for the second quarter of the demonstration completed by the External Quality Review Organization (EQRO) – MetaStar for the HMOs operating the BadgerCare+ program.

- Finalized review feedback of documents for accreditation gaps for the deeming strategy for accredited HMOs.

- Conducted an information systems capability assessment for one HMO and delivered a preliminary report to DHS and the HMO that contains analysis and results.
- Conducted a compliance with standards review for two HMOs and held the on-site visits; preliminary findings and the report are underway.
- In collaboration with DHS, drafted a Childless Adults Health Needs Assessment Guide and presented the new review activity outline to HMOs on a conference call. In addition, began identifying the sample population for the new review activity for CY 2017.

Quarter Three

a) Health Needs Assessment (HNA) for Childless Adults – DHS worked with the EQRO, MetaStar, and HMOs to develop a guide with the definitions on each measure HMOs will be evaluated for 2016 performance. Had conference calls with HMOs to gather feedback about the proposed measures and finalized the 2016 HNA evaluation methodology and timeframe. Also continued to receive quarterly HNA report from HMOs.

b) Pay-for-Performance (P4P) – Since 2009, DHS has successfully implemented a pay-for-performance program in which HMOs are held accountable to key metrics. For 2016, the P4P program is funded through a withhold of 2.5% of each HMO monthly capitation payments which is earned back by HMOs that meet targets on 14 different measures. The measures include a combination of preventive screenings (e.g. HEDIS Breast Cancer Screening, Childhood Immunizations), management of certain chronic conditions(e.g. Comprehensive Diabetes Care, Controlling High Blood Pressure), as well as behavioral health (e.g. Follow-Up After Mental Health Hospitalization, Antidepressant Medication Management) and dental measures (e.g. Annual Dental Visit).

   In July 2016, DHS received audited HEDIS data from HMOs for calendar year 2015. From July to September 2016, DHS also worked with our fiscal agent to calculate non-HEDIS measures directly from our encounter data system and with the EQRO to validate them. In mid-September 2016, DHS shared preliminary 2015 P4P results with HMOs for their review which were finalized with additional feedback in November 2016.

c) HMO Report Cards – After gathering feedback from the public and HMOs, DHS finalized HMO Report Cards comparing HMO performance across the measures in the P4P program. The HMO Report Cards are included in new members' enrollment packets to help them make an informed decision when selecting an HMO.

d) Performance Improvement Projects – DHS received the final Performance Improvement reports from HMOs for calendar year 2015 which were reviewed by MetaStar.

f) External Quality Review Activities

Following were the activities for the third quarter of the demonstration completed by the External Quality Review Organization (EQRO) – MetaStar for the HMOs operating the BadgerCare+ program.

- Finalized the results and delivered the final reports for three HMOs information systems capability assessments.
- Finalized the results and delivered the final report for one HMO's compliance with standards review.
- In collaboration with DHS, finalized the Childless Adults Health Needs Assessment HMO Guide and MetaStar Reviewer Guidelines, and presented the new review activity timeline and standards to HMOs on a conference call. In addition, proposed and solidified the timeframe for review.
- Validated 2015 Performance Improvement Projects (PIPs) for all HMOs but one (who received an extension).
- Updated the DHS-HMO contract references in the accreditation deeming plan/crosswalk document
- Compiled the MetaStar Certification/Accreditation Deeming Plan review results, for both phase I and phase II
- Identified and confirmed agreement to the fiscal year 2016-2017 SSI CMR timeframe for review and standards, including the review timelines and criteria for three HMOs currently on an SSI CMR corrective action plan.
- Performed data abstraction and drafted preliminary calendar year 2015 annual report for HBO initiative (medical home enrollees).
- Amended the Annual Technical Report to include results from the fiscal year 2015-2016 compliance with standards and information systems capabilities assessment reviews.

Quarter Four

e) Health Needs Assessment (HNA) for Childless Adults – Per the 2016-2017 BC+ and SSI HMO contract, HMOs are required to conduct a Health Needs Assessment (HNA) screening of newly enrolled childless adult (CLAs) members within two months of enrollment. In the fourth quarter of 2016, DHS modified the HNA contract requirements in the 2017 contract by increasing the penalty for HMOs that do not meet their 2017 HNA targets. DHS also worked with HMOs to calculate baselines for setting their 2017 HNA targets using HNA performance data from 7/1/15 to 6/30/16.

f) Pay-for-Performance (P4P) – Since 2009, DHS has successfully implemented a pay-for-performance program in which HMOs are held accountable to key metrics. For 2016, the P4P program is funded through a withhold of 2.5% of each HMO monthly capitation payments which is earned back by HMOs that meet targets on 14 different measures. The measures include a combination of preventive screenings (e.g. HEDIS Breast Cancer Screening, Childhood

Immunizations), management of certain chronic conditions(e.g. Comprehensive Diabetes Care, Controlling High Blood Pressure), as well as behavioral health (e.g. Follow-Up After Mental Health Hospitalization, Antidepressant Medication Management) and dental measures (e.g. Annual Dental Visit).

In November 2016, DHS validated the 2015 HMO P4P results with HMOs and finalized them. DHS also issued P4P baselines for 2017 HMO P4P measures which were shared with HMOs in November 2016.

Performance Improvement Projects – In early December 2016, HMOs submitted their 2017 Performance Improvement Projects (PIP) proposals to DHS using their 2015 P4P results and 2017 P4P targets. The PIP proposals were jointly reviewed by the EQRO and DHS in December 2016; the EQRO held conference calls in early January 2017 with each HMO to share the joint feedback.

g) External Quality Review Activities

Following are the current activities for the fourth quarter of the demonstration completed by the External Quality Review Organization (EQRO) – MetaStar for the HMOs operating the BadgerCare+ program.

- Reviewed and provided feedback for 35 PIP proposals for measurement year 2017.
- Conducted and delivered results of SSI Care Management Review for four organizations including the three HMOs placed under corrective action plans by DHS.
- Validated and reported performance measures for all HMOs to DHS.
- Confirmed dates for Comprehensive Review and Information Systems Capabilities Assessment for HMO due in this review year to be conducted 1st quarter of 2017.
- Completed OBMH record reviews for Selection 20.

Managed Care Reporting Requirements

Starting April 1, 2014 childless adults were enrolled in BadgerCare Plus fee-for-service benefits. Starting in July 2014 the state began enrolling childless adults into managed care with an average of 20,000 members in each month until all new members have been enrolled in managed care as applicable. HMOs are required to report to the DHS on the status of quality infinitives, PIPs, and other programmatic requirements.

Demonstration Evaluation

On November 12, 2014, the Centers for Medicare and Medicaid Services (CMS) approved the Department of Health Services (DHS) evaluation plan. The DHS has incorporated the approved evaluation plan as Attachment C.

The DHS signed an interagency agreement and contracted with the UW Population Health Institute to conduct the evaluation. DHS and the UW began work on the evaluation September 1, 2015. The UW's Scope of Work and Workplan are included as Attachment E.

During the third quarter of demonstration year 2 DHS and the UW Population Health Institute discussed suggested modifications to the CMS approved evaluation design. Included in Attachment C are the following documents:

- Suggested Modifications to Approved Evaluation Design
- Evaluation Design Change Summary Crosswalk
- CMS Comments and Questions on Suggested Modifications
- Wisconsin Response to CMS Comments and Questions

DHS and the UW Population Health Institute will incorporate these modifications into the second survey and final evaluation report. DHS is currently working on submitting a formal amendment request for CMS review and approval.

During the fourth quarter of demonstration year 3 the UW Population Health Institute completed the initial draft of the interim evaluation report. DHS reviewed the draft report and provided comments to the UW. The UW returned an updated draft to DHS and DHS is conducting the final review of the Interim report and will submit to CMS by June 2017.

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Attachment A – Budget Neutrality Monitoring Workbook

Childless Adults Draft Financial Statistics - Waiver Reporting for Quarter Ending Dec 2016

Childess Adult Quarterly Comparison	Claim Expenditures ($ in AF)	Prior Year QE Expenditures ($ in AF)	Ave Monthly Enrollment	Prior Year QE Ave Monthly Enrollment	Ave Monthly PMPM	Prior Year QE Ave Monthly PMPM
QE June 2014	101,210,605	22,157,735	111,187	18,660	302.75	395.80
QE Sept. 2014	137,243,424	21,246,908	130,036	17,487	351.42	404.97
QE Dec. 2014	167,024,246	20,296,922	143,883	16,288	386.86	415.43
QE Mar. 2015	190,022,630	18,692,247	160,613	14,762	394.29	422.27

Adult Waiver Quarterly Trends	Claim Expenditures ($ in AF)	Quarter-over-Quarter Percent Change	Ave Monthly Enrollment	Quarter-over-Quarter Percent Change	Ave Monthly PMPM	Quarter-over-Quarter Percent Change
QE June 2015	194,501,401	-	155,823	-	416.22	-
QE Sept. 2015	195,525,111	0.53%	150,708	-3.28%	432.46	3.90%
QE Dec. 2015	195,787,397	0.13%	151,100	0.26%	431.92	-0.12%
QE Mar. 2016	202,532,256	3.44%	153,951	1.89%	438.53	1.53%
QE June 2016	206,944,151	2.18%	149,962	-2.59%	460.03	4.90%
QE Sept 2016	208,091,719	0.55%	148,834	-0.75%	462.60	0.56%
QE Dec 2016	209,043,684	0.46%	148,295	-0.36%	469.88	1.57%

CORE Baseline (Childless Adults)	Claim Expenditures ($ in AF)	Fee for Service Enrollees	CAP Expenditures	CAP Members	Total Expenditures	Total Enrollees	Overall PMPM
Apr-13	2,624,273	2,383	4,956,173	16,741	7,580,446	19,124	396.38
May-13	2,582,125	2,333	4,832,357	16,330	7,414,482	18,663	397.28
Jun-13	2,409,378	2,203	4,753,430	15,989	7,162,808	18,192	393.73
Jul-13	2,553,051	1,926	4,721,124	15,922	7,274,175	17,848	407.56
Aug-13	2,395,752	1,832	4,671,819	15,674	7,067,571	17,506	403.72
Sep-13	2,359,752	1,836	4,545,410	15,272	6,905,162	17,108	403.62
Oct-13	2,568,860	1,898	4,411,923	14,809	6,980,783	16,707	417.84
Nov-13	2,222,150	1,657	4,372,572	14,633	6,594,722	16,290	404.83
Dec-13	2,444,132	1,579	4,277,285	14,288	6,721,417	15,867	423.61
Jan-14	2,372,043	1,519	4,069,353	13,844	6,441,396	15,363	419.28
Feb-14	2,153,802	1,403	3,929,873	13,330	6,083,675	14,733	412.93
Mar-14	2,373,347	1,360	3,793,829	12,830	6,167,176	14,190	434.61

BC Reform Adult Waiver (Childless Adults)	Claim Expenditures ($ in AF)	Fee for Service Enrollees	CAP Expenditures	CAP Members	Total Expenditures	Total Enrollees	Overall PMPM
Apr-14	26,293,463	96,182	3,144,558	9,532	29,438,021	105,714	278.47
May-14	31,276,064	100,972	2,951,909	8,878	34,227,973	109,850	311.59
Jun-14	33,724,699	105,854	3,819,912	12,144	37,544,611	117,998	318.18
Jul-14	34,866,576	100,968	7,541,232	23,898	42,407,808	124,866	339.63
Aug-14	31,278,043	86,034	13,633,326	44,239	44,911,369	130,273	344.75
Sep-14	31,688,502	73,344	18,235,745	61,625	49,924,247	134,969	369.89
Oct-14	30,266,965	56,976	23,979,739	82,485	54,246,704	139,461	388.97
Nov-14	25,478,921	44,182	28,569,601	99,066	54,048,522	143,248	377.31
Dec-14	26,403,009	35,918	32,326,011	113,022	58,729,020	148,940	394.31
Jan-15	26,394,875	33,569	34,803,062	121,838	61,197,937	155,407	393.79
Feb-15	25,007,418	33,697	36,623,234	128,387	61,630,652	162,084	380.24
Mar-15	29,129,303	30,584	38,064,738	133,765	67,194,041	164,349	408.85
Apr-15	29,456,121	29,722	37,519,234	132,317	66,975,355	162,039	413.33
May-15	27,360,880	28,230	36,302,788	127,131	63,663,669	155,361	409.78
Jun-15	28,891,476	28,546	34,970,901	121,523	63,862,377	150,069	425.55
Jul-15	29,659,951	26,494	35,844,716	124,332	65,504,667	150,826	434.31
Aug-15	28,853,707	25,755	36,152,405	125,021	65,006,112	150,776	431.14
Sep-15	28,864,462	25,540	36,149,870	124,981	65,014,332	150,521	431.93
Oct-15	29,296,944	25,971	36,168,361	124,108	65,465,305	150,079	436.21
Nov-15	28,427,953	27,012	36,052,707	123,951	64,480,661	150,963	427.13
Dec-15	29,971,594	29,061	35,869,837	123,196	65,841,431	152,257	432.44
Jan-16	30,065,391	31,689	35,724,664	122,387	65,790,055	154,076	427.00
Feb-16	30,824,207	29,776	36,215,887	124,301	67,040,094	154,077	435.11
Mar-16	32,445,700	25,521	37,256,408	128,179	69,702,108	153,700	453.49
Apr-16	31,988,700	25,109	36,606,162	126,178	68,594,862	151,287	453.41
May-16	32,564,891	24,708	36,412,900	125,171	68,977,791	149,879	460.22
Jun-16	33,137,412	24,426	36,234,086	124,295	69,371,498	148,721	466.45
Jul-16	31,921,124	23,535	36,280,462	124,368	68,201,586	147,903	461.12
Aug-16	35,069,296	24,017	36,401,304	124,244	71,470,600	148,261	482.06
Sep-16	31,699,488	23,487	36,720,045	124,663	68,419,533	148,150	461.83
Oct-16	31,719,283	23,586	36,150,762	123,328	67,870,045	146,914	461.97
Nov-16	30,788,801	23,826	36,162,354	123,324	66,951,156	147,150	454.99
Dec-16	29,946,084	24,176	35,948,288	122,509	65,894,372	146,685	449.22

*MC Enrollees have some of their expenditures in FFS Claims as well: Wrap around, Pharmacy, etc.
**FFS Claims are pulled on a date of service basis. PMPM comparisons may be skewed due to claims lag for months of Oct 2016 through Dec 2016
*** Expenditures and enrollment may not tie to future quarterly reports as numbers will be adjusted to account for claims lag
**** All data for Jul 2016 - Dec 2016 pulled on Jan 23, 2017 from DSS, not from MBES quarterly report
***** Note that expenditures are not net of drug rebates. Net expenditures will be reported in MBES for the CMS 64 quarterly report.

Attachment B – Summary of Cost-Sharing for TMA Adults Only

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

TMA Adults (Demonstration Population 1)

Monthly Premium Amount Based on FPL Percentage	Monthly Premium Amount as 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 – 339.99%	7.4%
240 – 249.99%	7.7%
250 – 259.99%	8.05%
260 – 269.99%	8.3%
270 – 279.99%	8.6%
280 – 289.99%	8.9%
290 – 299.99%	9.2%
300% and above	9.5%

Attachment C – Demonstration Evaluation Plan & Approved Modifications


WI BadgerCare Reform Final Approve


BadgerCare Reform Demonstration Evalua


Suggested Modifications to Appr


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Attachment D – BadgerCare Plus Reform Waiver Project Work Plan

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Attachment E – University of Wisconsin Scope of Work & Project Work Plan

BadgerCare Reform
Waiver Evaluation - S

Evaluation of Wisconsin's BadgerCare Plus Health Coverage

for

Parents & Caretaker Adults and for Childless Adults

2014 Waiver Provisions

Interim Evaluation Report – Year 01

Submitted to the

Wisconsin Department of Health Services

April 20, 2017

University of Wisconsin
Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

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This work also benefited from the regular consultation, review and oversight by staff of the Wisconsin Department of Health Services, including project manager Craig Steele, with Eric Bakken, Mitzi Melendez, Leah Ramirez, and Rachel Witthoft.

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iii. ABBREVIATIONS & GLOSSARY OF TERMS

CARES	Wisconsin Medicaid's Eligibility and Enrollment System
CLA	Childless Adults: Adults without dependent children who are eligible for Wisconsin's BadgerCare program
CMS	U.S. Centers for Medicaid and Medicare Services
DHS	Wisconsin Department of Health Services
Enrollment Spell	Unless otherwise noted, an enrollment spell begins with the enrollment start date and ends with an enrollment gap of more than 1 month.
FPL	Federal Poverty Level
Hazard regression modeling	Hazard models adjust for duration dependence in the outcome variable and are useful to understand the factors associated with the occurrence and timing of an event (e.g., disenrollment from Medicaid).
HIP	University of Wisconsin Health Innovation Program: Location of servers hosting BadgerCare claims and encounter data for evaluation project
HIPAA	Health Insurance Portability and Accountability Act: Federal Law governing privacy of patient and consumer health information
Kaplan Meier Survival curve	A Kaplan Meier survival curve illustrates the proportion of individuals in a population that has not yet experienced the event of interest (e.g., disenrollment) plotted against time since baseline.
Metropolitan area	A county that contains a core urban area of 50,000 or more population, as designated by the Year 2000 U.S. Census. https://www.census.gov/population/metro/
RRP	Restrictive Reenrollment Period: Period of disenrollment following non-payment of a required BadgerCare premium
TMA	Transitional Medical Assistance: also known as "Extensions." A Medicaid program that offers up to 1 year of additional Medicaid health insurance benefits for certain low-income individuals who would otherwise lose coverage due to an increase in income.
UWPHI	University of Wisconsin Population Health Institute: independent evaluators for Wisconsin's BadgerCare 2014 waiver

I. EXECUTIVE SUMMARY

The UW Population Health Institute is conducting an evaluation of the Wisconsin BadgerCare Reform Demonstration Project, as outlined by the Wisconsin Department of Health Services (DHS) and approved by the federal Centers for Medicare and Medicaid Services (CMS). The evaluation uses rigorous methods to arrive at an understanding of how the changes implemented under Wisconsin's 2014 Medicaid 1115 Waiver Demonstration affect two Medicaid populations: (1) parents and caretaker adults who are eligible for Medicaid through Transitional Medical Assistance (TMA Adults) and (2) childless adults (CLAs) with an effective income level at or below 100% of the federal poverty level (FPL).

The evaluation addresses the 17 evaluation questions defined by DHS in the "BadgerCare Reform Demonstration Draft Evaluation Design" of 10/31/2014, approved by CMS on 11/12/14. The hypotheses focus on programmatic changes authorized by the 1115 Waiver: Premium changes, three-month RRP; and Standard Plan coverage for CLAs.

The evaluation requires administrative data from the Wisconsin DHS on (a) claims and encounters, (b) diagnostic codes, (c) enrollment, and disenrollment reason codes, and (d) premium payment information. The evaluation team also conducted a survey in 2016, and will do another in 2018, of currently enrolled and disenrolled BadgerCare members. The survey assesses measures of utilization, health, and response to premiums.

Data Collection

Administrative Data: The collection of administrative data (encounter data from CARES and claims data via the Business Objectives data warehouse) have presented various challenges and setbacks. Most of these have been addressed, and CARES enrollment files are in use. The limited access to claims and encounter data in Year 1 required some re-arrangement of the workplan. We shifted our focus to evaluation questions that did not require the use of claims and encounter data.

Survey data: A survey of current and former BadgerCare members, in the field from May-September 2016, attained a response rate of 57%. The 1,305 respondents represent the following beneficiary groups: 1) parents/caretaker adults, 2) childless adults, 3) TMA beneficiaries, and 4) beneficiaries currently enrolled in an RRP.

Data Analysis

This Year 01 Interim Evaluation Report provides a descriptive overview of the waiver populations: TMA and CLA beneficiaries. Preliminary findings are reported here for TMA-related questions 8; 10-12 and for CLA-related question 17.

Note: All findings reported here are preliminary and remain subject to further exploration and analysis during the remaining three years of this evaluation period.

Transitional Medicaid Adults (TMA)

Question 8. What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?

The study population is the universe of Medicaid beneficiaries potentially eligible for TMA. For this population, we examine the relationship between the program's premium policy and enrollment outcomes, comparing outcomes across three policy periods: 1) no premium present, March 2008 – June 2012; 2) premiums required for enrollees with income at or above 133%FPL, July 2012-March 2014; and 3) premiums required after six months for enrollees with income from 100-133% FPL and required upon enrollment for enrollees with income greater than 133% FPL, April 2014 – September 2015.

Overall TMA Characteristics:

- No major differences emerge in the average characteristics of enrollees who enroll in, or take up, TMA under the three different premium policies.
- The fraction of TMA enrollees in the lowest income categories increases under Policies 2 and 3, particularly those with incomes between 100-133% FPL, and decreases in the fraction in higher income categories, particularly those with incomes 200% FPL and higher.
- Those beneficiaries who move to a higher income level (and enroll in TMA) are different from those who stay at the same income level in predictable ways: age, education level, income at initial enrollment, and household size are strongly associated with moving to TMA enrollment.
- Premium policy under TMA does not appear to be an important determinant of initial enrollment behavior.

Premium Payment:

- Premium non-payment is highest in the first month of TMA enrollment. Individuals who continue enrollment beyond the first month are likely to continue payment and enrollment.

Effect of premiums on TMA take-up and exits:

- The 2012 waiver caused a decrease in take-up of TMA, driven by those who transitioned with income 133% FPL or greater. This finding is consistent with the new introduction of premiums for those with incomes at or above 133% FPL, resulting in a decrease in program take-up.
- The 2014 waiver saw a smaller decrease in TMA take-up, driven by those with incomes between 100-133% FPL. This is consistent with the introduction of premiums for those with incomes between 100-133% FPL after 6 months resulting in a decrease in program take-up.
- Both waivers are associated with an immediate, one-time increase in exits, which is much larger for the 2012 waiver. There is no apparent change in the relative exit rate after this.
- The 133% FPL threshold is an important determinant of length of enrollment spell. The 2014 waiver decreased the average length of enrollment by 2.1 months for those above 133% FPL relative to those below 133% FPL. This represents an increase in the degree that the 133% margin mattered for length of enrollment spell, magnifying the difference between enrollees with income below and above 133% FPL relative to the 2012 waiver.

Question 10. What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment?

- Individuals who started TMA with incomes between 100-133% FPL after April 2014 experienced a slightly decreased likelihood of experiencing six months of enrollment compared to similar individuals under the 2012 waiver. After the 2014 waiver, 85.9% of TMA enrollees with income from 100%-133% FPL had more than six months of enrollment compared to 92.2% before the waiver.

- Those with incomes between 100-133% FPL who entered TMA after implementation of the 2014 waiver decreased their mean length of TMA enrollment by roughly 1 month, from 10.8 months pre-2014 to 9.8 months post-2014.

- Large increases occurred in the percentage of people who experienced an RRP – from less than 2% before the 2014 waiver to 12% after the waiver. The group of individuals with income greater than 133% shows particularly large increases.

- Among those who experienced an RRP, the mean length of RRP decreased from 8.7 to 2.8 months, consistent with the change in RRP policy.

Question 11. Does the RRP impact vary by income level? and

Question 12. If there is an impact from the RRP, explore the break-out by income level.

Characteristics of individuals entering TMA under the 2012 waiver and under the 2014 waiver:

- The RRP impact may vary by income level either because higher-income individuals have a different willingness to pay premiums or because they have different private insurance options available that may be more appealing. For the purposes of this report, we only test this difference at one break point – individuals with incomes >160% FPL. This number was chosen because it represents the upper half of the group with income >133% FPL in TMA.

- The higher-income subgroup >160% show a pattern very similar to the overall pattern of those individuals >133% FPL. The mean length of RRP show a more pronounced change for individuals >160% FPL than the changes observed at the 133% breakpoint.

Childless Adults (CLA)

Question 17. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?

The analyses reported in this Interim Evaluation Report compare enrollment outcomes for newly eligible CLA beneficiaries enrolled in the Standard Plan to outcomes for the continuing CLA beneficiaries enrolled in the Standard Plan after April 2014. “Continuing CLA” beneficiaries refer to childless adults enrolled in the Core plan immediately before April 2014 and enrolled in the Standard Plan after April 2014.

Characteristics of Continuing and New Childless Adult Beneficiaries:

- The two comparison groups differ substantially: Relative to continuing CLA enrollees (N=11,159), the new CLA enrollees (N=248,217) are younger, and more likely to be non-White and male. On average, the new CLA enrollees had fewer total Medicaid and CLA enrollment months before April 2013 than the continuing CLA enrollees.

- Potential explanations exist for the non-equivalence of the study groups across these characteristics: 1) the availability of the Standard Plan may attract a different childless adult population than did the Core Plan; and/or 2) beneficiaries who remained enrolled in the Core plan five years after its introduction may differ systematically from the eligible CLA population.

Health coverage continuity for Continuing and New Childless Adult Beneficiaries:

- The large majority of enrollment spells for continuing CLA beneficiaries were "legacy" spells defined as enrollment spells that began before April 2014. Among continuing CLA beneficiaries, the average duration of these legacy spells in the post-waiver period is longer, and the likelihood of renewal is greater than new spells. This comparison is useful for considering the level of enrollment mobility for the new CLA population relative to a stable insured CLA population when they face the same coverage and enrollment flexibility.

- New CLA beneficiaries experienced less continuous health insurance coverage than continuing CLA beneficiaries, when continuity is defined by enrollment spell duration, renewal and disenrollment. It is highly plausible that underlying differences between the two study groups may explain this divergence in coverage continuity, although we cannot separate that potential explanation from the availability of Standard Plan coverage.

Survey Progress Report

The UW Survey Center conducted a mixed-mode mail and telephone survey of three subgroups:

1. Parents and Caretakers
    - Parents/Caretakers who remained on the program pre- and post-April 2014
    - Parents/Caretakers who joined post-2014
    - Parents/Caretakers with incomes >100% FPL who had transitioned off the BadgerCare program after the April 2014 policy change
2. Childless adults (CLA)
    - CLA who remained eligible from pre-2014 Core Plan coverage
    - CLA who gained eligibility post-2014
    - CLA who, with incomes >100% FPL, lost BC coverage post-April 2014
3. Transitional Medical Assistance (TMA)
    - TMA who did not recently experience a restrictive reenrollment period (RRP) in two groups: 100-133% FPL and >133% FPL
    - TMA individuals who recently experienced an RRP

The survey process was underway from May-September 2016, and attained an overall 57% response rate. Survey weights, currently being developed, will help account for differences in sampling probabilities and for differential non-response across subgroups of interest. This Year 01 Interim Evaluation Report includes an initial descriptive view of some of the survey data elements, reflecting raw, unweighted responses, which are not inferential and are not intended for conclusion. Complete analysis will be available in the forthcoming scientific report that will be delivered separately to DHS.

II. DEMONSTRATION WAIVER AND EVALUATION BACKGROUND

The UW Population Health Institute (The Institute) is conducting an evaluation of the Wisconsin BadgerCare Reform Demonstration Project, as outlined by the Wisconsin Department of Health Services (DHS) and approved by the federal Centers for Medicare and Medicaid Services (CMS). BadgerCare is Wisconsin's combined Medicaid and Children's Health Insurance Program (CHIP) for low-income families and adults without dependent children.

A. Waiver Overview and Target Populations

The 2014 Wisconsin waiver concerns two beneficiary populations, adults who are eligible for Transitional Medical Assistance, and adults without dependent children. In the following paragraphs, we describe these populations and provide an overview of waiver's provisions. The waiver provisions were effective on April 1, 2014.[1]

Transitional Medical Assistance (TMA). TMA extends Medicaid coverage for current beneficiaries for up to 12 months following an increase in income beyond 100% of the federal poverty level (FPL). TMA is available to adults who initially enrolled in Medicaid under parent/caretaker eligibility and had an income of less than 100% FPL at the time of enrollment. The July 2012 DHS waiver introduced a premium requirement for TMA beneficiaries with income at or above 133% FPL. The premium amount was based on a sliding scale relative to household income with a cap of 9.5% of household income. Under the 2014 waiver, these provisions remained in place. The 2014 waiver introduced a premium requirement for TMA beneficiaries with income between 100% and 133% FPL. Unlike the higher-income TMA beneficiaries, however, this requirement only takes effect after the 6th month of TMA enrollment. The method for calculating the premium amount is the same for all TMA beneficiaries. The 2014 waiver also stipulates that TMA adults who do not make a required premium payment are dis-enrolled from BadgerCare at the end of their eligibility month and placed in a three-month Restrictive Reenrollment Period (RRP). During the 3-month RRP, these individuals are ineligible for TMA if and until they pay their outstanding premium balance. This RRP policy differs from the policy in place before the 2014 waiver. Specifically, from July 2012 to March 2014, TMA beneficiaries with income at or above 133% FPL who failed to pay a premium were subject to a 12-month RRP. During that 12-month RRP, these individuals were ineligible for TMA. There was no mechanism for a return to TMA within those 12 months.

[1] Additional detail regarding the 2014 WI Medicaid waiver and the Special Terms and Conditions may be found online at the following locations: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/Badger-Care-Reform/wi-BadgerCare-reform-demo-project-app-11102011.pdf; and https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-BadgerCare-reform-ca.pdf

Childless Adults (CLA). This demonstration population includes non-pregnant, non-disabled adults between 19 and 64 years of age, without dependent children. The 2014 waiver introduced a change in income eligibility and benefits for this population. Previously, the DHS offered coverage under its Core Plan to a limited number of CLAs with income up to 200% FPL. These plans required enrollment fees and provided a limited set of benefits relative to standard WI Medicaid coverage, the Standard Plan. Effective April 1, 2014, the WI DHS eliminated the Core and Basic Plans. The DHS transitioned CLAs beneficiaries with incomes at or below 100% FPL to the Standard Plan, and all new childless adult applicants with incomes that do not exceed 100% FPL are enrolled in the Standard Plan.
The WI Medicaid Standard Plan has no premiums for eligible members below 100% FPL, and provides the full range of Medicaid benefits.[2] CLAs with income above 100% FPL are no longer eligible for Medicaid coverage.

Evaluation Populations

Table II.1, below, shows the socio-demographic descriptors of the TMA and CLA beneficiary populations as of April 2015, one year after the initiation of the waiver policies. We additionally include a description of adults enrolled under parent/caretaker eligibility although the 2014 waiver does not include provisions specific to this eligibility category. Rather, this population plays an important role in the evaluation because it represents the pool of potential TMA beneficiaries, and it serves as a secular comparison group for several analyses.

[2] Additional detail regarding the CLA population and a comparison of benefits under the Core, Basic, and Standard plans may be found online:
https://www.dhs.wisconsin.gov/BadgerCareplus/standard.htm; and
https://www.forwardhealth.wi.gov/kw/pdf/2008-199.pdf

Table II.1. Sociodemographic Profile of Waiver Populations, April 2015			
Variable	PARENTS/ CARETAKERS	CHILDLESS ADULTS	TMA/Extensions (excess earnings category)
	Mean	Mean	Mean
Age	34.7	39.1	34.9
Female	72.9%	42.3%	71.9%
Non-Hispanic White	61.4%	60.3%	64.3%
Black	19.1%	24.3%	15.6%
Hispanic	9.4%	6.2%	9.6%
Other/unreported	8.1%	5.9%	8.5%
Citizen	96.3%	98.1%	96.0%
First language English	95.3%	97.8%	94.8%
Less than high school	21.3%	23.9%	15.2%
High school/GED	63.9%	55.3%	67.0%
More than high school	11.2%	6.2%	13.9%
Education missing	3.6%	14.6%	4.0%
Resides in a non-metropolitan area	66.5%	66.4%	64.1%
Number of children in household	2.2	0.07	2.1
Number of adults in household	1.6	1.2	1.7
Family income %FPL	37.2%	21.5%	127.8%
Length of enrollment spell in months	36.5	12.9	37.8
Number of Enrollees, April 2015	163,548	160,402	13,952

Source: Wisconsin CARES administrative eligibility system

B. Evaluation Design Approach and Methods

The evaluation uses rigorous methods to arrive at an understanding of how the changes implemented under Wisconsin's 2014 Medicaid 1115 Waiver Demonstration affect two Medicaid populations: (1) parents and caretaker adults who are eligible for Medicaid through Transitional Medical Assistance (TMA Adults) and (2) childless adults (CLAs) with an effective income level at, or below, 100% of the federal poverty level (FPL).

The evaluation addresses the 17 evaluation questions defined by DHS in the "BadgerCare Reform Demonstration Draft Evaluation Design" of 10/31/2014, approved by CMS on 11/12/14.[3] The UWPHI evaluation team built on the DHS design, submitting a Design Report in December 2016. The 2016 UWPHI design outlines our selected methodological approaches to answer each of the 17 questions and describes the data sources required.

The evaluation design documents may be found in the attachments to this report:

Attachment A: DHS Evaluation Design as originally submitted to and approved by CMS;
Attachment B: UW Design Report: Recommended Changes and Crosswalk; and
Attachment C: CMS Comments and UW/DHS Responses

The evaluation questions focus on programmatic changes authorized by the 1115 Waiver as described above in Section II.A. Generally, with respect to the TMA Adults, the evaluation assesses the following:

1. The effect of premiums on enrollment, access to care, the incidence of unnecessary services, health outcomes, and spending;
2. The effect of an RRP on payment of premiums and enrollment; and
3. The association of enrollment status to utilization and costs, and as experienced by those who are continuously enrolled and those who are exposed to an RRP.

For the CLA population, the evaluation assesses the effects of providing a more comprehensive benefit plan on health care use, continuity of Medicaid coverage, health outcomes, and costs.

[3] Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/Badger-Care-Reform/wi-BadgerCare-demo-eval-plan-20141031.pdf

III. WORKPLAN PROGRESS SUMMARY

This section summarizes the status of our data collection activities, and how it shapes the progression of the evaluation. The evaluation requires administrative data from the Wisconsin DHS on (a) claims and encounters, (b) enrollment and disenrollment reason codes, and (c) premium payment information. It also includes data from a survey of current and disenrolled BadgerCare members that assesses health care use, health, and response to premiums. The survey instrument from 2016 is available in Attachment E. A second survey will be fielded in 2018.

A. Administrative data from Wisconsin DHS

Enrollment, Disenrollment, RRP and Premium Payment Data

The evaluation team receives updates to BadgerCare eligibility and enrollment data, in a DHS system called CARES, every six months from the UW Institute for Research on Poverty (IRP). As of November 2016, we have obtained CARES data from January of 2006 through September of 2016.

The data, collected for programmatic purposes, present a range of challenges when deployed for research and evaluation. Our team continues to identify and resolve such challenges as they arise. Among them:

- Our evaluation team does not receive the BadgerCare case notes/text fields that explain the status of the case in detail. Lacking this detailed information, we often find that the variables from the RRP fields and premium data tables contradict the information contained in the main CARES eligibility data.

- RRPs included in initial CARES data may later be overridden or changed by DHS staff or the Income Maintenance agency staff, requiring a revision of work using adjusted data.

In September of 2016, we worked with DHS staff to draw up decision rules that allow determination of whether a person was on RRP at any point. The same types of problems persist with the premium data, and we continue to work our way through these challenges.

Unemployment insurance earnings data

In addition to the CARES updates, IRP also updates our unemployment insurance earnings data yearly. Currently we have data from calendar years 2008 through 2015. We are expecting the 2016 update shortly into 2017. These data have been cleaned, de-duplicated and are available to be matched to the CARES data as needed. This allows us to assess the income and employment experience of BadgerCare members as they leave coverage, and the degree to which they may have access to other sources of insurance coverage through an employer.

Claims/Encounter Data

In order to comply with the UW-Madison's revised requirements for storing and using HIPAA protected data while enabling the evaluation team's access to WI DHS claims and encounter data, our evaluation

team established a new "home" for the WI DHS data at the UW. The UW Health Innovation Program (HIP) is the new custodian for the claims and encounter data for this evaluation. Our team's data manager can directly access the data within Business Objects and move it to the HIP servers for use by the evaluation team's researchers.

Development of this arrangement required considerable technical, programmatic, and legal effort over the past year from multiple parties at the Wisconsin DHS, HIP, the UW administration, and our evaluation team. We expected that Wisconsin DHS claims and encounter data to becoming available for analysis to the UW evaluation team by December 2016. It ultimately became available on March 29, 2017.

B. Survey Data

The survey is intended primarily to support understanding of the following evaluation questions:

Q.6: Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?
Q.9: How is access to care affected by the application of new, or increased, premium amounts?
Q. 17. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?

The UW Survey Center, our team's subcontracted partner on this project, conducted a mixed-mode mail and telephone survey to reach a statistically valid sample and achieve high response rates. Our survey sample was designed in order to provide valid cross-sectional estimates and, also, to increase comparability with the responses from the 2014 BadgerCare evaluation survey. The 2016 sampling frame included current beneficiaries who met our study categories and all individuals who responded to the 2014 survey.

The 2016 survey respondents fall into three subgroups:

1. Parents and Caretakers
    - Parents/Caretakers who remained on the program pre- and post-April 2014
    - Parents/Caretakers who joined post-2014
    - Parents/Caretakers <100% FPL who had transitioned off of the BadgerCare program after the April 2014 policy change
2. Childless adults (CLA)
    - CLA who remained eligible from pre-2014 Core Plan coverage
    - CLA who gained eligibility post-2014
    - CLA who, with incomes >100% FPL, lost BC coverage post-April 2014
3. Transitional Medical Assistance (TMA)
    a. TMA who did not recently experience a restrictive reenrollment period (RRP) in two groups: 100-133% FPL and >133% FPL
    b. TMA individuals who recently experienced an RRP

Table S1 shows the sample of survey's target sub-groups as constructed in February 2016. The survey process was underway from May 10, 2016 - September 26, 2016. It included an initial mailing with a $5 incentive, two follow-up letters, and then a telephone follow-up to non-respondents. The survey attained an overall 57% response rate, with rates by specific subgroups detailed in Table S1 and by race and ethnicity in Table S2.

Table S1: Survey Sample and Response Rates by Subgroup

	Parents/ Caretaker Adults (including Transitioners)	Childless Adults	TMA/ Extensions	Current RRP	Total
Total Sample N	997	600	600	400	2,597
Non-Eligible Cases	31 across 3 groups			7	38
Respondents N	591	278	317	119	1,305
Response rate	**66%**	**55%**	**56%**	**35%**	**57%**
Mail	443	210	246	73	972
Phone	148	68	71	46	333

Table S2: Race and Ethnicity of Survey Respondents

	Parents/ Caretakers	Childless Adults	TMA	RRP
Hispanic	5.20%	3.32%	5.54%	8.40%
White, non-Hispanic	79.20%	73.41%	74.77%	51.26%
Black, non-Hispanic	7.80%	14.13%	7.38%	28.57%
Asian, American Indian, and other non-Hispanic	3.20%	4.99%	5.23%	5.88%
Multiple races, non-Hispanic	3.00%	2.49%	4.62%	3.36%
No race reported	1.60%	1.66%	2.46%	2.52%

Table S3 provides a comparison of the survey respondents relative to all adults enrolled in BadgerCare as of April 2015 according to race and ethnicity. Our team is in the process of developing survey weights which will enable us to account for differences in sampling probabilities and for differential non-response across subgroups of interest (e.g., accounting for the fact that some individuals may be under-represented relative to their size in the underlying population). These weights are being developed using our original sampling frame and sampled respondent lists for 2014 and 2016. Weighting should increase the generalizability of our estimates.

This Interim evaluation report includes, in Attachment F, an initial descriptive view of some of the data elements. These data as presented reflect raw, unweighted responses. A forthcoming full scientific report on the survey results will elaborate on these and other data. The information displayed here in Attachment F is not inferential and not intended for conclusion.

Table S3: Survey Respondents' Race and Ethnicity Compared to Enrolled BadgerCare Members, April 2015			
	White, non-Hispanic	Black non-Hispanic	Hispanic
Parents/Caretakers			
BC Members, April 2015	61.4%	19.1%	9.4%
Survey Respondents	79.2%	7.8%	5.2%
Childless Adults (CLA)			
BC Members, April 2015	60.3%	24.3%	6.2%
Survey Respondents	73.4%	14.1%	3.3%
Transitional Medicaid (TMA)			
BC Members, April 2015	64.3%	15.6%	9.6%
Survey Respondents	74.8%	7.4%	5.5%

C. Progression of Evaluation

The project work proceeds according to the work plan submitted with the original contract Scope of Work and agreement conditional on the availability of the requisite data. As needed, the team re-orders the sequence of tasks to align with available data. For example, the evaluation team pursued the enrollment-related analytic evaluation questions in Year 1 rather than later years as originally proposed because these data were available. By contrast, significant delays occurred in obtaining access to Medicaid claims and encounter data, preventing completion of some tasks originally scheduled for Year 1.

Table III.1 restates the original evaluation questions and briefly notes the progress-to-date for each question. The work plan, in Attachment E, provides further detail about the data source, timeline, and next steps. The remainder of this section of the Interim Evaluation Report is organized according to the programmatic changes authorized by the 1115 Waiver: For Transitional Medicaid (TMA) population, the premium and RRP policy changes, and for Childless Adults (CLA), the change in benefits from the Core plan to Standard plan coverage. The report presents preliminary findings for the evaluation questions addressed during this first year of the project: For the TMA population, questions 8, 10-12 and, for Childless Adults, Question 17.

Table III.1 Evaluation Questions: Progress-to-Date	
Evaluation Question	**Progress to Date**
TMA: Effect of Premiums on Utilization, Cost and outcomes	
1: Will the premium requirement reduce the incidence of unnecessary services? 2: Will the premium requirement lead to improved health outcomes? 3: Will the premium requirement slow the growth in healthcare spending? 4: Will the premium requirement increase the cost effectiveness (Outcomes/Cost) of Medicaid services? 5: Will the premium requirement increase the cost effectiveness (Utilization/Cost) of Medicaid services?	Protocol underway to obtain claims/encounter data; Cohorts developed Claims/encounter data access achieved in late March, 2017
TMA: Association of enrollment status to utilization and costs	
6: Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period? 7: Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for beneficiaries that have disenrolled and then re-enrolled?	Protocol underway to obtain claims/encounter data; Cohorts developed Claims/encounter data access achieved in late March, 2017 Year 01 Survey conducted.
TMA: Enrollment analysis by payment of premiums	
8: What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?	Datasets cleaned & constructed; Cohorts developed; Outcome measures selected & constructed; Initial selection of regression models; Preliminary analysis & findings
9: How is access to care affected by the application of new, or increased, premium amounts?	Protocol underway to obtain claims/encounter data; Year 1 survey conducted; Cohorts developed

TMA: Effect of RRP on Premium Payment and Enrollment	
10: What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment? 11: Does the RRP impact vary by income level? 12: If there is an impact from the RRP, explore the break-out by income level.	Datasets cleaned & constructed; Cohorts developed; Outcome measures selected & constructed; Initial selection of regression models; Preliminary analysis; Preliminary findings
CLA Adults: Effects of the Benefit Plan for Demonstration Expansion Group	
13. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries result in improved health outcomes?	Protocol developed to obtain and access claims/encounter data; Cohort developed; Analytic variables defined Claims/encounter data access achieved in late March, 2017
14. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries achieve a reduction in the incidence of unnecessary services?	
15. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Outcomes/Cost) of Medicaid services?	
16. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Utilization/Cost) of Medicaid services?	
17. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?	Dataset cleaned & constructed; Cohorts developed; Outcome measures selected & constructed; Initial selection of regression models; Preliminary analysis; Preliminary findings; Year 01 Survey conducted.

IV. INTERIM EVALUATION FINDINGS

The following pages provide preliminary findings to questions 8, 10-12, and 17. These findings are intended to provide an early view of the progress of the work, and are not considered definitive.

A. TRANSITIONAL MEDICAID POPULATION

This section describes TMA enrollment over time, including the probability of transitioning to TMA, by TMA status, income, premium payment status, and other demographic characteristics available through administrative eligibility data. We use an interrupted time series design and a regression discontinuity design in order to perform a causal analysis of the effect of premiums on TMA enrollment.

Question 8: Payment of Premiums and The Effect of Premiums on Enrollment

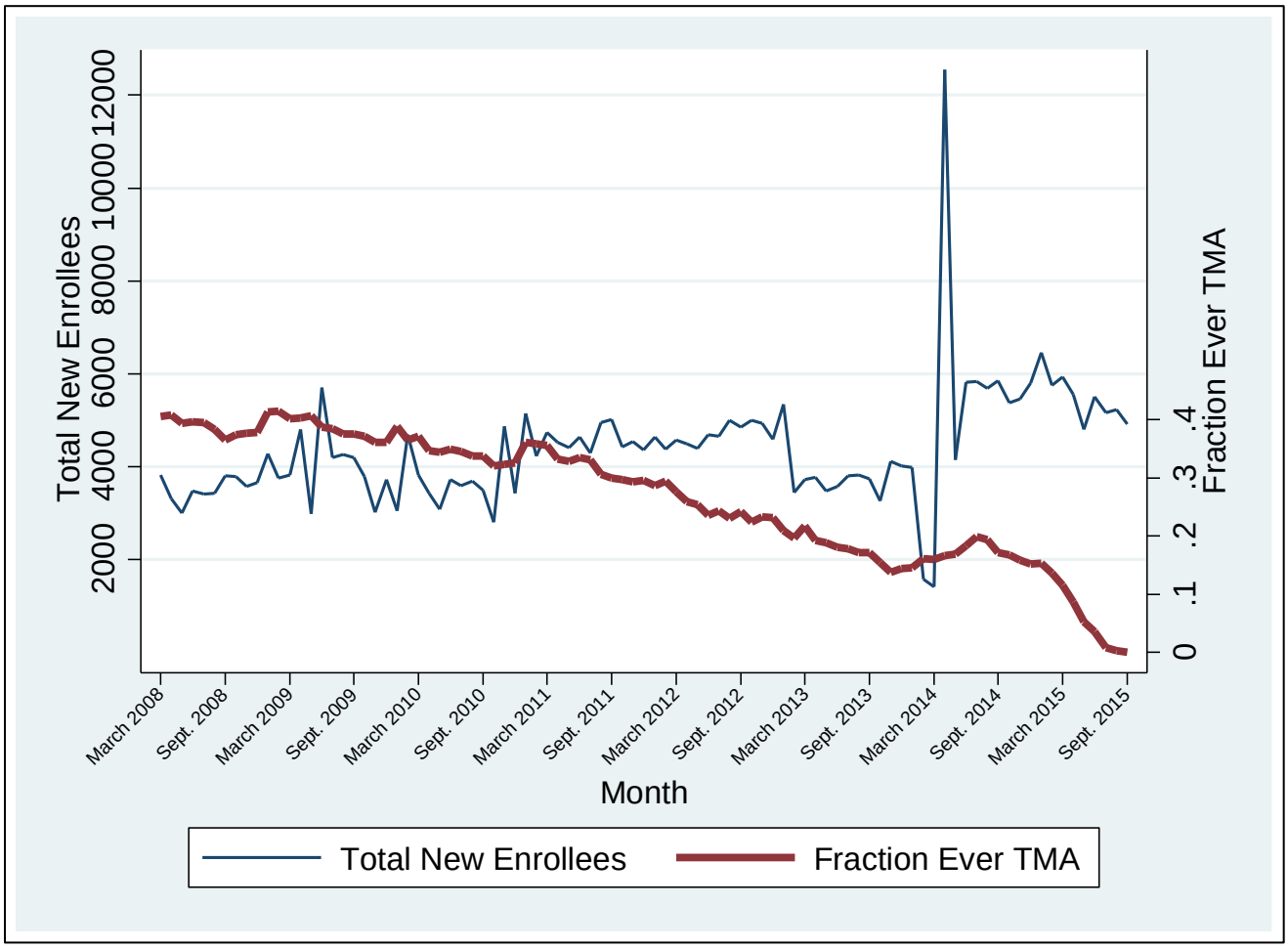
Descriptive analysis of TMA enrollment and premium payment
The study population is defined as the universe of enrollees who are potentially eligible to transition to TMA. We define this population as anyone with a new enrollment spell from March 2008 forward who begins their enrollment spell with a parental eligibility category and income <100% FPL. A new enrollment spell is defined when a BadgerCare enrollee who was not enrolled in the previous month is observed to be enrolled in the following month. Enrollees are observed from March 2008 to September 2015, the end of our available data.

The analysis considers three different premium policies for TMA beneficiaries:

- Policy 1 (3/1/2008-6/30/2012), no premiums
- Policy 2 (7/1/2012-3/31/2014), premiums for those 133% FPL and higher, the 2012 DHS waiver
- Policy 3 (4/1/2014-9/30/2015), premiums for all >100% FPL, with 100-133% FPL premiums beginning after 6 months, the 2014 DHS waiver

Figure Q.8.1 shows the change over time in the total number of new BadgerCare enrollees who are potentially eligible to transition to TMA, and the fraction who ever transitioned to TMA changed. The total number of new enrollees is relatively stable until early 2013, when we see a spike in the number of new enrollees who are potentially TMA-eligible in April 2014. These enrollees are exclusively adults with dependent children with incomes less than the poverty level, since we retain a consistent definition of potential TMA enrollees over time. There is no change in overall eligibility for this group, so the reason for this increase is unclear. It could be due to the MAGI changes or income redefinitions for exiting higher-income adults. Because the study time period is right-censored, we expect to see a decrease over time in the fraction of BadgerCare enrollees who transition to TMA. We see that this is generally true except for an anomalous increase in the fraction that transition to TMA coinciding with the spike in new enrollees in early 2014.

Figure Q.8.1. Number and Fraction of TMA Enrollees Over Time



Notes: For each month from March 2008 to September 2015, the figure shows the number of total new enrollees in BadgerCare who were potentially eligible to enroll in TMA. The figure also shows the fraction of these new enrollees who did enroll in TMA during the study period.

Table Q.8.1 describes the average TMA enrollee at the time of their initial enrollment in BadgerCare under the three different premium policies we observe for this population, Policy 1 (no premiums), Policy 2 (premiums for those 133% FPL and higher, the DHS 2012 waiver), and Policy 3 (premiums for all >100% FPL, with 100-133% FPL premiums beginning after 6 months, under the DHS 2014 waiver). This table is useful for considering whether enrollees may have differentially chosen to enroll in BadgerCare because of the different premium policies that applied to TMA. Overall characteristics of the populations at the time of initial enrollment are extremely similar, and it appears unlikely that premium policy under TMA was an important determinant of initial BadgerCare enrollment behavior.

Table Q.8.2 describes the average TMA enrollee at the time of their transition to TMA under the three different premium policies. This table is useful for considering whether there have been changes in the types of enrollees who take up TMA under the different policies. Note that because enrollment spells may be right-censored, we expect the average length of the enrollment spell to be much longer for

those who initially enrolled under earlier premium policy periods. Table Q.8.2 suggests that while there are some small differences in the types of enrollees who transition to TMA under these policies there are no major differences.

Table Q.8.1. Average TMA Enrollee Characteristics at Transition by Premium Policy at Enrollment

	Policy 1		Policy 2		Policy 3	
	Mean	SD	Mean	SD	Mean	SD
Household Size	3.52	1.32	3.50	1.34	3.30	1.46
Percent FPL at Enrollment	46.50	36.58	45.55	35.95	46.16	38.24
% Female	62%	48%	64%	48%	64%	48%
% Citizen	95%	21%	95%	22%	95%	21%
% Tribal Member	2%	14%	2%	14%	2%	14%
% Black	14%	35%	16%	36%	16%	37%
% White	65%	48%	63%	48%	63%	48%
% Hispanic	10%	29%	11%	31%	11%	31%
% Other Race/Ethnicity	8%	27%	9%	28%	9%	28%
% Resides in Metro Area	35%	48%	38%	49%	39%	49%
Education Level	0.88	0.63	0.89	0.61	0.95	0.55
Age	31.03	8.63	31.41	8.43	33.74	8.40
Length of Enrollment Spell	33.81	21.20	18.69	10.53	8.71	5.00
Months to TMA Enrollment	14.31	13.17	11.04	7.98	6.48	3.40
Number of Individuals	84,638		23,495		26,374	

Notes: The table summarizes the characteristics of TMA enrollees at the time of their initial enrollment in BadgerCare during each policy period: Policy 1 (3/1/2008-6/30/2012), no premiums; Policy 2 (7/1/2012-3/31/2014), premiums for those 133% FPL and higher; and Policy 3 (4/1/2014-9/30/2015), premiums for all >100% FPL, with 100-133% FPL premiums beginning after 6 months. The response values for Education Level are 0 (less than high school), 1 (high school), and 2 (more than high school).

Figure Q.8.2 shows the distribution of income for TMA enrollees at the time of their transition under Policy 1, Policy 2, and Policy 3. Overall, we see an increase in the fraction of TMA enrollees in the lowest income categories under Policies 2 and 3 relative to the first policy period. Additionally, there is a decrease in the fraction of TMA enrollees with higher income particularly in the highest-income category, those with incomes of 200% FPL and higher. The changes in the income distribution of TMA enrollees are larger for Policy 2 relative to Policy 1 than for Policy 3 relative to Policy 1.

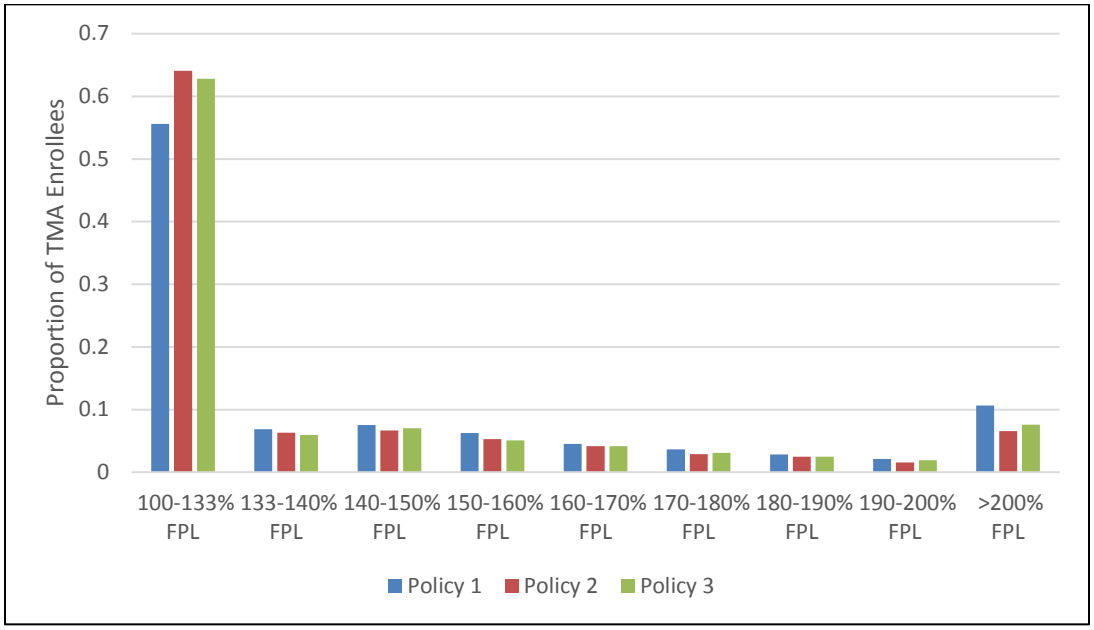
Table Q.8.2. Average TMA Enrollee Characteristics at Transition by Premium Policy

	Policy 1		Policy 2		Policy 3	
	Mean	SD	Mean	SD	Mean	SD
Household Size	3.55	1.30	3.50	1.34	3.37	1.44
Percent FPL at Enrollment	49.43	35.99	45.37	36.42	45.01	38.18
% Female	60%	49%	67%	47%	65%	48%
% Citizen	95%	21%	95%	22%	95%	23%
% Tribal Member	2%	12%	2%	16%	2%	14%
% Black	12%	32%	15%	36%	17%	38%
% White	68%	47%	63%	48%	61%	49%
% Hispanic	9%	29%	10%	30%	11%	31%
% Other Race/Ethnicity	7%	26%	9%	29%	8%	28%
% Resides in Metropolitan Area	35%	48%	35%	48%	37%	48%
Education Level	0.90	0.63	0.89	0.62	0.92	0.58
Age	31.69	8.75	30.80	8.50	32.37	8.66
Length of Enrollment Spell	35.76	20.98	30.42	17.68	21.07	16.82
Number of Individuals	55,760		23,152		23,193	

Notes: The table shows the characteristics of TMA enrollees in the first month of TMA enrollment during each policy period: Policy 1 (3/1/2008-6/30/2012), no premiums; Policy 2 (7/1/2012-3/31/2014), premiums for those 133% FPL and higher; and Policy 3 (4/1/2014-9/30/2015), premiums for all >100% FPL, with 100-133% FPL premiums beginning after 6 months. The response values for Education Level are 0 (less than high school), 1 (high school), or 2 (more than high school).

We next predict the probability that an individual transitions to TMA as a function of demographic characteristics at initial enrollment in BadgerCare. We estimate probit models and report average marginal effects in Table Q.8.3. Each coefficient in the table represents the change in the predicted probability of transitioning to TMA for a one-unit change in the characteristic, with all other characteristics held at the average. For each policy period, we first estimate the probability of ever transitioning. We then limit the sample to the individuals who transitioned. Among that population, we estimate the probability of transitioning with an income higher than 133%FPL. The latter analysis is useful to compare the predictors of a TMA transition according to enrollee income status at the time of transition.

Figure Q.8.2. Income Distribution at First TMA Month by Premium Policy



Notes: The figure shows the proportion of TMA enrollees whose income was in the described categories in their first month of TMA enrollment during each policy regime: Policy 1 (3/1/2008-6/30/2012), no premiums; Policy 2 (7/1/2012-3/31/2014), premiums for those 133% FPL and higher; and Policy 3 (4/1/2014-9/30/2015), premiums for all >100% FPL, with 100-133% FPL premiums beginning after 6 months.

The results are qualitatively similar across the three premium regimes, with similar sign and statistical significance (Table Q.8.3, columns a-c). The strongest predictor of ever transitioning to TMA is generally the beneficiary's education level, which is associated with increases of 15 to 40 percentage points in the probability of transition. For example, the coefficient on "Education Level 1" for Policy 1 should be interpreted as follows: relative to those with less than a high school education, the average member with a high school education is 23 percentage points more likely to enroll in TMA conditional on all other factors in the model.

Among individuals that ever transitioned to TMA, those with a higher level of income when they transition to TMA (i.e., > 133% FPL) are different from lower-income transitioners in predictable ways (Table Q8.3, columns d-f). For example, age, income at initial BadgerCare enrollment, and household size are strongly associated with transitioning to TMA with income above 133% FPL relative to transitioning with income at or below 133%FPL. The probability of a transition to TMA with income > 133% FPL increases with education level; however, the magnitude of association is generally smaller than the relationship between education level and the likelihood of ever transitioning.

Table Q.8.3. Predictors of Transitioning to TMA and Income at Transition by Premium Policy						
	Ever Transitioned			Transitioned with Income > 133% FPL		
	Policy 1 (a)	Policy 2 (b)	Policy 3 (c)	Policy 1 (d)	Policy 2 (e)	Policy 3 (f)
Household Size	0.00148	-0.0108	0.000940	-0.0600***	-0.0974***	-0.0621***
	(0.00258)	(0.00734)	(0.00369)	(0.00460)	(0.0154)	(0.00841)
Percent FPL at Enrollment	0.00551***	0.00398***	0.00381***	0.000822***	0.00111**	-0.00201***
	(0.000120)	(0.000736)	(0.000141)	(0.000162)	(0.000560)	(0.000307)
Female	0.0284***	0.193***	-0.00791	-0.103***	-0.0912*	-0.200***
	(0.00758)	(0.0238)	(0.0110)	(0.0126)	(0.0484)	(0.0250)
Citizen	-0.290***	-0.486***	-0.199***	-0.000854	-0.00217	0.121**
	(0.0189)	(0.0556)	(0.0262)	(0.0295)	(0.0943)	(0.0560)
Tribal Member	-0.290***	-0.169**	-0.108***	0.00704	-0.147	-1.021***
	(0.0257)	(0.0694)	(0.0397)	(0.0449)	(0.139)	(0.117)
Black	-0.263***	-0.118***	-0.0301**	-0.179***	-0.0224	-0.0404
	(0.00909)	(0.0267)	(0.0146)	(0.0163)	(0.0517)	(0.0332)
Hispanic	-0.0633***	-0.0485	0.0548***	-0.0437**	0.0689	0.0149
	(0.0122)	(0.0346)	(0.0176)	(0.0203)	(0.0669)	(0.0387)
Other Race/Ethnicity	0.00208	0.0974**	0.00723	-0.0675***	0.0820	-0.0236
	(0.0154)	(0.0411)	(0.0218)	(0.0248)	(0.0750)	(0.0490)
Resides in a Metro Area	-0.0229***	-0.0287	-0.00126	-0.0208*	-0.0351	-0.00208
	(0.00757)	(0.0217)	(0.0109)	(0.0124)	(0.0424)	(0.0241)
Education Level 1	0.232***	0.264***	0.147***	0.0590***	0.0479	0.0432
	(0.00802)	(0.0234)	(0.0139)	(0.0140)	(0.0475)	(0.0323)
Education Level 2	0.372***	0.334***	0.230***	0.186***	0.213***	0.0860*
	(0.0118)	(0.0355)	(0.0198)	(0.0191)	(0.0662)	(0.0440)
Age	-0.0105***	-0.0124***	-0.00222***	0.0142***	0.0124***	0.0152***
	(0.000420)	(0.00135)	(0.000608)	(0.000708)	(0.00264)	(0.00139)
Number of Observations	151,256	19,953	96,774	50,767	4,557	12,657

*Notes: Table shows the average marginal effects from probit models of the probability a member with the potential to enroll in TMA if they experience a change in earnings that qualifies them does enroll in TMA as a function of demographic characteristics . Independent variables are listed in the far left column; dependent variables are the column headings. Models are estimated for three different time periods reflecting the different premium policies. Policy 1 (3/1/2008-6/30/2012), no premiums; Policy 2 (7/1/2012-3/31/2014), premiums for those 133% FPL and higher; Policy 3 (4/1/2014-9/30/2015), premiums for all >100% FPL, with 100-133% FPL premiums beginning after 6 months. Education level is coded as 0 (less than high school), 1 (high school), or 2 (more than high school). Robust standard errors in parentheses. ***p<0.01; **p<0.05; *p<0.10*

We next characterize premium payment within the TMA population, the subset of BadgerCare enrollees that ever transitioned to TMA during the study period. For these subjects, the analysis includes only the months in which they were enrolled in TMA; income is measured in those months.

Table Q.8.4. Number and Fraction of TMA Who Paid Premiums by Premium Policy and Income

	First Eligible Month		All Eligible Months	
	Policy 2	Policy 3	Policy 2	Policy 3
Income				
100-133% FPL	34	154	298	7,083
	6%	20%	12%	71%
133-140% FPL	859	760	7,900	5,302
	61%	57%	81%	81%
140-150% FPL	884	827	9,275	6,205
	60%	52%	82%	80%
150-160% FPL	670	583	7,583	4,628
	57%	51%	83%	81%
160-170% FPL	557	467	5,955	3,656
	60%	50%	82%	81%
170-180% FPL	386	347	4,144	2,631
	60%	50%	81%	80%
180-190% FPL	297	262	3,062	1,931
	54%	47%	80%	78%
190-200% FPL	190	196	2,270	1,418
	54%	46%	79%	77%
>200% FPL	651	645	7,102	4,481
	44%	38%	73%	73%
Total Number	4,528	4,241	47,589	37,335
TMA Missing Payment Status	14,402	13,638	132,415	84,899
Fraction of Missing 100-133% FPL	98%	99%	98%	98%

Notes: Table shows the number and fraction of TMA enrollees who paid a premium by month of TMA eligibility and by %FPL during the eligible month. The "first eligible month" refers to the member's first month of TMA enrollment. "All Eligible Months" reflects all months of TMA enrollment. The table also reports the number and fraction of TMA enrollees for whom premium payment status was missing in the administrative data. Policy 2 (7/1/2012-3/31/2014) implemented premiums for those 133% FPL and higher; Policy 3 (4/1/2014-9/30/2015), implemented premiums for all >100% FPL, with 100-133% FPL premiums beginning after 6 months.

Table Q.8.4 shows the number and fraction of TMA enrollees who paid premiums under Policies 2 and 3 according to DHS administrative data. The results are stratified by income level. We report the number and fraction of TMA enrollees with evidence of premium payment in the first month of TMA enrollment and for all months of TMA enrollment. The most notable finding in this table is the higher average

probability of payment in all TMA enrollment months relative to the first month of TMA enrollment. This finding is explained by enrollee disenrollment. Specifically, enrollees who pay their premium in the first month are likely to continue paying and remain enrolled, while those who do not pay in the first month disenroll. Thus, the disenrolled individuals do not contribute to the denominator in subsequent months. The exception to this pattern is the lowest income group, who do not have premiums due in the first month of their TMA enrollment. The table also provides the fraction of TMA enrollees for whom premium payment status is missing in the administrative data. These enrollees are almost always those with incomes of 133% FPL or below, so they likely do not actually have premiums due.

Table Q.8.5 presents the average premium amount paid and the average premium amount unpaid under Policies 2 and 3. Consistent with the structure of analyses reported in Table Q8.4, we report these amounts for the first month of TMA enrollment and for all TMA enrollment months stratified by income at the time of TMA transition. The sample for this analysis includes TMA enrollees who had a record of a premium amount required under policy two or three.

Table Q.8.5. Average Paid and Unpaid Premium Amounts for TMA Enrollees by Premium Policy and Income

	First Eligible Month				All Eligible Months			
	Policy 2		Policy 3		Policy 2		Policy 3	
Income in FPL	Unpaid	Paid	Unpaid	Paid	Unpaid	Paid	Unpaid	Paid
100-133%	$ 5.47	$ 15.09	$ 17.46	$ 49.58	$ 9.92	$ 20.30	$ 29.80	$ 44.05
133-140%	$ 62.97	$ 70.90	$ 70.42	$ 74.62	$ 61.76	$ 72.89	$ 70.28	$ 76.36
140-150%	$ 76.70	$ 90.68	$ 85.18	$ 89.70	$ 75.30	$ 91.70	$ 86.09	$ 92.34
150-160%	$ 95.05	$108.91	$101.49	$112.98	$ 93.13	$112.52	$103.44	$113.05
160-170%	$111.23	$135.72	$119.98	$131.64	$110.01	$136.60	$123.61	$133.12
170-180%	$130.14	$152.90	$141.86	$150.23	$130.23	$158.12	$140.55	$154.91
180-190%	$153.12	$174.41	$165.46	$175.50	$153.54	$180.55	$166.57	$174.07
190-200%	$178.39	$194.87	$183.50	$199.01	$181.92	$198.99	$187.17	$203.67
>200%	$371.29	$335.40	$346.23	$323.30	$365.61	$346.79	$333.85	$325.13

Notes: Table shows the average amount of premium recorded as paid or not paid among TMA enrollees during the different premium policies by income level and eligible month. "First eligible month" refers to the member's first month of enrollment in TMA; "All Eligible Months" reflects all months of TMA enrollment. Policy 2 (7/1/2012-3/31/2014), premiums for those 133% FPL and higher; Policy 3 (4/1/2014-9/30/2015), premiums for all >100% FPL, with 100-133% FPL premiums beginning after 6 months.

Both paid and unpaid premiums generally appear to be very similar under Policy 2 and Policy 3 for the higher income groups and are increasing in income in the way we would expect. However, for the lowest income group, we see a dramatic increase in both paid and unpaid premiums under Policy 3 relative to Policy 2, reflecting the introduction of premiums for those in this income range. It is also notable that average unpaid premiums are nearly always lower than paid premiums within an income category. For example, under Policy 3, the average unpaid premium amount in the first eligible month was $119.98 for those 160-170% FPL, while the average paid premium amount was $131.64. Because the amount of the premium is always tied to income, this finding indicates that within and income category, it is the enrollees with relatively higher-incomes that are more likely to pay their premiums. The subset of TMA enrollees with income above 200% FPL at the time of transition is an exception to this pattern.

Causal analysis of the effect of premiums on TMA enrollment

We use an interrupted time series study design to compare the rate of transitions from BadgerCare adult to TMA status in order to understand whether premium requirements affect the incentive to enroll in, or take up, TMA. Because there is no simultaneous control group of potential TMA enrollees who did not face premium requirements to study, we use the arbitrary timing of introduction of the new premium requirements as a natural experiment. We compare TMA enrollment just before the introduction of the premium requirements to TMA enrollment just after introduction of the premium requirements. Any estimated difference at the date of introduction is interpreted as the causal impact of the premium requirements.

The interrupted time series design allows us to identify the causal effect of premiums on transition rates, under the assumption that enrollment behavior in the TMA population would have evolved similarly over time if not for the premium requirements. We model the time series of enrollment using an interrupted time series design with a local linear regression analysis (i.e., a regression that allows the functional form to fit the natural shape of the data) and studied the change at the implementation of the 2012 and 2014 waiver implementations. We interpret these results as causal implications of the two waivers.

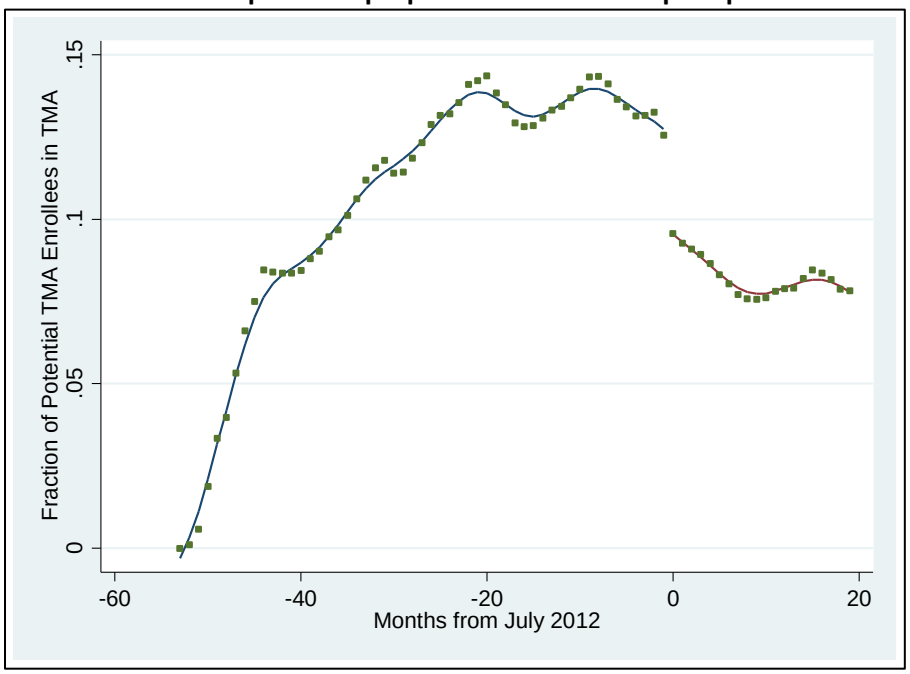
However, we note that the waivers changed more than just premiums. For potential and actual TMA enrollees in particular, there were changes to restrictive re-enrollment policy. As such, the results can only be interpreted as solely attributable to the premium requirements if we believe that other waiver-related changes would not independently affect enrollment in this population. We analyze two measures of TMA enrollment for the interrupted time series analysis; both measures are constructed at the level of the month such that each dot in Figures Q.8.3 and Q.8.4 represents the average for one calendar month. The first outcome measure is a proportion in which the numerator is the number of new TMA spells, and the denominator is the number of active spells for all enrollees that are potentially eligible to transition to TMA enrollment. The second outcome measure is the total number of new TMA spells. .

Figure Q.8.3 presents average TMA enrollment by month during the first and second premium policy regimes. There was no premium requirement for TMA enrollees before July 2012. At that time, DHS introduced a premium requirement for TMA enrollees with incomes at or above 133%FPL.
Both overall enrollment in TMA and the number of new TMA spells decreased after the introduction of the premium requirement relative to the no premium policy regime. The decreases are driven by those with incomes higher than 133% FPL (results not shown). As shown in Table 8.6, the magnitude of the change measured by the regression analysis is a 3-percentage point decline in enrollment as a fraction of active spells with a decline in the number of new TMA spells of more than 3,500. Both estimates are statistically significant at the 1% level.

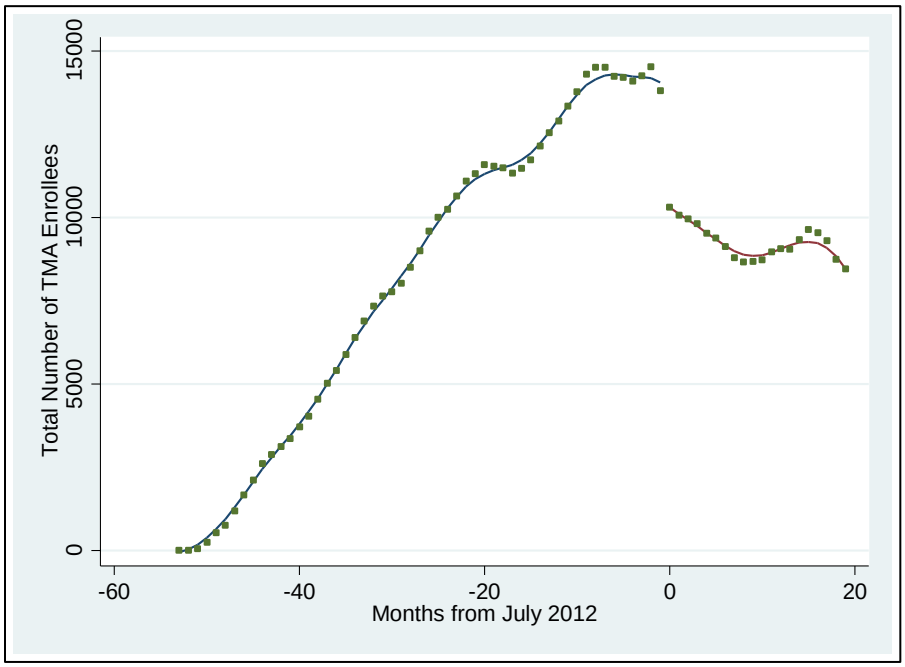
Figure Q.8.4 similarly illustrates TMA enrollment during the 2nd and 3rd policy regime. Months -20 through -1 represent the 2nd policy regime in which the DHS required premiums of TMA enrollees with income at or above 133% FPL. Months 0 through 20 represent the premium policy under the DHS 2014 waiver, the introduction of premiums after 6 months of enrollment for those with incomes between 100-133% FPL in addition to required premiums for those at or above 133% FPL. The 2014 waiver caused a decrease in TMA enrollment in both outcome measures, although much smaller than that caused by the 2012 waiver. The decreases are driven by the population with incomes between 100-133% FPL and is consistent with the introduction of premiums for this group after 6 months resulting in a decrease in program take-up. The magnitude of the change measured by the regression analysis is a less than 1 percentage point decline in TMA enrollment as a fraction of active spells with a decline in the number of new TMA spells of less than 700. (See Table 8.6). Both estimates are statistically significant at the 1% level. We note that the change in overall Wisconsin Medicaid eligibility policies in April 2014 may have changed the composition of the pool of potential TMA enrollees.

Figure Q.8.3. Change in TMA Enrollment Due to Premium Implementation: 2012 Waiver

Panel A. New TMA spells as a proportion of all active spells per month



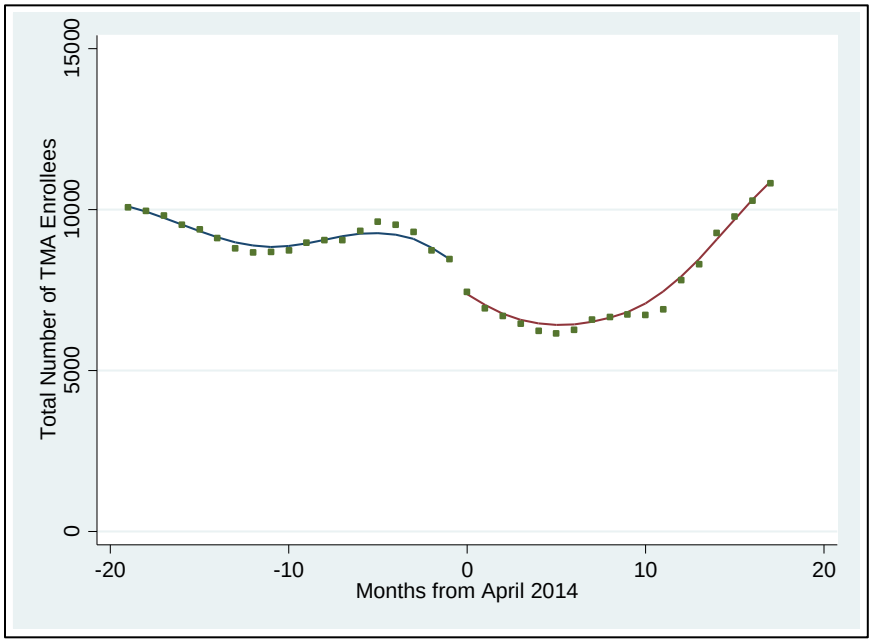
Panel B. Total number of new TMA spells per month



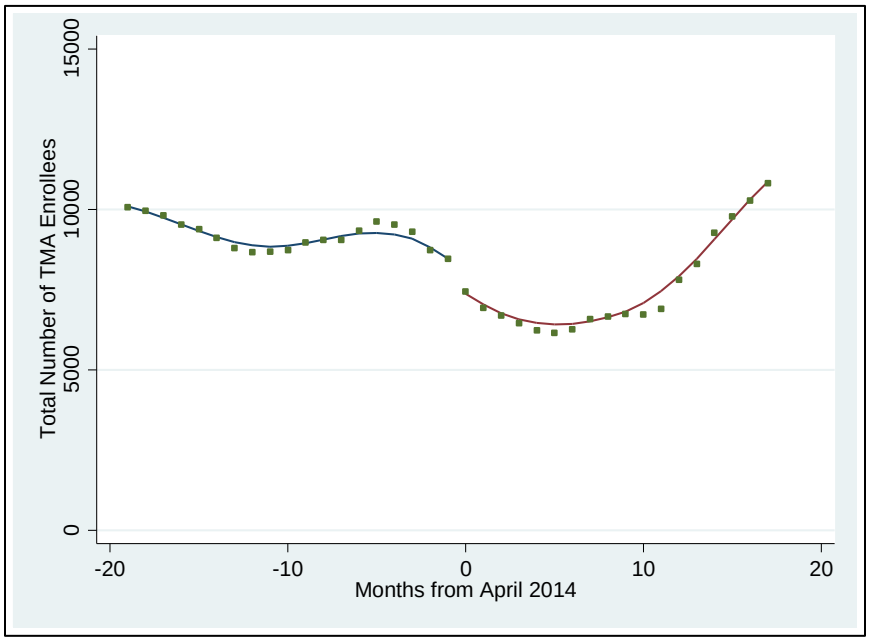
Notes: Figures show TMA take-up by month from March 2008 to March 2014 (July 2012 = 0). Panel A shows the fraction of those potentially eligible to enroll in TMA (defined in text) who were enrolled in TMA in each month. Panel B shows the total number of TMA enrollees in the analysis sample. Each dot on the graph represents the relevant quantity for a particular month; estimated local linear regression lines are superimposed on the graphs.

Figure Q.8.4. Change in TMA Enrollment Due to Premium Implementation: 2014 Waiver

Panel A. New TMA spells as a proportion of all active spells per month



Panel B. Total number of new TMA spells per month



Notes: Figures show TMA take-up by month from July 2012 to September 2015 (April 2014 = 0). Panel A shows the fraction of those potentially eligible to enroll in TMA (defined in text) who were enrolled in TMA in each month. Panel B shows the total number of TMA enrollees in the analysis sample. Each dot on the graph represents the relevant quantity for a particular month; estimated local linear regression lines are superimposed on the graphs.

We next use the interrupted time series design to study the effect of premium policy on the probability of exit from TMA. The outcome measure is the number of TMA exits per month defined as the number of active TMA spells that end in the month. We modeled the time series of exits using an interrupted time series design with a local linear regression analysis and studied the change in exits at the waiver implementation. Figure Q.8.5 depicts the number of TMA exits by month. In Panel A, we compare monthly TMA exits before and after implementation of the DHS July 2012 waiver premium policy. In Panel B, we compare monthly TMA exits under the DHS 2012 waiver premium policy to TMA exits under the DHS 2014 waiver premium policy. Each dot on the graph represents the number of spells ending in one month.

Under each waiver, there is a temporary increase in the number of TMA exits in the month immediately after waiver implementation. This sharp increase is larger in magnitude for the 2012 waiver (an increase of more than 2,000 exits) and is smaller in magnitude and less noticeable for the 2014 waiver (an increase of approximately 400 exits). After this unsustained spike in exits, we observe an increase in the overall level of TMA exits relative to the preceding premium policy period. For the regression analysis, we focus on the level change by excluding the month of implementation. The regression analysis does not statistically detect an overall increase in the level of exits resulting from either waiver beyond the one-time changes at the point of implementation. (See Table Q8.6).

We next use a regression discontinuity (RD) design within the TMA population in order to study the effect of premium amounts on enrollment spell length. The regression discontinuity design compares the enrollment behavior of TMA enrollees who have incomes just low enough to qualify them for a particular premium amount to those who have incomes just higher, qualifying them for a higher premium amount. The strength of this design is that it ensures populations are highly similar (as all study subjects have taken up TMA) rather than relying on a comparison to adults who did not take up TMA. We know from the descriptive analysis that individuals who do not enroll in TMA are different from those who enroll in TMA in observable ways; they may also be different in unobservable ways that are predictive of the enrollment outcome. We perform the RD analysis for each level of the required premium under each waiver. All regression results discussed in this section of the text are summarized in Table Q.8.6, which includes the coefficients and standard errors from the local linear regression analyses. Reported standard errors are heteroscedasticity-robust.

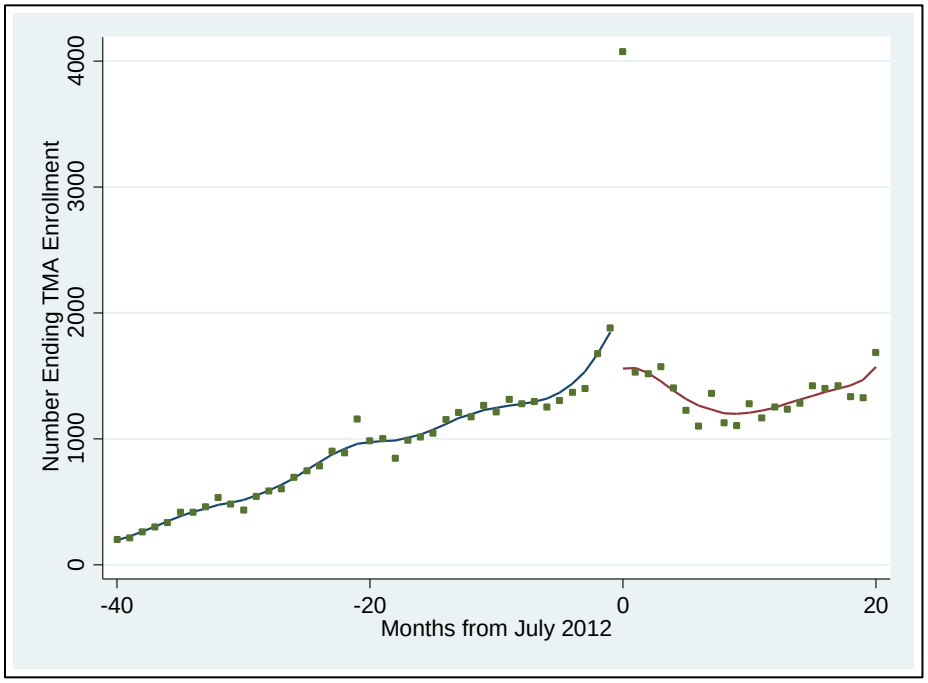
Figure Q.8.6 compares the average length of a TMA enrollment spell by income level for all enrollees with at least one month of TMA enrollment under the DHS 2012 and 2014 waivers. Each dot on the graph represents the average length of spell for a one-percentage FPL bin. For example, the dot at 100% represents all TMA enrollees with incomes above 100% and below 101% FPL. Spells with less than twelve months of exposure to each waiver are not included in this analysis. Panel A pools spells from the 2012 waiver period (July 2012 – March 2014), and Panel B pools spells from the 2014 waiver period (April 2014 – September 2015).

These graphs suggest that the 133% FPL threshold, shown with a vertical red line, is an important determinant of length of enrollment spell under both premium policies. The disjuncture in the length of spell on either side of the red vertical line provides visual evidence of this relationship. It is difficult to see any evidence in these graphs that the other premium thresholds are important determinants of length of enrollment spell. Regression evidence supports these conclusions, although the differences at the 133% threshold are not statistically different from zero in the 2012 waiver. The magnitude of the decrease in length of enrollment spell is -.6 months for the 2012 waiver and suggests a decline of 2.1 months for the 2014 waiver.

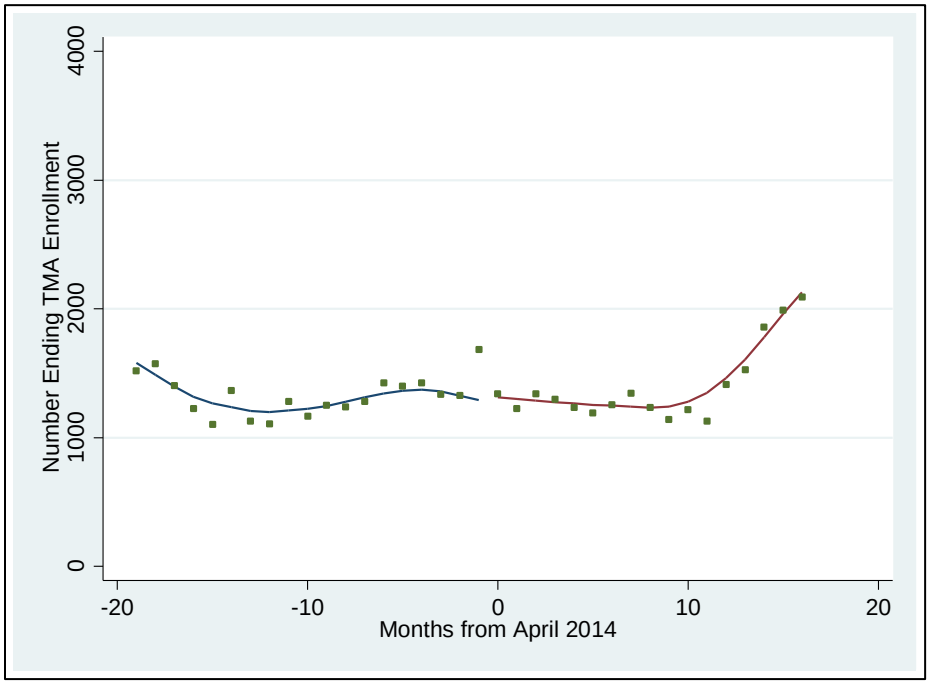
Differences in TMA enrollment spell length at the higher income thresholds where premiums changes are not typically statistically different from zero in our regression analyses beyond a couple of anomalies which are sensitive to the model specification and unlikely to be causal. Average length of enrollment decreased for both those with income between 100-133% FPL and those with income greater than 133% FPL for the 2014 waiver relative to the 2012 waiver. However, the difference between the income groups was larger for the 2014 waiver at the 133% FPL threshold. This finding suggests that the 2014 waiver increased the degree that the 133% margin mattered for length of enrollment spell, magnifying the difference between enrollees with income below and above 133% FPL. Because the 2014 waiver made the premium policies more similar for those above and below 133% FPL, this result is somewhat in contrast to what we might expect. It also appears sensitive to the specification of the regression and merits further exploration in future analyses.

Figure Q.8.5. Change in TMA Exits Due to Premium Implementation

Panel A. Change in Number of Exits at 2012 Waiver



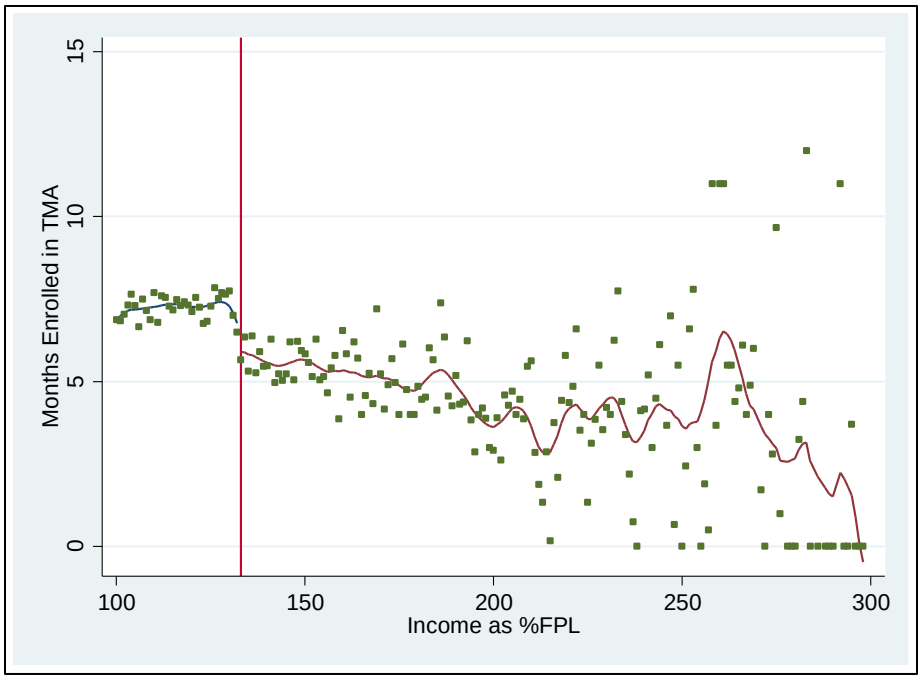
Panel B. Change in Number of Exits at 2014 Waiver



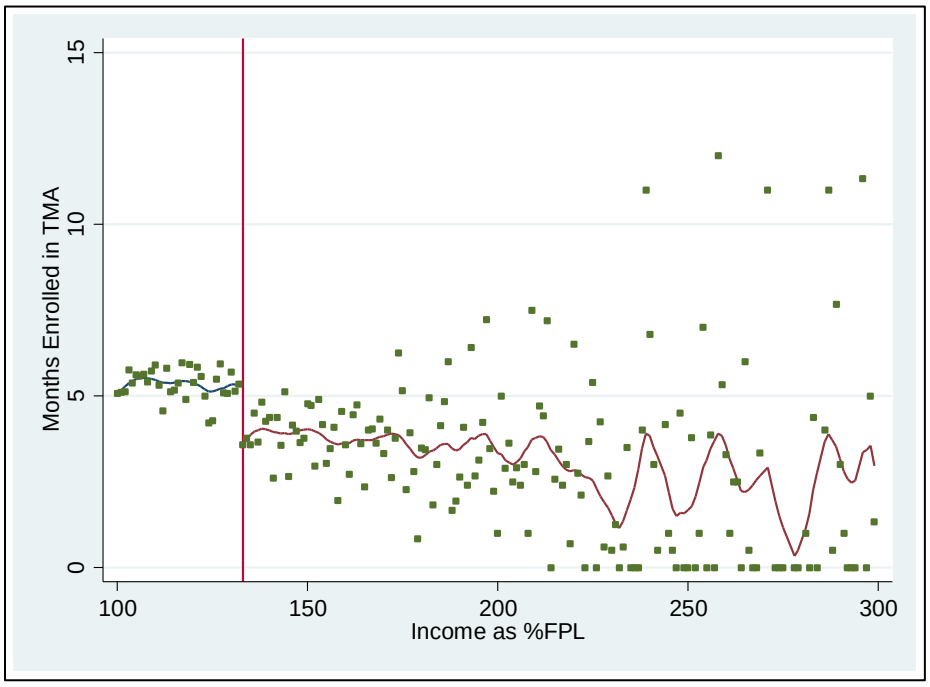
Notes: Figures show the fraction of active TMA enrollment spells which end for each month. Panel A describes spell ends March 2008 to March 2014 (July 2012 = 0) and Panel B shows spell ends July 2012 to September 2015 (April 2014 = 0). Each dot on the graph represents the relevant quantity for a particular month; estimated local linear regression lines are superimposed on the graphs.

Figure Q.8.6. Length of TMA Spell by Income

Panel A. Number of Months Enrolled, 2012 Waiver



Panel B. Number of Months Enrolled, 2014 Waiver



Notes: Figures show the length of TMA enrollment spells by income as a percent of the federal poverty line. Panel A shows enrollment spells beginning after July 2012 and ending before March 2014 (Policy 2) and Panel B shows spells beginning after April 2014 and ending by September 2015 (Policy 3) . Each dot on the graph represents the relevant quantity for a particular month; estimated local linear regression lines are superimposed on the graphs.

Table Q.8.6. Summary of Results		
	2012 Waiver	2014 Waiver
TMA Take-up		
As Fraction of Total	-0.029***	-0.007***
	(.0015)	(.001)
Number	-3,559***	-679***
	(288)	(92)
Number of TMA Exits	-187	77
	(115)	(46)
TMA Spell Length		
at 133% FPL	-0.569	-2.107***
	(0.509)	(.638)
at 140% FPL	-.262	-.747
	(.624)	(.757)
at 150% FPL	-.204	.917
	(.636)	(.779)
at 160% FPL	1.859***	.750
	(.701)	(.816)
at 170% FPL	-.930	-.685
	(.825)	(.967)
at 180% FPL	-.243	1.867*
	(.997)	(.994)
at 190% FPL	.145	.539
	(1.010)	(1.347)
at 200% FPL	-.247	.405
	(1.296)	(1.607)
*Notes: Table shows results of estimation of the change at the threshold date or income level corresponding to Figures Q.8.3-Q.8.6. Robust standard errors in parentheses. ***p<0.01; **p<0.05; *p<0.10*		

Questions 10-12: Restrictive Reenrollment Period for Failure to Pay Premium

Q10: What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment?

The objective here is to understand whether the 3-month RRP led to differences in premium payment behavior and length of spell among TMA individuals. To identify the effects of RRPs on premium payment and enrollment, we evaluate changes in RRP policy described in Section II.A. Specifically, observe related impacts before and after the 2014 waiver in the stringency of RRP enforcement along with changes under the 2014 waiver that affected the lower income group (100-133% FPL) specifically.

Approach

Our previously submitted Evaluation Design Report describes two related evaluation strategies:

1. A month-level hazard analysis in the post-wavier period focusing on changes in enrollment among individuals with income between 100-133% who "cross-over" from being exempt from premiums to being subject to premiums and RRP in their sixth month of enrollment.

2. A historical comparison that examines enrollment trends among similar TMA cohorts that were subject to RRP the 2012 waiver versus the 2014 waiver. This model takes advantage of the fact that cohorts in earlier and later periods are substantially similar in their demographics and behaviors, but that they are subject to different RRP policies.

For this first Interim Evaluation Report, we focus on the second approach. The first approach remains a topic of substantial interest, but requires developing and refining a file structure that facilitates person-month level analysis (rather than aggregating all months of a TMA spell into a single row of data).

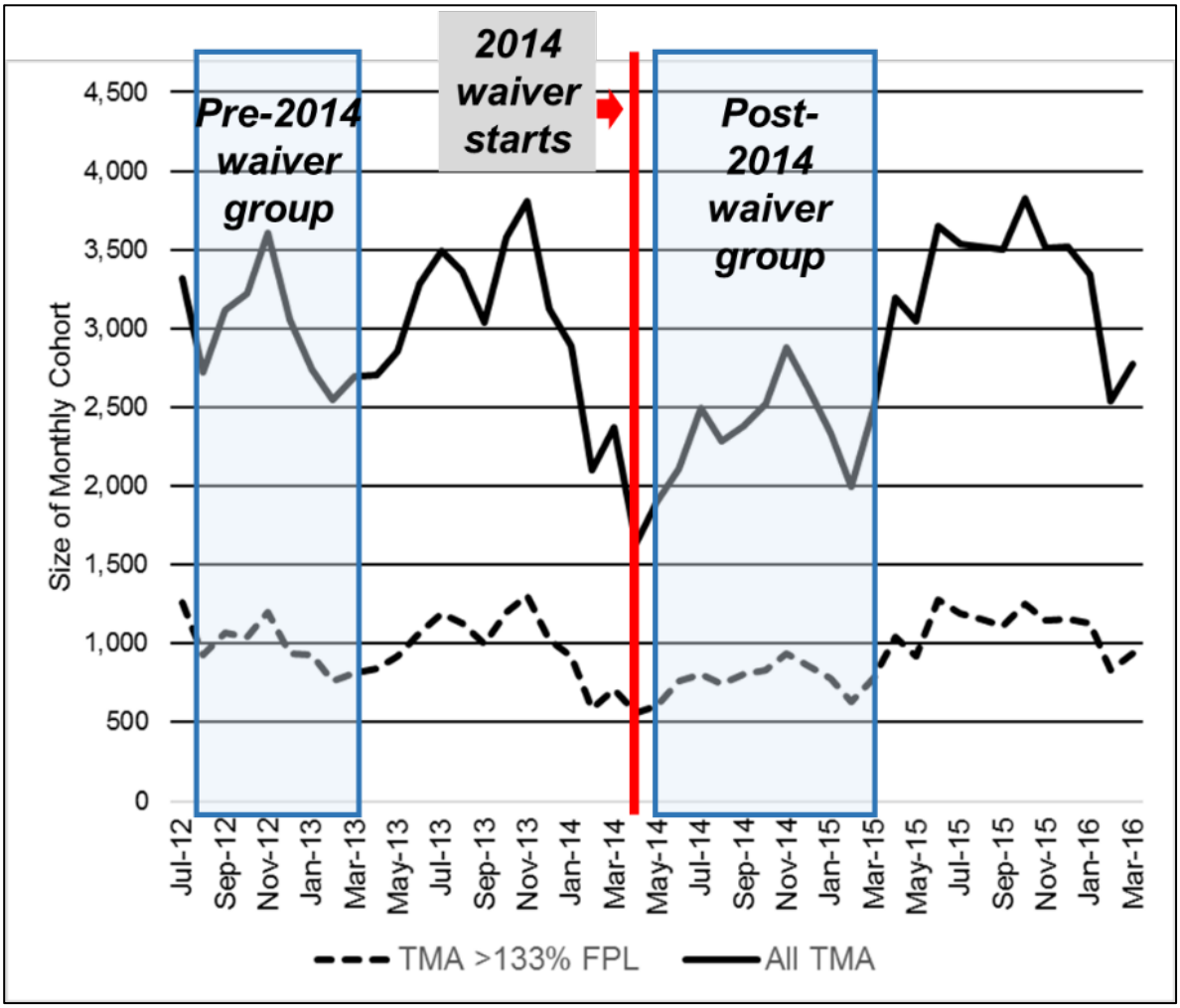
Preliminary Findings

For the purposes of our analyses, we focus only on individuals who had periods of enrollment in TMA (i.e., enrollment spells) that could be observed under either the 2012 waiver or the 2014 waiver for at least 12 months. The 2012 waiver was in effect from July 2012 through the end of March 2014, and the 2014 waiver was introduced in April 2014. Our observation period extends through May of 2016. As such, our "pre-2014 waiver group" includes individuals who began their TMA enrollment spells between July 2012 and March 2013. Our "post-2014 waiver group" includes individuals who began TMA enrollment between April 2014 and May 2015.

These inclusion criteria ensure that each cohort is exposed to only one type of RRP policy, and that we observe each sample member for the entire length of his/her TMA enrollment spell, a maximum of 12 months. We impose a 1-month "washout" period at the beginning of each RRP policy period, July 2012 and April 2014 respectively, to address transitional changes that might otherwise contaminate trends within the groups.

Figure Q.10.1 shows the trends in the size of monthly cohorts of individuals entering TMA from July 2012 to March 2016. The study groups for this analysis are shown with blue shading. The bold line shows the total number of individuals entering TMA in each study month, while the dotted line shows the number of individuals entering TMA who have incomes >133% FPL. Only this latter group of TMA enrollees is subject to premiums and RRP in their first month.

Figure Q10.1. Trends in TMA Cohort Size



In a sensitivity analysis, not shown, we relax our restrictions. We find that rates of RRP continued to increase in late 2015, but most of the other trends related to spell length remain similar when including cohorts from late 2013-early 2014 or individuals in late 2015.

The mean size of new cohorts during this time period is about 2,300 individuals per month. Figure Q10.1 shows how the size of new cohorts fluctuated over the study period, with the largest cohorts in late 2013 before the 2014 waiver but with entry cohort sizes returning to the pre-waiver levels in 2015. The smallest cohorts occurred around the time of the 2014 waiver. Individuals in the higher income group comprised about one-third of new cohorts across the study period.

Characteristics of TMA population: Tables Q10.1 and Q10.2 display characteristics of the TMA study population during the 2012-2014 time period compared to the 2014-2016 time period. The sample is divided into two subgroups: individuals entering TMA with incomes 100-133% FPL and those entering with incomes >133% FPL. Pairwise t-tests are used to compare differences in means between the two samples and p-values are displayed in the table.

Table Q10.1. Characteristics of Individuals entering TMA at 100-133% FPL by time period

	Entered TMA 7/2012-3/2013	Entered TMA 4/2014-5/2015	p-value for difference
Age	33.124	33.178	0.567
Female	71.8%	73.8%	p<.001
Non-Hispanic white	65.1%	61.5%	p<.001
Non-Hispanic black	15.6%	18.3%	p<.001
Hispanic	9.0%	9.9%	0.013
Other race/ethnicity	8.1%	8.5%	0.198
Citizen	96.0%	95.9%	0.691
Resides in a metropolitan area	39.8%	39.3%	0.414
High school graduate	93.5%	97.3%	p<.001
First month of TMA income (% FPL)	113.538	111.277	p<.001
N	17,896	14,462	

Table Q10.2. Characteristics of individuals entering TMA at >133% FPL by time period

	Entered TMA 7/2012-3/2013	Entered TMA 4/2014-5/2015	p-value for difference
Age	34.542	34.639	0.492
Female	67.7%	68.1%	0.559
Non-Hispanic white	69.1%	65.5%	p<.001
Non-Hispanic black	12.6%	15.5%	p<.001
Hispanic	8.6%	10.4%	p<.001
Other race/ethnicity	7.6%	7.1%	0.186
Citizen	96.0%	95.8%	0.536
Resides in a metropolitan area	39.3%	39.5%	0.85
High school graduate	98.1%	98.8%	0.503
First month of TMA income (% FPL)	173.892	176.555	p<.001
N	8,512	7,162	

When comparing within income group, both tables show no time period differences with respect to age, citizenship, and metro residence. The TMA population in the later time period, April 2014 – May 2015, is more likely to be black and Hispanic and slightly less likely to be white. There are also modest, but

significant, income differences. For the group with income between 100% -133% FPL, the percentage of individuals that are high school graduates increased in the later time period.

Differences in outcomes of interest: Table Q10.3 and Q10.4 display means for five key outcomes related to the study question for individuals pre-and post-2014 waiver. The outcomes are disaggregated by initial income group (100-133% FPL or >133% FPL):

1. TMA enrollment longer than six months;
2. Total months of TMA enrollment;
3. An indicator for whether an individual entered an RRP;
4. Months of RRP (among those with any RRP); and
5. Months of RRP (averaged across the full sample, including individuals who did not experience an RRP).

Outcome #5 can be calculated by multiplying outcome #3 by outcome #4:

Months of RRP across the full sample = (Months of RRP among those with any RRP) x (percentage of individuals who entered RRP in the sample)

It helps illustrate the average effect of changes in prevalence of RRP and length of RRP in the entire TMA population. For current purposes, we restrict our analyses to first instances of an RRP; most individuals in the sample only enter RRP once in their TMA history.

Table Q10.3. Outcomes for TMA Enrollees 100-133% FPL by time period

	Entered TMA 7/2012-3/2013	Entered TMA 4/2014-5/2015	p-value for difference
More than 6 months of TMA enrollment	92.2%	85.9%	p<.001
Length of TMA enrollment (months)	10.77	9.79	p<.001
Any RRP indicator	1.7%	11.5%	p<.001
Length of RRP in months (if any)	8.73	2.82	p<.001
Length of RRP in months (averaged across the population)	0.15	0.324	p<.001

Table Q10.3 shows that individuals under the 3-month RRP who started TMA with income between 100%-133% FPL experienced a slightly decreased likelihood of experiencing 6 months of enrollment – 92.2% versus 85.9% (first row). The mean length of TMA enrollment in this group decreased by roughly 1 month on average, 10.77 versus 9.79 (second row). There were large increases in the percentage of people who experienced an RRP – from under 1.7% to 11.5% after the 2014 waiver (third row). Consistent with the policy change, the mean length of RRP among those who experienced an RRP decreased from 8.73 to 2.82 months (fourth row).

Some individuals' mean RRP length is less than 12 months during the 2012-2013 period because they may have been removed from the program or otherwise left before the 12-month period of restrictive reenrollment. In a separate analysis not displayed here, we find that all individuals during this period with an RRP of less than 12 months did not reenter the program. Across the entire study population, including beneficiaries who did not enter an RRP, the mean length of RRP was 0.15 months in the 2012-2013 period, which increased to 0.324 months in the 2014-2015 period (fifth row).

Table Q10.4 Outcomes for TMA Enrollees >133% FPL by time period			
	Entered TMA 7/2012-	**Entered TMA 4/2014-5/2015**	**p-value for difference**
More than 6 months of TMA enrollment	72.0%	64.3%	p<.001
Length of TMA enrollment (months)	8.70	8.15	p<.001
Any RRP indicator	8.4%	29.5%	p<.001
Length of RRP in months (if any)	9.25	3.36	p<.001
Length of RRP in months (averaged across the population)	0.773	0.992	p<.001

Among individuals who entered TMA >133% FPL, the probability of staying for 6 months decreased from 72.0% to 64.3% (first row, Table Q10.4). The mean length of TMA in this group did not decrease substantially after April 2014 – going from 8.70 to 8.15 months (second row). The percentage of individuals with any RRP increased from 8.4% to 29.5% (third row), whereas the mean length of RRP decreased from 9.25 months to 3.36 months among those individuals who experienced an RRP (fourth row). Notably, the mean number of RRP months within the post-waiver cohort is longer than 3 months (fifth row). In a separate analysis, not reported here, we find some cases of 12-month RRPs that persist after the 2014 waiver. We are currently investigating the potential explanations for this finding. Averaged in the full study population, the mean length of RRP increased slightly – from 0.77 to approximately 1 month.

TMA enrollment spell length: To provide more insight into the changes in timing of TMA enrollment spell lengths, Figures Q10.2 and Q10.3 plot survival curves for length of TMA enrollment for individuals entering TMA with incomes between 100%-133% FPL and at or above 133% FPL during the two-time periods. Survival curves help to illustrate that percentage of individuals who remain in the program over successive intervals of time (in this case the percent remaining in each month, up to 12 months when TMA enrollment ends for all individuals).

Figure Q10.2. Enrollment Spell Length for Individuals entering TMA with Incomes 100-133% FPL

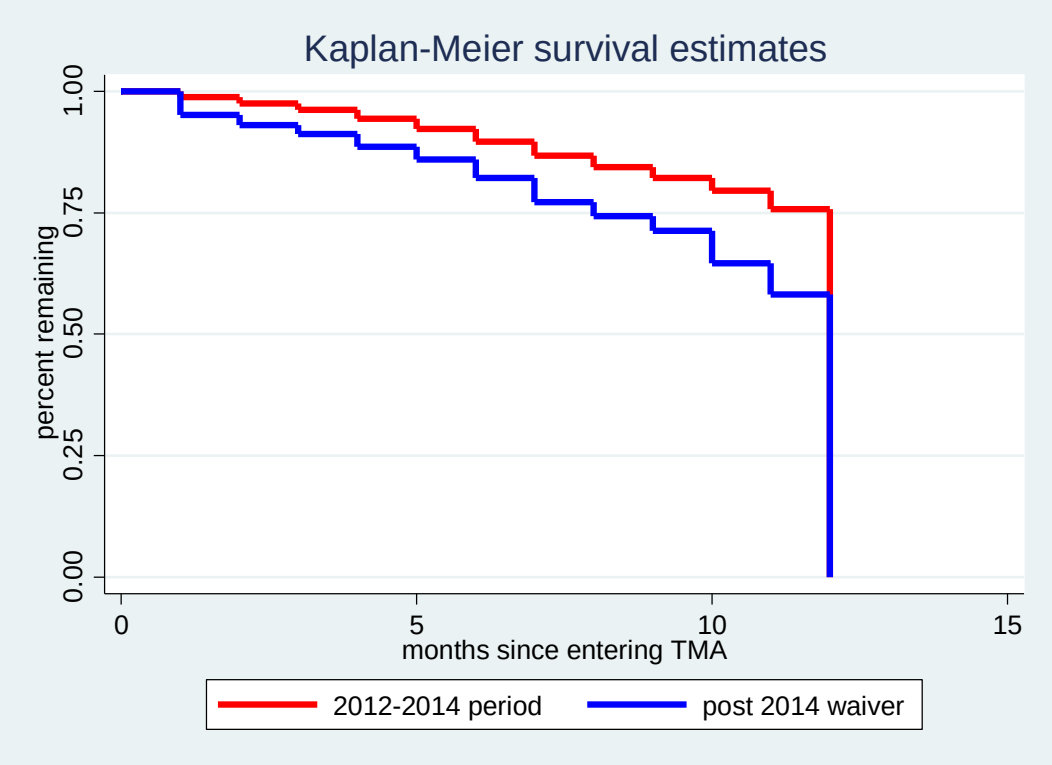
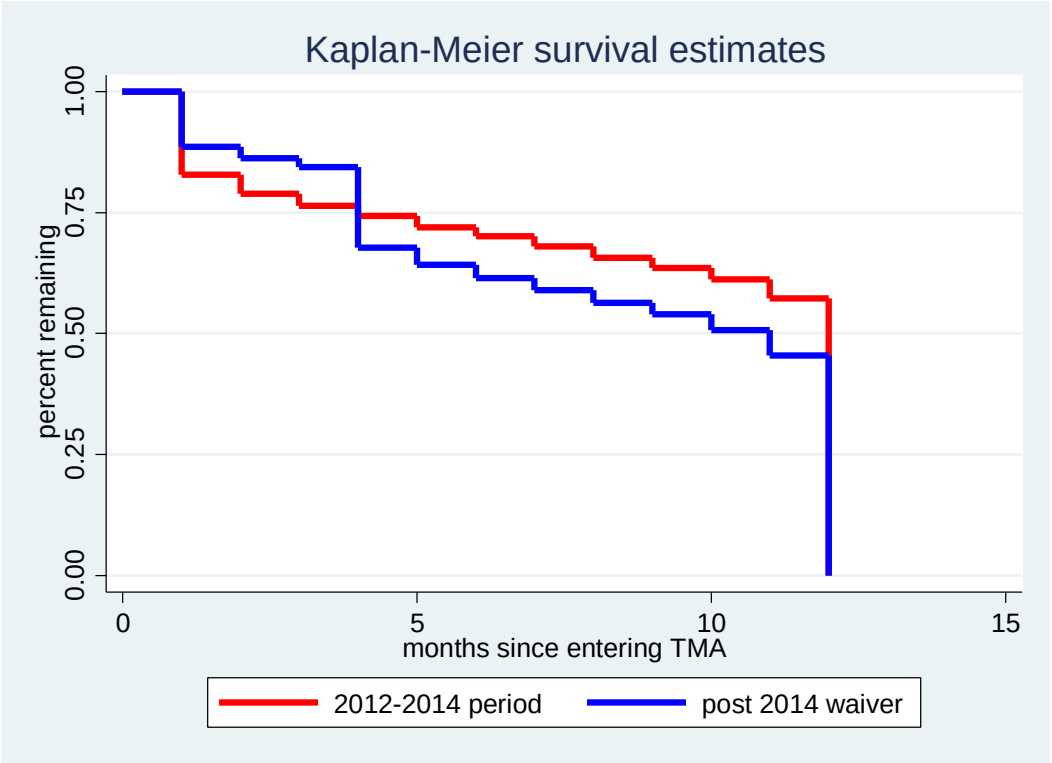


Figure Q10.3. Enrollment Spell Length for Individuals entering TMA with Incomes >133% FPL



The survival curves illustrate that individuals entering TMA with income between 100%-133% FPL have consistently lower odds of retention in every month after the first month in the post-2014 waiver period relative to the comparison cohort in the 2012-2014 period. The gap in monthly retention between the two groups, showing that that 2014 waiver members are increasingly less likely to retain TMA as time goes on, widens after six months--the time of first exposure to RRP for individuals with incomes 100-133% FPL.

For individuals entering TMA with income at or above 133% FPL, retention in TMA is actually higher in the first four months after the 2014 waiver than it is for their counterparts in the earlier period. However, after four month's retention in the post-waiver TMA group decreases below the levels of the TMA comparison group shown in red.

Regression Estimates

To test for differences in the outcomes related to enrollment and RRP entry after the waiver, we estimated three regression models using ordinary least squares (OLS) regression (Table Q.10.5). OLS coefficients for binary outcomes can be interpreted as linear probabilities, in percentage points. All models adjusted for socio-demographic covariates. Model 1 compares changes only for individuals with income between 100% - 133% FPL during the 2012-2013 period compared to 2014-2015, Model 2 compares changes only for individuals with income at or above 133% FPL for the same time periods.

We hypothesized that there would be larger effect sizes among individuals with income at or above 133% FPL, since these individuals are affected by the changes in the premium and RRP policy beginning in their first month. By contrast, individuals with income between 100% - 133% FPL did not face a premium and RRP during the 2012-2013 period, and are only affected by the 2014 waiver's premium and RRP policy after the first six months of enrollment in the 2014-2015 period.

Regression estimates presented here are very similar to the unadjusted differences presented in Tables Q.10.3 and Q.10.4. Specifically, for both income groups, after the 2014 waiver the probability of remaining enrolled for six months decreases, and length of TMA also decreases. We observe the largest change among individuals entering TMA with income between 100-133% FPL. After implementation of the 2014 waiver, the probability of entering an RRP increases dramatically (particularly for individuals >133%), while the average length of RRP, among those with any RRP, decreases by more than 5 months in both income groups. Averaged across the population there is a modest increase in the mean length of time that individuals spend in RRP of about 0.2 or 0.3 months in the post-waiver period relative to the duration spent in an RRP in the pre-waiver period.

Table Q10.5 Regression Estimates for Changes in Outcomes After the 2014 Waiver		
	Model 1: Changes after 2014 waiver for individuals 100-133%	**Model 2: Changes after 2014 waiver for individuals >133%**
More than 6 months of TMA enrollment	-0.064	-0.071
	(0.004)**	(0.010)**
Length of TMA enrollment (months)	-1.038	-0.491
	(0.043)**	(0.089)**
Any RRP indicator	0.1	0.213
	(0.004)**	(0.008)**
Length of RRP in months (if any)	-5.780	-5.355
	(0.121)**	(0.149)**
Length of RRP in months (averaged across population)	0.188	0.252
	(0.014)**	(0.045)**
*Note: Standard errors are shown in parentheses. Regression models adjust for individual age, sex, race/ethnicity, citizen status, metro residence, and high school graduation. *p<.05, **p<.001.*		

Q11. Does the RRP impact vary by income level? and
Q12: If there is an impact from the RRP, explore the break-out by income level.

The third regression model tests for differences in outcomes related to enrollment and RRP entry from 2012-2013 compared to 2014-2015 within the relatively higher income segment of the TMA population, adults with income above 160% FPL. We do not have a clear hypothesis about whether these relatively higher income enrollees who face premiums will have lower retention after the 2014 policy change than those closest to the cutoff. While these individuals may have greater resources with which to pay premiums, they may also be more likely to leave the program if they can obtain private health insurance.

The RRP impact may vary by income level either because higher-income individuals have a different willingness to pay premiums or because they have different private insurance options available that may be more appealing. For the purposes of this report, we only test this difference at one break point – individuals with incomes >160% FPL compared to those with income between 133% and 160% FPL. This number was chosen because it represents the upper half of TMA enrollees with income at or above 133% FPL in TMA. We present these results in Table Q.11.1.

The results for the higher-income subgroup with income above 160% FPL are very similar to the overall pattern of results for individuals with income above 133% FPL presented in Table Q.10.5 under the column heading, "Model 2." For mean length of RRP, the effect is even more pronounced for individuals >160% FPL. Further exploring subgroup differences by income will be an important task for future work.

Table Q11.1 Regression Estimates for Individuals >160% FPL after 2014 waiver

	Changes after 2014 for individuals 133-160%	Changes after 2014 for individuals >160% FPL
More than 6 months of TMA enrollment	-0.057	-0.083
	(0.012)**	(0.015)**
Length of TMA enrollment (months)	-0.420	-0.504
	(0.117)**	(0.134)**
Any RRP indicator	0.216	0.227
	(0.018)**	(0.013)**
Length of RRP in months (if any)	-4.571	-6.166
	(0.202)**	(0.205)**
Length of RRP in months (averaged across the population)	0.369	0.126
	(0.052)**	(0.075)

*Note: Standard errors are shown in parentheses. Regression models adjust for individual age, sex, race/ethnicity, citizen status, metro residence, and high school graduation. *p<.05, **p<.001.*

Question 17: Childless Adults' Benefit Plan and Continuity of Coverage

Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?

The objective of this question is to understand whether and to what extent the provision of standard Medicaid benefits to childless adult (CLAs) beneficiaries increased continuity of health coverage. In this Interim Evaluation Report, we focus on enrollment-related outcomes from the CARES data that characterize continuity of health insurance coverage. In subsequent reports, we will include measures that reflect continuity of health care.

The Wisconsin Department of Health Services is specifically interested in measuring CLA Standard Plan enrollees' outcomes relative to the two comparators, A and B, described below. Table Q17.1 provides an operational definition of the study groups we have constructed to execute the requested comparisons. These groups are mutually exclusive. In this Interim Evaluation Report, we report our preliminary findings for Comparison B.

A. Comparison of CLA beneficiaries' outcomes while enrolled in the Standard Plan relative to their outcomes while enrolled in the Core Plan; and
B. Comparison of post-waiver outcomes for two groups of CLA beneficiaries enrolled in the Standard Plan: new CLA beneficiaries who became eligible on or after April 2014; and continuing CLA beneficiaries who transitioned from Core plan coverage to Standard Plan coverage in April 2014.

Table Q17.1. Study groups and time periods to implement the requested comparisons for Question 17

Study Time Period	Continuing CLA Enrollees	Parents/Caretakers	New CLA Enrollees
4/1/13 - 3/31/15 **Comparison A**	CLAs with at least one month of Core plan enrollment between April 2013-March 2014 and one month of Standard plan enrollment between April 2014-March 2015. Core plan beneficiaries who enrolled after October 2009 are excluded.	Parent/caretakers with at least one month of Standard plan enrollment between April 2013-March 2014 and one month of Standard plan enrollment between April 2014-March 2015.	
4/1/14 – 3/31/16 **Comparison B**	CLAs with at least one month of Core plan enrollment between April 2013-March 2014 and one month of Standard plan enrollment between April 2014-March 2015.		CLAs with at least 1 month of Standard plan enrollment beginning on or after 4/1/2014 and no Core plan enrollment between April 2013-March 2014.

The UW's Evaluation Design Report (Attachment B) outlines several analytic tasks to address Question 17. For ease of reference to the Design Report, we restate those analytic tasks here followed by our preliminary results.

> *"Descriptive analysis of administrative data. We will describe the continuity of health insurance coverage for CLA beneficiaries by sample membership (i.e., new and continuing enrollees), and for continuing CLA enrollees relative to the continuing parent/caretaker comparison group. "*

Comparison B: A comparison of post-waiver outcomes for two groups of CLA beneficiaries enrolled in the Standard plan: new CLA beneficiaries who became eligible on or after April 2014; and continuing CLA beneficiaries who transitioned from Core plan coverage to Standard plan coverage in April 2014

Table Q17.2 summarizes demographic characteristics and Medicaid enrollment history for the continuing CLA enrollees and the new CLA enrollee populations. These data are useful for considering if there are compositional differences between the study groups that may also be related to coverage continuity. The demographic variables reflect the most recently reported data for each subject through March of 2016 unless noted. The Medicaid enrollment variables capture Core and Standard plan enrollment between January 2009 - March 2013. Because study groups are defined in part based on Medicaid enrollment between April 2013– March 2014, we omit these 12 months in the construction of the enrollment history variables.

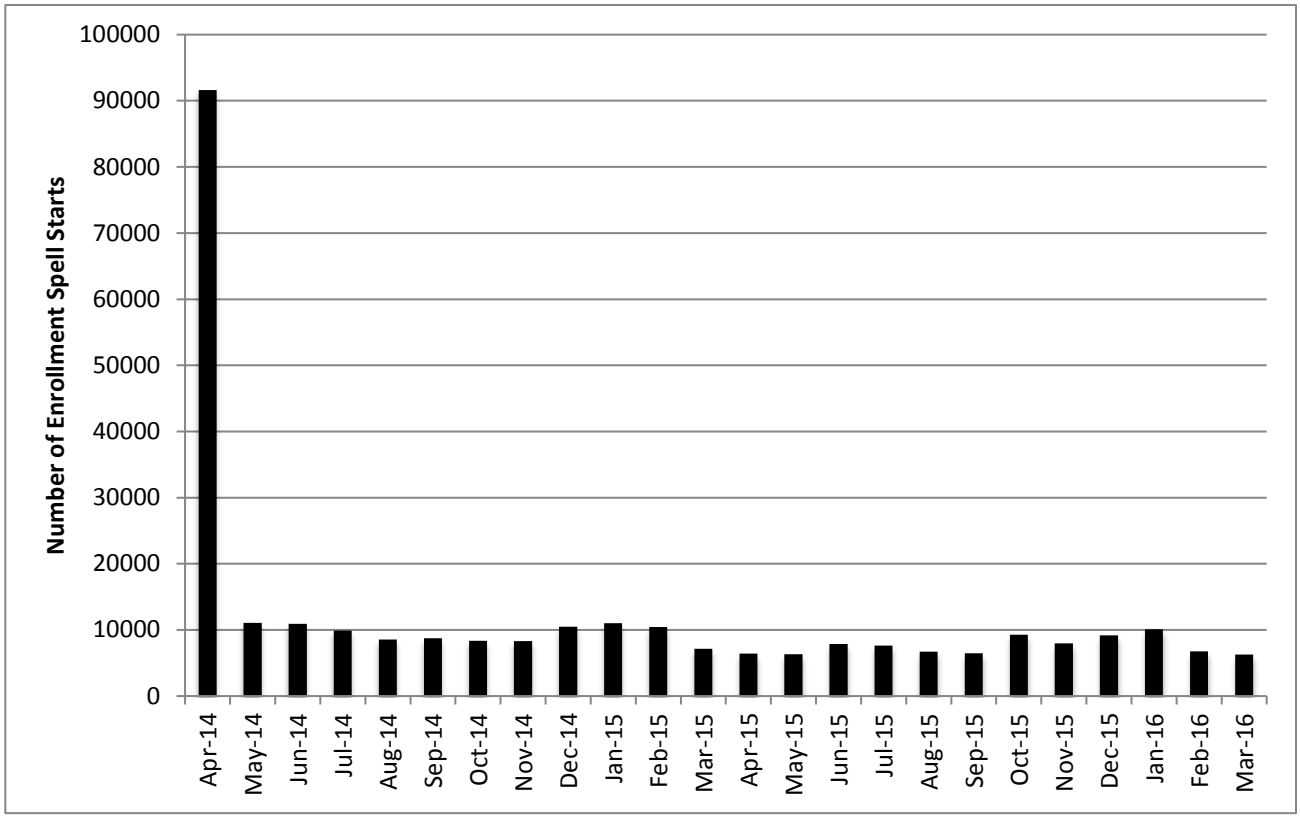
Relative to continuing CLA enrollees (N=11,159) the new CLA enrollees (N=248,217) are younger, and more likely to be non-White and male. On average, the new CLA enrollees had fewer total Medicaid and CLA enrollment months before April 2013 than the continuing CLA enrollees. We note two potential explanations for the non-equivalence of the study groups across these characteristics: 1) the availability of the Standard plan may attract a different childless adult population than did the Core Plan; and/or 2) beneficiaries who remain enrolled in the Core plan five years after its introduction may differ systematically from the Core plan population as a whole. Within the scope of this evaluation, we cannot determine which of these (or other) explanations may prevail. However, it is important to consider the potential source of differences between the groups and how these differences may influence health coverage continuity.

Figures Q17.1 and Q17.2 illustrate the distribution of enrollment spell starts by month for the study period, April 2014 through March 2016. For purposes of this analysis, an enrollment spell begins with the enrollment start date and ends with an enrollment gap of more than 1 month. For example, if a beneficiary enrolls in April 2014, disenrolls in June 2014, re-enrolls in July 2014 and again disenrolls in December 2014, we define the enrollment spell start as April 2014 and the spell end as December 2014. Figure Q17.1 illustrates the distribution of spell starts for new CLA enrollees.

Table Q17.2. Average Characteristics of Continuing and New Childless Adult Beneficiaries					
	(1) Continuing		(2) New		
	%/Mean	SD	%/Mean	SD	p-value
Gender, Citizenship, Race, Ethnicity					
% Female	53	50	41	49	<0.01
% Citizen	99	10	98	14	<0.01
% Tribal Member	1	9	2	14	<0.01
% Black	15	35	23	42	<0.01
% White	77	42	61	49	<0.01
% Hispanic	4	19	7	25	<0.01
% Other Race/Ethnicity	3	18	6	24	<0.01
% Resides in a metropolitan area	41	49	38	49	0.26
Education level					
% < high school graduate	16	37	23	42	<0.01
% >= high school graduate	63	48	62	49	<0.01
% missing education	21	40	16	37	<0.01
Age as of April 2014					
19-34	16	37	47	50	<0.01
35-49	27	44	27	44	0.64
50+	57	49	26	44	<0.01
Core and Standard plan enrollment, 1/2009 - 3/2013					
Total months enrolled	37.2	10.3	3.6	10.3	< 0.01
Total CLA months enrolled	36.9	10.7	0.7	4.0	< 0.01
Number of individuals	11,159		248,217		

Continuing beneficiaries have at least 1 month of CLA Core enrollment between April 2013-March 2014, and at least one month of CLA Standard Plan enrollment between April 2014-March2015. New beneficiaries have at least one month of CLA Standard Plan enrollment on or after April 2014 and no CLA Core enrollment between April 2013-March2014.

Figure Q17.1 Enrollment spell starts by month for new CLA beneficiaries, April 2014 - March 2016



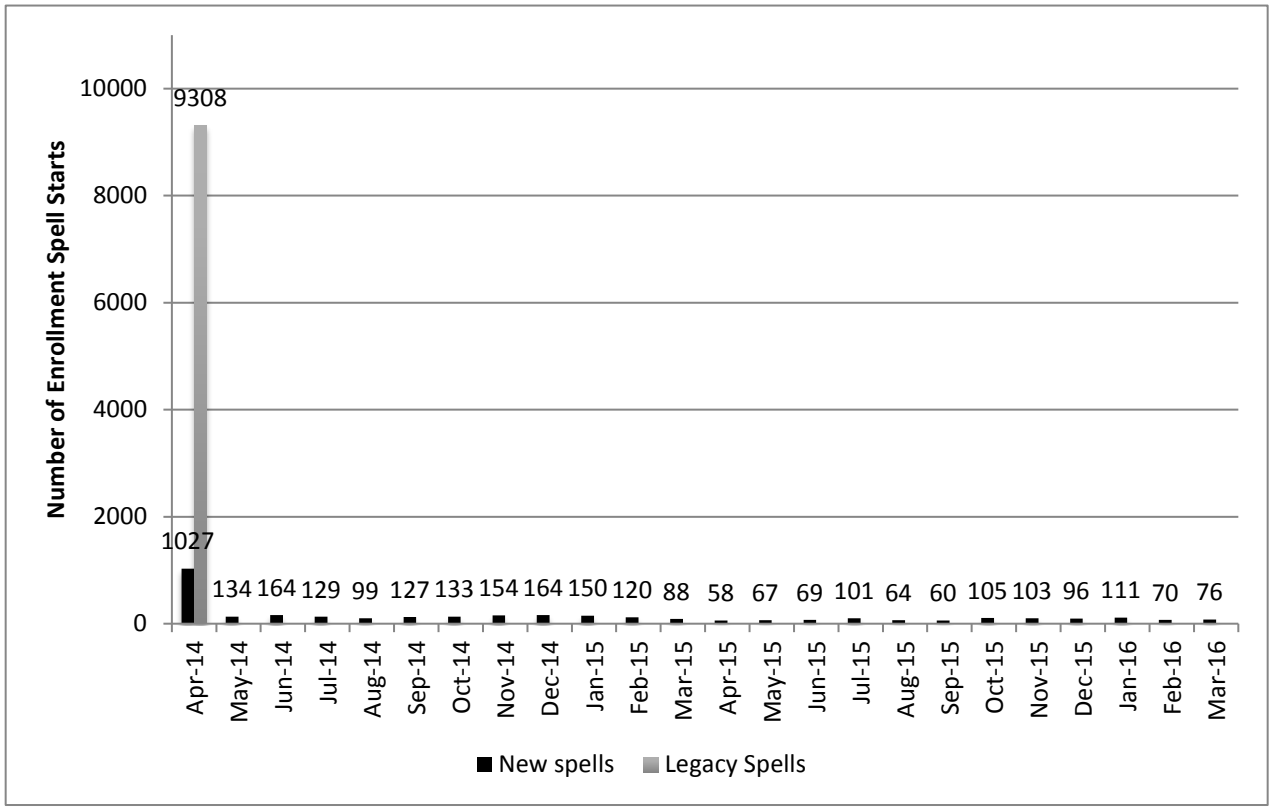
Note: New beneficiaries have at least one month of CLA Standard plan enrollment on or after April 2014 and no CLA Core enrollment between April 2013-March 2014.

In the first month of Standard plan availability for childless adults in Wisconsin, 91,617 adults enrolled. New spell starts quickly settled to a rate of roughly 10,000 per month through the first year of the waiver. New spells are defined as spells that began on or after April 2014. From April 2015 – March 2016, the number of new spell starts per month ranged from approximately 6,200 to 10,000 among new CLA beneficiaries.

Figure Q17.2 illustrates the distribution of spell starts for continuing CLA enrollees. For this group, we define a second type of spell in order to account for all spells active for continuing CLA enrollees during the demonstration period. A "legacy" spell begins before April 2014 and ends on or after April 2014. In Figure Q17.2, we assign legacy spells a start date of April 2014.

Figure Q17.2 shows that, among continuing CLA beneficiaries in April 2014, 9,308 individuals had an active enrollment spell that began before April 2014 (i.e., a legacy spell). Additionally, 1,027 childless adults began a new enrollment spell in April 2014. These are individuals who had at least one month of Core enrollment from April 2013-March2014 and exited the Core plan before April 2014. Throughout the first two years of the waiver, we observe new enrollment spells in each month among the continuing CLA study group. The frequency of these spell starts was typically less than 150 spell starts/month.

Figure Q17.2. Enrollment spell starts by month for continuing CLA beneficiaries, April 2014-March 2016



Note: Continuing beneficiaries have at least 1 month of CLA Core enrollment between April 2013-March 2014, and at least one month of CLA Standard plan enrollment between April 2014-March2015. New spells have a start date on or after 4/2014. Legacy spells began before 4/2014 and end on or after 4/2014.

Table Q17.3 defines the evaluation outcomes for continuity of health insurance. Each outcome is assessed at the level of enrollment spell. We assess the duration of enrollment spells, the probability of spell renewal, and the probability of disenrollment in the post-waiver period, April 2014 – March 2016. We consider only the renewals and enrolled months that occur on or after 4/2014 when comparing spell disposition for the continuing and new CLA enrollees. We define the renewal month as month 12 of the enrollment spell (e.g., December for a spell start in January).

Table Q17.3. Continuity of health insurance coverage outcome measures

Outcome	New Enrollment Spells	Legacy Enrollment Spells
Duration	Total number of months from enrollment start to disenrollment	Total number of months from 4/2014 to disenrollment
Renewal	Enrolled >= 1 month beyond renewal month	
Disenrollment	A gap of >=2 months in CLA enrollment before 3/2016	

Table Q17.4 shows that the large majority of spells that we observe for continuing CLA beneficiaries began before April 2014. Among continuing CLA beneficiaries, the average duration of legacy spells in the post-waiver period is longer than their new spells, and the likelihood of renewal is greater than their new spells. We test the equivalence of new spell outcomes between continuing and new CLA enrollees. This comparison is useful for considering the level of enrollment mobility for the new CLA population relative to a stable insured CLA population when they face the same coverage and enrollment flexibility.

We find statistically significant differences in the disposition of new spells across the continuing and new CLA enrollees. The average enrollment duration for new spells is 11.0 months for continuing CLA enrollees and 10.8 months for new CLA enrollees. Slightly more than one-third of each study group is likely to renew, specifically 38% of continuing CLA beneficiaries and 35% of new CLA beneficiaries. Just under half of new spells ended in disenrollment before March 2016 for continuing CLA beneficiaries while 53% of new spells ended in disenrollment before March 2016 among new CLA beneficiaries. These unadjusted findings suggest a tendency toward greater enrollment continuity among the continuing CLA enrollees than the new CLA enrollees when faced with a common benefits package and open enrollment.

Table Q17.4. Frequency and characteristics of enrollment spells for continuing and new CLA beneficiaries, 4/2014 - 3/2016

	Continuing CLA Enrollees		**New CLA Enrollees**	
	(I)	**(2)**	**(3)**	**Columns (2) vs. (3)**
	Legacy Spells	New Spells	New Spells	
	Mean [SD]	Mean [SD]	Mean [SD]	p-value
Average spell length, post-waiver	17.6	11.0	10.8	0.10
	[0.09]	[0.13]	[0.01]	
Probability of renewal, post-waiver	0.85	0.38	0.35	<0.01
	[0.004]	[0.008]	0.001	
Probability of disenrollment, post-waiver	0.45	0.49	0.53	<0.01
	[0.005]	[0.008]	[0.001]	
N Spells	9,308	3,469	287,591	

Continuing beneficiaries have at least 1 month of CLA Core enrollment between April 2013-March 2014, and at least one month of CLA Standard Plan enrollment between April 2014-March2015. New beneficiaries have at least one month of CLA Standard Plan enrollment on or after April 2014 and no CLA Core enrollment between April 2013-March 2014. A legacy spell begins before 4/2014 and ends on or after 4/2014; only the spell months post-waiver are considered here. A new spell begins on or after 4/2014.

Regression Estimates

We implement regression analyses to compare the continuity of coverage outcomes across study groups adjusting for demographic characteristics and the month and policy period in which the spell began in order to better isolate the association between Standard Plan coverage and the outcome. We use two samples for each analysis. Sample 1 includes new spells only, those initiated on or after 4/2014.

Sample 2 includes all spells active on or after April 2014 including legacy spells and new spells. While Sample 1 includes only a subset of the spells observed for the continuing CLA group, it allows us to observe the disposition of spells that are initiated for each group under the same policy regime (i.e., Standard plan coverage and open enrollment).

We use ordinary least squares regression to compare average spell duration for new CLA enrollees relative to continuing CLA enrollees in the post-waiver period, April 2014 – March 2016. Each coefficient in Table Q17.5 represents the mean difference in spell duration (in months) associated with a one-unit change in the characteristic holding all other variables at their mean value. Standard errors are in parentheses below the estimate. Consistent with the unadjusted findings (Table Q17.4), the average duration of new spells among new CLA enrollees is shorter than new spells among continuing CLA enrollees by a magnitude of 0.37 months. Including all active spells, the average duration of spells among new CLA enrollees is 0.65 months shorter than spells among continuing CLA enrollees.

Several potential explanations exist for these differences in spell length including the new enrollment and benefit features under the waiver and differences in the characteristics of new and continuing CLA enrollees that may be related to spell length. This descriptive analysis cannot distinguish between these possibilities; however, differences between new and continuing CLA enrollees in socio-demographic attributes and Medicaid enrollment history (Table Q17.2) suggest the plausibility of the latter explanation.

To estimate the association between the availability of Standard plan coverage for childless adults and the probability of spell renewal, we use logit regression and present the average marginal effects from these analyses in Table Q17.6. Each estimate in Table Q17.6 represents the difference in the probability of spell renewal associated with a one-unit change in the characteristic holding all other variables at their mean values. The probability of spell renewal is lower among new CLA enrollees than among continuing CLA beneficiaries by 4.5 and 6.4 percentage points for the sample of new spells and of all active spells respectively. Individuals who renew their enrollment spell relative to those who do not are also older, more likely to be female, and less likely to be of Hispanic origin.

Table Q17.5. The mean difference in spell duration between new and continuing CLA beneficiaries		
	(1)	(2)
	New Spells	Active Spells
	β (se)	β (se)
New CLA beneficiary	**-0.366*** **	**-0.649*** **
	(0.127)	(0.130)
Female	0.151***	0.147***
	(0.0338)	(0.0359)
White	ref	ref
Black	0.269***	0.229***
	(0.0333)	(0.0340)
Other Race	0.169***	0.158***
	(0.0502)	(0.0501)
Hispanic	-0.386***	-0.411***
	(0.0483)	(0.0483)
Ages 19-34	ref	ref
Ages 35-49	0.455***	0.475***
	(0.0295)	(0.0295)
Ages 50+	0.479***	0.486***
	(0.0354)	(0.0362)
% FPL	-0.00769***	-0.00871***
	(0.00203)	(0.00230)
< High school graduate	ref	ref
>= High school graduate	-0.0439	-0.0294
	(0.0308)	(0.0309)
Missing education	-1.003***	0.985***
	(0.0463)	(0.0467)
Resides in non-metropolitan area	ref	ref
Resides in metropolitan area	-0.454***	-0.441***
	(0.0263)	(0.0262)
Post waiver spell start	n/a	-7.556***
		(0.154)
Constant	7.610***	15.54***
	(0.145)	(0.127)
N	290,996	300,304

*Column (1) includes all spells initiated on or after 4/2014. Column (2) includes all spells active on or after 4/2014. Regression models adjust for calendar month of enrollment spell start with the inclusion of calendar month indicator variables. Standard errors are clustered at the person-level to account for correlation within person across multiple spells. ***p<0.01, **p<0.05, *p<0.10*

Table Q17.6. The mean difference in the probability of spell renewal for new CLA beneficiaries relative to continuing CLA beneficiaries in the post-waiver period, April 2014 - March 2016		
	(1)	**(2)**
	New Spells	**Active Spells**
	Average Marginal Effect (se)	**Average Marginal Effect (se)**
New CLA beneficiary	**-0.0450*** **	**-0.0639*** **
	(0.00885)	(0.00955)
Female	0.0275***	0.0281***
	(0.00195)	(0.00199)
White	ref	ref
Black	-0.000786	-0.00171
	(0.00240)	(0.00245)
Other Race	0.00614	0.00657
	(0.00400)	(0.00410)
Hispanic	-0.0407***	-0.0403***
	(0.00394)	(0.00380)
Ages 19-34	ref	ref
Ages 35-49	0.0395***	0.0406***
	(0.00226)	(0.00230)
Ages 50+	0.0529***	0.0535***
	(0.00238)	(0.00244)
% FPL	-0.000741***	-0.000841***
	(0.0000278)	(0.0000286)
< High school graduate	ref	ref
>= High school graduate	-0.00333	-0.00268
	(0.00234)	(0.00240)
Missing education	-0.0271***	-0.0267***
	(0.00329)	(0.00329)
Resides in non-metropolitan area	ref	ref
Resides in metropolitan area	-0.0282***	-0.0284***
	(0.00201)	(0.00202)
Post waiver spell start	n/a	-0.550***
		(0.00549)
N	290,996	300,304

*Column (1) includes all spells initiated on or after 4/2014. Column (2) includes all spells active on or after 4/2014. Regression models adjust for calendar month of enrollment spell start with the inclusion of calendar month indicator variables. Standard errors are clustered at the person-level to account for correlation within person across multiple spells. The average marginal effect represents the difference in the probability of spell renewal associated with a one-unit change in the characteristic holding all other variables at their mean values. ***p<0.01; **p<0.05; *p<0.10*

We next characterize the likelihood that a spell ends in disenrollment before March 2016, the end of the observation period for this analysis. For this set of analyses we include only one spell per subject: the first new spell per subject on or after 4/2014; or the first active spell per subject on or after 4/2014. We implement Cox proportional hazard models to estimate the adjusted relative probability of disenrollment (conditional on being enrolled in the prior month) for new beneficiaries compared to continuing beneficiaries. Hazard models are useful to understand the factors associated with the occurrence and timing of event. The event in this case is disenrollment.

Each exponentiated coefficient in Table Q17.7 should be interpreted as the percentage difference in likelihood of disenrollment in the first 2 years post-waiver relative to the excluded category. During the post-waiver period, new spells for new CLA beneficiaries are 8.9% more likely to end in disenrollment than new spells for continuing CLA beneficiaries. This estimate is slightly larger (10.1%) when we allow the legacy spell to serve as a subject's first spell. The strongest predictor of disenrollment is age less than 35 years.

Overall, preliminary analyses indicate that, in the first two years of the waiver period, the new CLA beneficiaries experienced less continuous health insurance coverage than continuing CLA beneficiaries when continuity is defined by enrollment spell duration, renewal and disenrollment. It is highly plausible that underlying differences between the two study groups may explain this divergence in coverage continuity, although we cannot separate that potential explanation from the availability of Standard Plan coverage.

Table Q17. 7. Cox proportional hazards estimates of the relative probability of disenrollment for new beneficiaries compared to continuing CLA beneficiaries in the post-waiver period, April 2014 - March 2016		
	(1)	**(2)**
	First New Spell	**First Active Spell**
	Hazard Ratio (se)	**Hazard Ratio (se)**
New CLA beneficiary	**1.089*** **	**1.101*** **
	(0.0281)	(0.0325)
Female	0.958***	0.960***
	(0.00526)	(0.00520)
White	ref	ref
Black	1.015**	1.021***
	(0.00703)	(0.00700)
Other Race	0.994	0.997
	(0.0113)	(0.0112)
Hispanic	1.106***	1.110***
	(0.0121)	(0.0120)
Ages 19-34	ref	ref
Ages 35-49	0.849***	0.846***
	(0.00557)	(0.00550)
Ages 50+	0.851***	0.853***
	(0.00575)	(0.00568)
% FPL	1.000***	1.001***
	(0.0000144)	(0.0000134)
< High school graduate	ref	ref
>= High school graduate	1.031***	1.029***
	(0.00694)	(0.00685)
Missing education	1.152***	1.153***
	(0.0108)	(0.0106)
Resides in non-metropolitan area	ref	ref
Resides in metropolitan area	1.102***	1.099***
	(0.00632)	(0.00622)
Post-waiver spell start	n/a	1.794***
		(0.0599)
N	251,133	259,320

*Column (1) includes all spells initiated on or after 4/2014. Column (2) includes all spells active on or after 4/2014. Regression models adjust for calendar month of enrollment spell start with the inclusion of calendar month indicator variables. Standard errors are clustered at the person-level to account for correlation within persons across multiple spells. ***p<0.01; **p<0.05; *p<0.10*

V. NEXT STEPS

Ongoing progress on the BadgerCare waiver evaluation requires that we continue, in collaboration with DHS, to establish a more efficient process to create data files within the DHS data warehouse. With that expectation, the project-wide focus of Years 02 and 03 will involve the following methodological work:

- Merge enrollment data files for evaluation populations to their claims and encounter data in order to construct analytic files for health care outcomes analyses.
- Construct claims- and encounter- based measures of unnecessary services and health outcomes, as summarized in Table 2 of the Approved Evaluation Design (Attachment A).
- Begin development of cost of care measures.
- Integrate findings from survey data with analyses from administrative data, toward a comprehensive response to hypotheses, particularly Questions 6, 9, and 17 as outlined in the Approved Evaluation Design (Attachment A).

Hypotheses-specific analyses for each of the waiver populations will proceed as follows and within the project workplan (Attachment E):

Transitional Medicaid (TMA) population

- To further extend our analysis of the impact of the 2014 waiver: estimate hazard models to evaluate the month-level risk of disenrollment based on both fixed individual characteristics and time-varying covariates (e.g., the change in exposure to premiums in the 6th month for individuals with incomes 100-133% FPL observed after the 2014 waiver)
- To further disentangle differences across income groups: stratify the sample in additional analysis by income levels and also conduct multivariate analysis to examine whether income differences arise after adjusting for other factors.
- Estimate models that link the enrollment data with premiums paid in order to calculate the impact of RRP policies on total amounts of premiums paid to the state.
- Integrate analysis of administrative data with survey data in order to examine differences that arise between individuals surveyed from the TMA and RRP categories in the 2016 survey.
- Begin evaluating changes in health care use attributable to the RRP policy – for example, changes in use of medical care before and after an RRP is experienced.

Childless Adults (CLA)

- Conduct analysis of health insurance coverage continuity for continuing CLA enrollees relative to continuing parent enrollees.
- Examine the impact on health care use of enrollment in the Standard plan relative to the Core plan. Investigation of this broad question requires a stepped approach. During the evaluation's second year, we will prioritize two types of outcomes: 1) unnecessary care use; and 2) use of services for which the benefits under the Standard plan differed most significantly from Core plan coverage (e.g., mental health and substance use disorder treatment).

VI. ATTACHMENTS

A. Approved Waiver

B. DHS Evaluation Design as originally submitted to and approved by CMS

C. UW Recommended Changes and Crosswalk

D. CMS Comments and UW/DHS Responses

E. Workplan timeline and adjustment table

F. Survey Instrument

G. Descriptive view of raw survey responses

ATTACHMENT A: DHS' WAIVER EVALUATION DESIGN, ORIGINALLY SUBMITTED TO AND APPROVED BY CMS

BadgerCare Reform Demonstration Draft Evaluation Design

October 31, 2014

Table of Contents

1. Executive Summary

In response to Section XI (Sections 47 – 48) of the Special Terms and Conditions (STCs) for the Wisconsin BadgerCare Reform Demonstration Project approved for the Wisconsin Department of Health Services, this document describes the proposed design for evaluating the effectiveness of the Demonstration in terms of the following domains of focus: Better Care, Better Health, and Reducing Costs.

Specifically, the evaluation design which is a mix of both quantitative and qualitative research techniques focuses on the application of rigorous scientific methods to arrive at an understanding of how the changes implemented under the Demonstration impact two Medicaid populations—(1) those individuals who are eligible for Medicaid through Transitional Medical Assistance (TMA Adults) and (2) those childless adults with an effective income level at, or below, 100% of the federal poverty level (FPL). As shown in the following figure, the Demonstration will result in a premium payment requirement for Parents & Caretaker Relatives over 133% FPL from the first day that transitional medical assistance (TMA) is effective (A2/A2). These premiums will be based on a sliding scale (Appendix 1) relative to household income with a cap of 9.5% of household income. Members between 100% and 133% FPL (A1/A1) will be eligible for TMA coverage for the first six (6) months of enrollment without paying a premium, but then will be required to pay premiums thereafter on the same scale. For both groups, once the period during which they are required to pay a premium begins, premium payment will be a condition of continued enrollment. Adults who do not make a premium payment will be dis-enrolled from BadgerCare Plus after a 30-day grace period and prohibited from reenrolling in BadgerCare Plus for 3 months—at which time they are eligible to re-enroll with the applicable premium payment structure.

Figure 1A: Plan Assignment and Premium Requirement Thresholds for TMA Adults

FPL	Before	After	STC- Cross Reference
<= 100%	C	C	N/A
>100 & <=133%	A1	A1	Population 1
> 133%	A2	A2	Population 1

Standard Plan

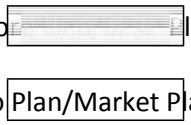
With respect to the TMA Adults, the evaluation will assess the impact of the premium requirement on measures such as the incidence of unnecessary services (e.g., Emergency Department visits or Inpatient Stays for Ambulatory Care Sensitive Conditions, 30 Day-All Cause Readmissions), changes in the cost of care (e.g., total allowed amounts for care in the demonstration period for the population as a whole and within sub-groups stratified on premium rate, education level, gender, etc.), measures of health process outcomes (e.g., preventive screening adherence rates), and measures of health outcomes as a function of cost (i.e., cost-effectiveness). Many of these measures will utilize claims, enrollment, and eligibility data from administrative sources, but factors affecting disenrollment will be identified using survey instruments and case studies (requirements are described in sections 3.3 and 3.4, respectively).

The second population included in this Demonstration is the non-pregnant, non- disabled childless individuals between 19 and 64 years of age whose income level does not exceed 100% of FPL. As depicted below, populations D/D* will move from the Core Plan or Basic Plan (limited benefit plans available to childless adults prior to April 1, 2014) to the Standard Plan—although, Basic Plan members were required to reapply before being enrolled to the Standard Plan. Please see appendix 3 for a full description of the BadgerCare Plus benefit plans and covered services. Childless adults with incomes that do not exceed 100% FPL who were previously enrolled in the BadgerCare Plus Core Plan have been transitioned to the BadgerCare Standard Plan, and those above 100% FPL may have moved to the federal Marketplace. Effective April 1, 2014, all new childless adults with incomes that do not exceed 100% FPL will be enrolled in the Standard Plan.

Figure 1B: Plan Assignment Changes for Childless Adults (CLA)

FPL	Before	After	STC Cross-Reference
100%	D	D*	Population 2
200%	B	B	N/A

Standard Plan



*Population also includes individuals formerly on Core Plan wait-list

As with the evaluation of the Demonstration's impact on the TMA population, the evaluation of the Demonstration's impact on the CLA population will focus on measures of better health, better care, and reducing costs, and this evaluation will also study the effect an expanded set of available services has on these outcomes.

As outlined in the following table, the evaluation design will utilize multiple research methodologies and data sources to provide answers to the following questions— derived from Section 48, paragraph b of the STCs—for the TMA and CLA populations.

Table 1: Evaluation Questions and Associated Data Analysis Methods

Evaluation Question	Evaluation Method			
	Case Study	Administrative Data Analysis	Case-Control Matching Study	Enrollment/ Disenrollment Survey
For the TMA: Demonstration participants: Payment of Premiums				
1. Will the premium requirement reduce the incidence of unnecessary services?	Y	Y	Y	--
2. Will the premium requirement lead to improved health outcomes?	Y	Y	Y	--
3. Will the premium requirement slow the growth in healthcare spending?	Y	Y	Y	--
4. Will the premium requirement increase the cost effectiveness (Outcomes/Cost) of Medicaid services?	Y	Y	Y	--
5. Will the premium requirement increase the cost effectiveness (Utilization/Cost) of Medicaid services?	Y	Y	Y	--
Association of Enrollment Status to Utilization and/or Costs				
6. Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?	Y	Y	Y	Y
7. Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for individuals that have disenrolled and then re-enrolled?	Y	Y	Y	Y
Enrollment Analysis by Payment of Premiums				

Evaluation Question	Evaluation Method			
	Case Study	Administrative Data Analysis	Case-Control Matching Study	Enrollment/ Disenrollment Survey
8. What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?	Y	Y	Y	--
9. How access to care affected by the application of new, or increased, premium amounts?	Y	Y	Y	Y
Payment of Premiums and 3-Month Restrictive Re-enrollment				
10. What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment?	Y	Y	Y	Y
11. Does this impact vary by income level?	Y	Y	Y	--
12. If there is an impact, explore the break-out by income level.	Y	Y	Y	--
For CLA Adults: Effects of the Benefit Plan for demonstration expansion group				
13. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries result in improved health outcomes?	Y	Y	Y	--
14. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries achieve a reduction in the incidence of unnecessary services?	Y	Y	Y	--
15. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Outcomes/Cost) of Medicaid services?	Y	Y	Y	--
16. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Utilization/Cost) of Medicaid services?	Y	Y	Y	--
17. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?	Y	Y	Y	Y

2. Evaluation Design Overview

2.1 Development Approach

In order to develop an evaluation design that is capable of answering the questions set forth in the preceding table, the following logic models were employed to focus development of the design on the activities and external influences that affect the outcomes being studied.

Figure 2a: Program Logic Model for BadgerCare Reform – TMA Adults

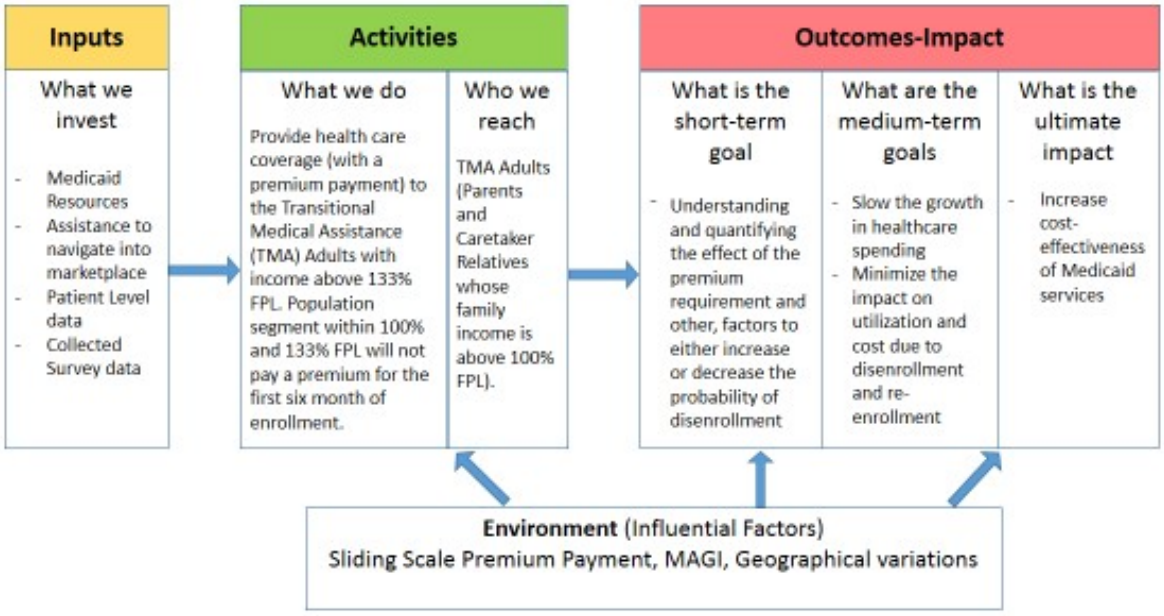
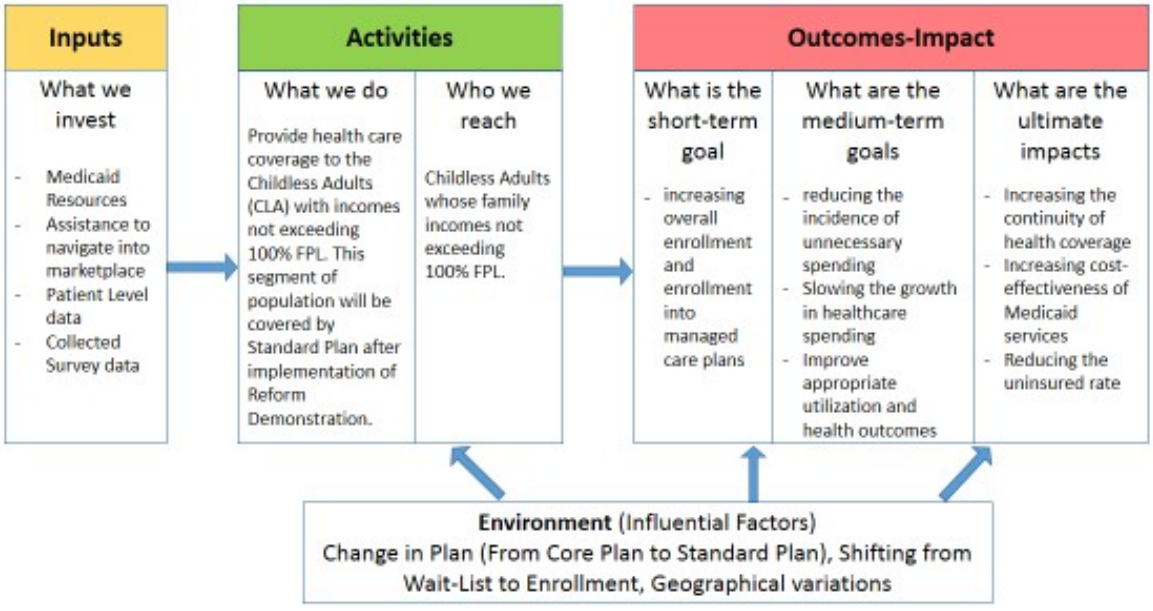


Figure 2b: Program Logic Model for BadgerCare Reform – Childless Adults



These models will also provide the logical framework to be used in evaluating the effectiveness of the Demonstration. Logic models (Taylor-Powelare et. al., 2003) are graphical representations of the logical relationships between the resources, activities, outputs and outcomes of a program. Whereas there are many ways in which logic models can be presented, the underlying purpose of the logic model is to identify the possible "if-then" (causal) relationships between the elements of the program. For example, the current logic model identifies the resources available for the Demonstration program, the types of activities that can be effectively implemented using those resources, and the specific outputs and outcomes that can be expected as a result of those activities.

2.2 **Target Populations**

As described previously, two target populations will be studied under this evaluation—TMA Adults and Childless Adults.

2.2.1 TMA Population.

In the TMA population, the Demonstration will enable the State to test the impact of requiring a premium payment that aligns with the insurance affordability program in the federal Marketplace based on their household income when compared to federal poverty level (FPL). This population is divided into two segments—those individuals with incomes above 133 percent of the FPL (who will be required to pay a premium starting from the first day of enrollment) and those with incomes between 100-133 percent of the FPL (who will be required to pay a premium after the first 6 calendar months of TMA coverage).

2.2.2 CLA Population.

The Childless Adults (CLA) population consists of Non-pregnant, Non- Disabled Childless Adults between 19 and 64 years of age who have family incomes that do not exceed 100 percent FPL. As a result of the

Demonstration, this population will be moved from the Core or Basic Plan to the Standard Plan[1]—which offers more comprehensive services compared to the Core or Basic Plan. This population will likely include a large portion of the individuals who were on the Core Plan wait-list.

The State will isolate or exclude from the evaluation any overlapping initiatives (e.g. integrated care models coupled with payment reform) that target the TMA or CLA populations. At this time the State has not identified any current initiatives that would impact this evaluation, and will provide a detailed analysis plan for controlling the effects of such initiatives on the current evaluation's studied outcomes.

2.3 **Stage of Development**

The Demonstration project began April 1, 2014 and will continue until December 2018. There will be short-term, medium-range and long-term outcomes expected from this project. The target populations will be monitored using claims, eligibility and enrollment data. At the end of the demonstration period, the study populations will be surveyed regarding enrollment and

disenrollment events. The populations will also be surveyed for case studies (to be identified by the selected evaluator) to augment the findings generated by the analysis of administrative data.

2.4 **Inputs**

The State and CMS have dedicated resources to the Medicaid Program. The State has modified the program to reduce the uninsured population in the state as well as increase health outcomes for the Medicaid population. To evaluate these goals, the evaluator will collect enrollment and medical claims data from the interChange System (hosted and operated by HP Enterprise Services), eligibility data from the Client Assistance for Re-employment and Economic Support System (CARES). In addition, the evaluator will develop and collect data using a survey of selected members. The State will also support the activities and human resources necessary to complete the evaluation process through the demonstration period, December 31, 2018

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[1] Basic Plan members were required to reapply before being enrolled in the Standard Plan

2.5 **Activities**

During the Demonstration, the State will provide healthcare coverage to both the TMA and CLA population in accordance with the terms outlined. As outlined in STC 26, the State will hold a public forum (initial within first 6 months and annually thereafter) to solicit comments on the progress of the demonstration project and will provide a summary of the forum in the subsequent Quarterly Report submitted following the close of the quarter in which the forum is held. In addition to these summaries, the Quarterly Report will include initial findings included as part of the evaluation design—e.g., enrollment/disenrollment rates, measures of unnecessary services, counts of services accessed, etc—.

2.6 **Outcomes**

The evaluation will assess whether the Demonstration achieves the following goals:

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

Successful accomplishment of these goals will be demonstrated or inferred by achievement of short-, medium-, and long-range goals within the two study populations.

2.6.1 TMA Population

The short term goal is:

a) understanding and quantifying the effect of the premium requirement and other, factors to either increase or decrease the probability of disenrollment

The medium range goals are:

b) slowing the growth in healthcare spending

c) minimizing the impact on utilization and cost due to disenrollment and re-enrollment

d) improve appropriate utilization, quality and health outcomes The

long term goal is:

e) increasing cost-effectiveness of Medicaid services

2.6.2 CLA Population

The short term goal is:

a) increasing overall enrollment and enrollment into managed care plans

The medium range goals are:

b) reducing the incidence of unnecessary spending

c) slowing the growth in healthcare spending

d) improve appropriate utilization and health outcomes The

long term goals are:

e) increasing the continuity of health coverage

f) increasing cost effectiveness of Medicaid services

g) reducing the uninsured rate

In the following sections, the evaluation design describes the Core Elements of the evaluation—including the specific research questions posed, the methods used to arrive at the answers to those research questions, the outcome measures used to evaluate the impact of the demonstration, and the sources of those measures. The evaluation design also provides details on the sources of data that will be used to perform the analyses (i.e., the independent, dependent, and co-varying factors that will be studied) as well as an explanation of the establishment of the baseline measures and control groups for each of the populations under study.

3. Evaluation Design

Having framed the evaluation design development in terms of the preceding logic models, the following evaluation questions identified in STC 48.b. will be addressed using a variety of research methodologies.

Table 2: Evaluation Questions and Associated Data Analysis Methods

Evaluation Question	Evaluation Method			
	Case Study	Administrative Data Analysis	Case-Control Matching Study	Enrollment/ Disenrollment Survey
For the TMA: Demonstration participants: Payment of Premiums				
1. Will the premium requirement reduce the incidence of unnecessary services?	Y	Y	Y	--
2. Will the premium requirement lead to improved health outcomes?	Y	Y	Y	--
3. Will the premium requirement slow the growth in healthcare spending?	Y	Y	Y	--
4. Will the premium requirement increase the cost effectiveness (Outcomes/Cost) of Medicaid services?	Y	Y	Y	--
5. Will the premium requirement increase the cost effectiveness (Utilization/Cost) of Medicaid services?	Y	Y	Y	--
Association of Enrollment Status to Utilization and/or Costs				
6. Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?	Y	Y	Y	Y
7. Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for individuals that have disenrolled and then re-enrolled?	Y	Y	Y	Y
Enrollment Analysis by Payment of Premiums				
8. What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?	Y	Y	Y	--
9. How access to care affected by the application of new, or increased, premium amounts?	Y	Y	Y	Y
Payment of Premiums and 3-Month Restrictive Re-enrollment				
10. What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment?	Y	Y	Y	Y
11. Does this impact vary by income level?	Y	Y	Y	--
12. If there is an impact, explore the break-out by income level.	Y	Y	Y	--
For CLA Adults: Effects of the Benefit Plan for demonstration expansion group				
13. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries result in improved health outcomes?	Y	Y	Y	--
14. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries achieve a reduction in the incidence of unnecessary services?	Y	Y	Y	--

Evaluation Question	Evaluation Method			
	Case Study	Administrative Data Analysis	Case-Control Matching Study	Enrollment/ Disenrollment Survey
15. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Outcomes/Cost) of Medicaid services?	Y	Y	Y	--
16. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Utilization/Cost) of Medicaid services?	Y	Y	Y	--
17. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?	Y	Y	Y	Y

The proposed research methods used to answer these questions—and the application of the methods to specific research questions—are described in the following sections. The DHS will procure for an independent evaluator before the end of the second demonstration year, March 31, 2016. The DHS will consult with CMS if the selected evaluator proposes additional research methods.

3.1 **Administrative Data Analysis**

Analysis of administrative data will be conducted using Medicaid enrollment and claims data from the interChange System and from the Medicaid eligibility determination and maintenance system, Client Assistance for Re-employment and Economic Support System (CARES), hosted by Deloitte.

3.2 **Case-Control Matching Study**

Within the TMA population for which FPL is 133% or more, there will be a portion of the population that will lose the coverage due to non-payment of premiums.
The best estimate about the percent of drop-outs is that approximately 40% will fall into this category within first twelve months of the demonstration. To answer the research questions related to this section of the TMA population, matching sample will be constructed from the remainder 60% of the cohort who maintained their coverage during the first year. The matching will be executed following standard statistical procedures such as, propensity score matching or exact covariate matching. Since the case group and the matched control group are drawn from a somewhat homogenous population, i.e. TMA with 133% or more FPL, any matching method for a specific outcome may inherit biases due to unobserved covariates. To overcome any shortcomings from this situation Heller, Rosenbaum & Small (2009) recommended to perform sensitivity analysis using split-sample technique. In our case we will execute matching to determine comparable control group and apply 10%-90% split-sample technique to test the sensitivity of biases due to unobserved covariates.

Here we discuss the split-sample approach in the context of a research question: Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for individuals that have disenrolled and then re-enrolled? This is a direct comparison of costs and utilization between the groups of members who were continuously enrolled versus the members who were disenrolled and reenrolled again. Let's call the disenrollment/re-enrollment group as treatment and continuously enrolled group as control. The treatment group may have different health outcomes and/or costs than the control group due to some cofactors which are not adjusted. As Zhang et.al., (2011) mentioned 'after adjustment for observed covariates, the key source of uncertainty in an observational study is the possibility that differences in outcomes between treated and control subjects are not effects of the treatment but rather biases from some unmeasured way in which treated and control subjects were not comparable'.

Heller, Rosenbaum, and Small (2009) suggested to split the sample at random into a small planning sample of 10% and large analysis sample of 90% to perform a sensitivity analysis that asks how failure to control some unmeasured covariates might alter the conclusion of the research question. The planning sample will be used to design the study and guide the analysis plan – whereupon the planning sample will be discarded. All analyses and interpretations will be based on untouched, unexamined, untainted analysis sample.

As an example, we demonstrate how the research question 5 will be analyzed using the proposed method. The research question states: 'Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for individuals that have dis-enrolled and then re-enrolled?' For the overall analysis the whole cohort will be considered at the beneficiary level analysis for several outcome variables. One of those is unnecessary ED visits.

The predictor variables are FPL level and the indicator variable whether the beneficiary lost coverage due to dis-enrollment after controlling for some demographic factors. This analysis will produce measures of impact of dis- enrollment over the costs and/or unnecessary utilization. To highlight this effect in some form of causation, we will have to apply method of observational studies where the beneficiaries who were dis-enrolled during the first year after demonstration will be considered as 'Cases'. Applying matching technique we will find comparable controls from the pool of beneficiaries who had continuous coverage during the first year. Furthermore, to

avoid the risk of bias in finding right controls, we will employ split-sample technique to determine the sensitivity of that bias. We propose to have a 10%-90% split for planning and analysis pair samples as were done in Heller, Rosenbaum & Small (2009) and Zhang, Small, Lorch, Srinivas and Rosenbaum (2011).

3.3 **Enrollment/Disenrollment Survey**

DHS intends to contract with an independent evaluator during the second year of the demonstration and will conduct two surveys during the course of the demonstration. DHS will target completing a survey at the end of the second demonstration year and one at the end of the fourth year of the demonstration.
The surveys will be designed so that the sample size represents all major demographic sections of the study population and all levels of FPL eligibility.

We are proposing two separate surveys be employed for the two study populations. The focus for TMA Adults population will be to capture the effects of premium payments on enrollment status. For the Childless Adults, the surveys will try to discern the effects of enhanced benefits, based on survey respondents answers regarding their service needs, on health outcomes.

The survey data will be matched with claims and eligibility data used in administrative analysis to find the impact of premium payments on disenrollment, re-enrollment, churning and subsequently its impact on healthcare cost and utilization. DHS will update Table 3 to include additional measures identified from the surveys.

3.4 Case Study

The case study will be designed to provide information to address several of the questions included in the BadgerCare Demonstration Reform program. The first set of questions (1-10) relate to the TMA Adults (Population 1) and the second set (11-14) for Childless Adults (Population 2). To address these questions, in addition to administrative data analysis, case-control study and application of survey methodology, we propose phone interviews to investigate how premium payment and restrictive enrolment impacted health outcomes, costs and general impact of the program.

4. Data Analysis and Interpretation

The data analysis plan includes the four methods of evaluation previously discussed—Administrative Data Analysis, Case-Control Matching Study, Case Study and Enrollment/ Disenrollment Survey Study. As depicted in the Question/Method Matrix (Table 2, below), each research question will be evaluated by different combinations of these methods. The proposed methods can be modified and adapted according to the evaluator's determination satisfying the standards agreed upon by the State and CMS. The outcome measures for each of these questions and related factors that will be needed to complete the analyses are described later in this section. The data analyses will be organized by the two study populations—TMA Adults and Childless Adults, respectively.

Further, in order to most effectively utilize these methods to research the questions specified in STC 48.b. The questions will be further broken out into a larger number of more specific research questions. The following question/method matrix identifies the research methods that will be employed to address each of the resulting research questions, and a description of the application of each method to the study of the associated question is detailed in this section.

Table 3: Evaluation Questions and Associated Data Analysis Methods

Evaluation Question	Evaluation Method			
	Case Study	Administrative Data Analysis	Case-Control Matching Study	Enrollment/ Disenrollment Survey
For the TMA: Demonstration participants: Payment of Premiums				
18. Will the premium requirement reduce the incidence of unnecessary services?	Y	Y	Y	--
19. Will the premium requirement lead to improved health outcomes?	Y	Y	Y	--
20. Will the premium requirement slow the growth in healthcare spending?	Y	Y	Y	--
21. Will the premium requirement increase the cost effectiveness (Outcomes/Cost) of Medicaid services?	Y	Y	Y	--
22. Will the premium requirement increase the cost effectiveness (Utilization/Cost) of Medicaid services?	Y	Y	Y	--
Association of Enrollment Status to Utilization and/or Costs				
23. Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?	Y	Y	Y	Y
24. Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for individuals that have disenrolled and then re-enrolled?	Y	Y	Y	Y
Enrollment Analysis by Payment of Premiums				
25. What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?	Y	Y	Y	--
26. How access to care affected by the application of new, or increased, premium amounts?	Y	Y	Y	Y
Payment of Premiums and 3-Month Restrictive Re-enrollment				
27. What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment?	Y	Y	Y	Y
28. Does this impact vary by income level?	Y	Y	Y	--
29. If there is an impact, explore the break-out by income level.	Y	Y	Y	--
For CLA Adults: Effects of the Benefit Plan for demonstration expansion group				
30. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries result in improved health outcomes?	Y	Y	Y	--
31. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries achieve a reduction in the incidence of unnecessary services?	Y	Y	Y	--

32. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Outcomes/Cost) of Medicaid services?	Y	Y	Y	--
33. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Utilization/Cost) of Medicaid services?	Y	Y	Y	--
34. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?	Y	Y	Y	Y

4.1 Population Segment Definition

In order to facilitate the discussion of the analyses applied to the two study populations, each population "segment" will be described in further detail below:

Figure 3A: Plan Assignment and Premium Requirement Thresholds for TMA Adults

FPL	Before	After	STC- Cross Reference
<= 100%	C	C	N/A
>100 & <=133%	A1	A1	Population 1
> 133%	A2	A2	Population 1

Standard Plan

Figure 3B: Plan Assignment Changes for Childless Adults (CLA)

FPL	Before	After	STC Cross-Reference
100%	D	D*	Population 2
200%	B	B	N/A

Core Plan/Basic Plan

No Plan/Market Place

*Population also includes individuals formerly on Core Plan wait-list

Segment A1: Parents and Caretaker Relatives who are non-pregnant, non- disabled whose effective family income is between 100% and 133% of FPL.

Segment A2: Parents and Caretaker Relatives who are non-pregnant, non- disabled whose effective family income is over 133% of FPL.

Segment A1: Same baseline population as Segment A1, but these members will have a twelve-month extension to have the same benefit as A1. Hence this segment of the population will not be considered for the initial analysis plan. When

more detailed information will be available in 2015 for this segment, the analysis plan can be amended based on policy decisions reached.

Segment A2: Same baseline population as Segment A2, who will be subjected to pay premiums during Demonstration based on sliding scale cost-sharing structure

Segment B: Non-pregnant, non-disabled childless individuals who are from 19 through 64 years old with an effective income between 100% and 200% FPL.

Segment B: Same baseline as population Segment B, who will be transitioned from Core Plan/Basin Plan to marketplace in the Demonstration project and is not a part of the evaluation design.

Segment C: Parents and Caretaker Relatives who are non-pregnant, non- disabled whose effective family income does not exceed 100% of FPL. The benefits for this segment will remain unchanged after the implementation of the Demonstration Reform and is not a part of the evaluation design.

Segment D: Non-pregnant, non-disabled childless individuals who are from 19 through 64 years old with an effective that does not exceed 100%, before Demonstration.

Segment D*: This segment of the study population will include all the baseline population which are entering Demonstration from segment D and all the uninsured or people on the Core Plan waitlist who qualified to be part of Segment D.

4.2 **Data Analysis Method**

The three major analytical strategies will be adopted for the data analysis to test the evaluation hypotheses. The methods are described in further detail below.

1. Means Test
2. Multivariate Regression modeling
3. Cost-Effectiveness Analysis

Means Test

For all the measures that are population based, the predictors cannot be associated to the changes that are observed in time. The overall measures are compared before and after implementation time periods. The changes will be viewed as the effects of the reform demonstration. Multiple comparisons will be carried out to determine measurement changes from baseline and over time.

Multivariate Regression Modeling

The measures from Medicaid Adult Core Set and NCQA HEDIS will be modeled using difference-in-difference (DID). These measures are population based, with overall rates and percentages are calculated related to sections of populations. Individually each member will have dichotomous response for each of the measures indicating whether or not the member received services (e.g. screening) received during a specific time period. Those dichotomous variables are then modeled by predictors and control variables.

For the hypothesis where the outcome is measured as the indicator of dis- enrollment, similar dichotomous variables will be used. The annual total cost variables are on continuous type but most likely will be positively skewed. For this reason all cost data will be log-transferred before modeling by predictors and control variables.

Cost-Effectiveness Analysis

Cost-effectiveness analysis typically relates cost of care to the quality outcomes as a population-based measure. The primary factor in this analysis is how the effect of time is addressed. For example, adherence to control medication may have a significant impact on Asthma outcomes. If the intervention is geared toward raising medication adherence, then the cost of care will increase during the first few months of the intervention due to higher rates of medication refill.

However, the long term effect of the higher adherence in terms of reduced ER visit or hospitalizations might not be observed immediately. So the cost- effectiveness will be very low (potentially negative) for initial months. For each of the outcomes the potential lag-time will be considered for cost-effectiveness analysis.

For each research question described in the preceding Question/Method Matrix (Table 3, above), the outcome variable(s) and the predictors are stated below. We found that most of the questions needed to be analyzed by controlling several variables. Instead of repeating those under each question, the list is mentioned here. Unless otherwise mentioned for any given question it will be assumed that the research question will be analyzed using this set of control variables.

Demographics (Age[Group], Gender, Race & Ethnicity), Education, County, Region, Risk Score[ACG or CDPS], belongs to MCO or FFS, Tribal population*. Some risk scores use Age and Gender as predictors. In that case, age and gender can be dropped for modelling purposes.

Questions 1 thru 12 relate to the population segments A2 and A2. Population segment A2 data is used to create baseline measures for comparison of measures calculated at a future date during the Demonstration. Otherwise, data from population segments A2 and A2 will be merged to develop statistical models and case-control studies. All 12 research questions will be analyzed at the beneficiary level. The claims and eligibility data will be used to create beneficiary level variables. The questions for which the cofactors or outcomes are time-varying variables longitudinal analysis methods are proposed.

The reports that will be generated to monitor health outcomes shown in Table 3, will be calculated at aggregate level.

Question 1: Will the premium requirement reduce the incidence of unnecessary services?

Hypothesis 1.1: The incidence of unnecessary services (such as Emergency Department visits and Inpatient Stays for Ambulatory Care Sensitive Conditions (ASCs), 30-Day All Cause Readmissions and overall inpatient stays) will be lower for TMA members in the demonstration than the incidence of unnecessary services for the same population prior to the demonstration.

Members in transitional medical assistance who are paying premiums will be more engaged in the health care decision making process and will make more efficient use of preventive and primary care, reducing the incidence of unnecessary services such as Emergency Department visits and Inpatient Stays for Ambulatory Care Sensitive Conditions (ASCs), 30-Day All Cause Readmissions and overall inpatient stays.

Outcome Variables: Emergency Department visits and Inpatient Stays for Ambulatory Care Sensitive Conditions (ASCs), 30-Day All Cause Readmissions and overall inpatient stays.

Predictor / Explanatory Variable(s): FPL (hence sliding scale premium).

Data Analysis Method: Changes in the number of unnecessary services over time (during the prior year and the five-year duration of the study) will be examined as a function of the individual premium payment levels determined by the premium schedule. This explanatory variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s) and perform sub-group analyses (i.e., separate models for different sub-sections of the population). For case-control analyses a split-sample method will be used to assign individuals to the case and control groups. The samples will be determined during the first year of the Demonstration and this

division of the sample will be maintained during the rest of the study period for comparison purposes.

Question 2: Will the premium requirement lead to improved health outcomes?

Hypothesis 2.1: Health care outcomes (as defined in table 3 below) for the TMA population who are paying premiums will be better than the health care outcomes for these members prior to the demonstration.

Hypothesis 2.2: Health care outcomes (as defined in table 3) for TMA members who are paying premiums will be better than health care outcomes for members not paying premiums.

TMA members who are paying premiums will be more engaged in the health care decision making process and will make more efficient use of preventive and primary care, leading to improved health outcomes.

Table 4: Outcome Measures Frequently used by DHS to Determine Healthcare Quality

Focus Area	NQF Measure #	CMS Adult Core Set #	Measure
Preventive / Screening	0031	Measure 3	Breast Cancer Screening (BCS) (HEDIS-NCQA)
Chronic	0057	Measure 19	Comprehensive Diabetes Care- HbA1c Testing (HEDIS-NCQA)
	0063	Measure 18	Comprehensive Diabetes Care- LDL-C Screening (HEDIS-NCQA)
Mental Health	0105	Measure 20	Antidepressant Medication Management (AMM- Effective Continuation Phase) (HEDIS)
	0004	Measure 25	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-Engagement of AOD Treatment) (HEDIS-NCQA)
			Tobacco Cessation (Counseling only) – Wisconsin specific measure – the percentage of adult smokers that received tobacco cessation counseling during the calendar year
	0576	Measure 13	Follow-up After Hospitalization for Mental Illness – 30 Days After Discharge (FUH-30) (HEDIS-NCQA)
Emergency Dept.			Ambulatory Care – Emergency Department Visits (AMB) sans revenue code 0456 (HEDIS-NCQA)

DHS will explore including additional health care outcomes measures from medical record data as agreed upon with HMOs and other Medicaid providers in the state.

Outcome Variables: The outcome variables will be recorded as member-specific data. The screening, preventive and primary care indicators are binary variables based on whether a member reported to have obtained the age, gender, and chronic condition specific services specified by NCQA for relevant HEDIS measures.

Predictor/Explanatory Variable(s): FPL (hence sliding scale premium).

Data Analysis Method: The changes in the likelihood that a member will receive screening, preventive and primary care services over time (during the prior year and the five-year duration of the study) will be examined as a function of the individual premium payment levels determined by the premium schedule. This explanatory variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates.
Therefore, we are proposing to develop generalized estimation equation (GEE) models for the binary outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population) will be performed.

For case-control analyses a split-sample method will be used to assess the assignments of individuals to the case and control groups. The samples will be determined during the first year of the Demonstration and this division of the sample will be maintained during the rest of the study period for comparison purposes.

Question 3: Will the premium requirement slow the growth in healthcare spending?

Hypothesis 3.1: Healthcare spending for TMA members paying premiums during the demonstration will be lower compared to the healthcare spending for the same members prior to the demonstration.

Hypothesis 3.2: Healthcare spending for TMA members paying premiums during the demonstration will be lower compared to the healthcare spending for members (of similar makeup) outside of the demonstration.

Outcome Variable: The evaluation will consider using Allowed Amounts, Paid Amounts, and/or per member costs as the outcome variable for cost calculations (e.g. the allowed amount is calculated as the amount paid by Wisconsin Medicaid for services based on the maximum allowable fee schedule or the capitation payments made to Medicaid HMOs).

Predictor / Explanatory Variable(s): FPL levels defined in terms of levels on the sliding premium scale.

Data Analysis Method: Healthcare spending over time (during the prior year and the five-year duration of the study) will be evaluated as a function of individual premium payment level. This explanatory variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population) are proposed.

Since the cost data are generally positively skewed (with long right side tail), assumptions related to linear regressions do not hold true for modeling purposes. Some kind of transformation of cost data is needed to apply linear regression methods. Most common of those are log transformations of the cost data. This process might result in hidden biases during transforming back to the predicted values of the cost data (Manning & Mullahy, 2001) and corrective measures can be adopted as described in that research publication.

For case-control analyses a split-sample method will be used to assign individuals to the case and control groups. The samples will be determined during the first year of the Demonstration and this division of the sample will be maintained during the rest of the study period for comparison purposes. See section 5 for data collection methods and baseline development.

Question 4: Will the premium requirement increase the cost effectiveness (Outcomes/Cost) of Medicaid services?

Hypothesis 4.1: The cost-effectiveness for TMA members paying premiums during the demonstration will be higher (over time) as compared to the cost effectiveness for the same members prior to the demonstration.

Outcome Variable: Cost-Effectiveness is usually calculated as cost divided by a measure of health outcomes. In this case the cost variable(s) utilized in Question 2 can be used along with the measure of unnecessary services utilized in Question 1 in combination with the health care outcomes measures listed below:

Predictor / Explanatory Variable(s): FPL levels defined in terms of levels on the sliding premium scale.

Data Analysis Method: The need is to analyze the changes in cost-effectiveness (specifically aimed at unnecessary services over time and the health outcomes defined in table 3 above), during the baseline year and the five-year duration of the study, as explained by the individual premium payment requirements by FPL. This outcome variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s). Sub-group analyses (i.e., separate models for different sub- sections of the population) are proposed.

For case-control matching study using split-sample technique, samples can be determined during the first year of the Demonstration. This division of the sample will be maintained during the rest of the study period for comparison purposes.

Question 5: Will the premium requirement increase the cost effectiveness (Utilization/Cost) of Medicaid services?

Hypothesis 5.1: The cost-effectiveness for TMA members paying premiums during the demonstration will be higher (over time) as compared to the cost effectiveness for the same members prior to the demonstration.

Outcome Variable: Cost-Effectiveness will be determined as to whether changes in cost resulted in fewer unnecessary utilization healthcare services. In this case the cost variable(s) used in Question 2 can be used along with the measure of unnecessary

services (such as Emergency Department visits and Inpatient Stays for Ambulatory Care Sensitive Conditions (ASCs), 30-Day All Cause Readmissions, and overall inpatient stays).

Predictor / Explanatory Variable(s): FPL levels defined in terms of levels on the sliding premium scale.

Data Analysis Method: The need is to analyze the changes in cost-effectiveness (specifically aimed at reduction of unnecessary services), during the prior year and the five-year duration of the study, as explained by the individual premium payment requirements by FPL. This outcome variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population) are proposed.

For the case-control matching study, the control group will be identified by propensity score matching and the split-sample technique used to determine the sensitivity of bias present in the matching method. The case and control samples will be determined during the first year of the Demonstration. This division of the sample will be maintained during the rest of the study period for comparison purposes.

Question 6: Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re- enrolled after the 3-month restrictive re-enrollment period?

Hypothesis 6.1: Utilization, costs, and health care outcomes will not be impacted for those individuals who were disenrolled, but re-re-enrolled after the 3-month restrictive re-enrollment period due to the limited amount of time that individuals would not have access to benefits.

Outcome Variable: Unnecessary services (i.e. ED Visits and Inpatient Stays for Ambulatory care Sensitive Conditions) and avoidable events (i.e. 30-Day All-Cause

Readmissions and Unnecessary Medical Services and Devices) as well as the health care outcomes defined in table 3.

The evaluation will consider using Allowed Amounts, Paid Amounts, and/or per member costs as the outcome variable for cost calculations (e.g. the allowed amount is calculated as the amount paid by Wisconsin Medicaid for services based on the maximum allowable fee schedule or the capitation payments made to Medicaid HMOs).

Predictor / Explanatory Variable(s): FPL levels defined in terms of levels on the sliding premium scale. Disenrollment/Re-enrollment history will be used to identify common patterns of disenrollment and re-enrollment and the effect of these patterns on the outcome variable will be assessed.

Data Analysis Method: We are proposing longitudinal regression methods for this analysis. The enrollment / disenrollment / re-enrollment information can be used multiple ways. Indicator variables can be developed to identify whether a member had any of these statuses within a certain unit of time and these variables will be added to the regression model. Alternatively, the enrollment status can be counted and categorized to discover differential effects of disenrollment/re-enrollment vs. continuous enrollment.

Question 7. Are costs, utilization of services, and/or health outcomes different for those that are continuously enrolled compared to costs/utilization for individuals that have disenrolled and then re- enrolled?

Hypothesis 7.1: Utilization, costs, and health care outcomes will not be different for those individuals who are continuously enrolled compared to those for individuals that have disenrolled and then re-enrolled due to the limited amount of time that individuals would not have access to benefits.

Outcome Variable: Unnecessary services (i.e. ED Visits and Inpatient Stays for Ambulatory Care Sensitive Conditions) and avoidable events (i.e. 30-Day All Cause Readmissions and utilization of unnecessary medical services and devices).

The evaluation will consider using Allowed Amounts, Paid Amounts, and/or per member costs as the outcome variable for cost calculations (e.g. the allowed amount is calculated as the amount paid by Wisconsin Medicaid for services based on the maximum allowable fee schedule or the capitation payments made to Medicaid HMOs).

Predictor / Explanatory Variable(s): FPL (hence sliding scale premium). Disenrollment/Re-enrollment history (Identify few frequent patterns of disenrollment / re- enrollment and create dummy variables on those patterns).

Data Analysis Method: We are proposing longitudinal regression methods for this analysis. The enrollment / disenrollment / reenrollment information can be used multiple different ways. Indicator variable can be developed whether a member had any of these statuses within a certain unit of time and use the variable in models. Otherwise, the enrollment status can be counted and categorized to discover differential effects.

A Case-Control matching method using split-sample approach will be employed to determine if there are significant different outcomes between the groups of different insurance status.

Question 8. What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?

Hypothesis 8.1: TMA members with higher incomes will transition faster out of BadgerCare Plus than TMA members with lower income. The impact of the premium will vary by income level as TMA members with higher income will have more health care coverage options than members with lower income levels and may transition out of BadgerCare Plus faster.

Outcome Variable: Disenrollment/Re-enrollment history (Identify frequent patterns of disenrollment / re-enrollment and create dummy variables on those patterns).

Predictor / Explanatory Variable(s): FPL (hence sliding scale premium) with possible categorization into wider intervals (smaller number of buckets). STC Attachment B.

Data Analysis Method: Depending on the type of outcome variable that is used the analysis method will be selected. For example, if enrollment / disenrollment indicator is a categorical variable then either logistic regression analysis or generalized linear models can be employed to answer the research question.

Question 9. How is access to care affected by the application of new, or increased, premium amounts?

Hypothesis 9.1: The premium requirement will have no effect on access to care.

Outcome Variable: Access to care can be defined as availability of Preventive Care, Behavioral Health Care, Specialist Care, Post-Acute Care, will be measured through survey questions for TMA population related to accessing needed care such as whether members have a primary care physician and if they have had difficulties scheduling appointments with providers for needed care.

Predictor / Explanatory Variable(s): FPL (hence sliding scale premium) with possible categorization into wider intervals (smaller number of buckets). Appendix 1. Also, dummy variables can be created to depict if the premium payment is new or an increased amount from past payments.

Data Analysis Method: Generally 'Access To Care' can be determined as continuous or discrete variable, depending on the emphasis of the domain of care. Based on that determination an appropriate regression model can be developed for longitudinal data.

Question 10. What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment?

The 3-month restrictive re-enrollment period for failure to make a premium payment will have variable impact on membership continuation and enrollment. We envision that after the restrictive re-enrollment period is over and members reenroll again their

likelihood of paying regular premiums will increase. The comprehensive benefit package that Wisconsin Medicaid members receive will incentivize them to continue paying their premiums and remain enrolled in Medicaid after their return beyond the restrictive reenrollment period. We also presume that this effect will vary by income level, since members with higher incomes will have more opportunities to purchase health insurance outside of BadgerCare Plus. The next three hypotheses are based on this context.

Hypothesis 10.1: The 3-month restrictive re-enrollment period for failure to make a premium payment will increase retention for both payment of premiums (after members return to Wisconsin Medicaid) and TMA member's enrollment after adjusting for the member's acuity.

Outcome Variable(s): This is a Dyad Outcome. A suitable combination category class can be created based on the premium amount and pattern of enrollment / disenrollment. The categories will be created so that variability can be observed based on 3-month restrictive enrollment.

Predictor / Explanatory Variable: This is a Binary variable and based on whether any member had experienced this condition.

Data Analysis Method: The categorization of dual outcome variables will create a nominal variable since there may not be a logical ordering between the categories. The logistic regression method for nominal variables may be applied to answer this research question.

Question 11. Does this impact (as described in Question 10) vary by income level?

Hypothesis 11.1: The impact (as described in Question 10) will vary by income level and other variables.

Outcome Variable: This is a Dyad Outcome. A suitable combination category class can be created based on the premium amount and pattern of enrollment / disenrollment.

The categories will be created so that variability is observed based on 3-month restrictive enrollment.

Predictor / Explanatory Variable(s): Categorical variables created by smaller number of income classes.

Data Analysis Method: The categorization of dual outcome variables will create a nominal variable since there may not be a logical ordering between the categories. The logistic regression method for nominal variables may be applied to answer this research question.

Question 12. If there is an impact (as described in Question 10), explore the break-out by income level.

Hypothesis 12.1: (as described in Question 10) We will explore the break-out by income level.

Outcome Variable: This is a Dyad Outcome. A suitable combination category class can be created based on the premium amount and pattern of enrollment / disenrollment.
The categories will be created so that variability is observed based on 3-month restrictive enrollment.

Predictor / Explanatory Variable(s): Categorical variables created by smaller number of income classes.

Data Analysis Method: The categorization of dual outcome variables will create a nominal variable since there may not be a logical ordering between the categories. The logistic regression method for nominal variables may be applied to answer this research question.

To find the break-out point(s) in the income level where significant differences are observed, exploratory analyses can be employed using different cut-off points of the income scale.

Questions 13 thru 16 relate to the population segment D and D*. Population segment D data are used to create baseline measures where only comparison of measures will be made to a future date during the Demonstration. Otherwise, data from population segments D and D* will be merged to develop statistical models and for case-control studies. Note: population segment D* will have new members who were on the uninsured or on the Core Plan waitlist before implementation of the Demonstration and were enrolled to BadgerCare Plus after the Demonstration.

Question 13. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries result in improved health outcomes?

Hypothesis 13.1: Childless adults who were previously (prior to April 1, 2014) enrolled in the BadgerCare Plus Core Plan will have better health outcomes in the demonstration than prior to the demonstration due to the enhanced benefit package in the Standard Plan such as mental health and dental.

Hypothesis 13.2: Newly eligible childless adults enrolled in the Standard Plan starting on April 1, 2014 will have better health outcomes as compared to the childless adults enrolled in the Core Plan for a similar period of enrollment during the demonstration.

Outcome Variable: Health Outcome Measures as shown in the following Table 3.

Table 5: Outcome Measures Frequently used by DHS to Determine Healthcare Quality

Focus Area	NQF Measure #	CMS Adult Core Set #	Measure
Preventive / Screening	0031	Measure 3	Breast Cancer Screening (BCS) (HEDIS-NCQA)
Chronic	0057	Measure 19	Comprehensive Diabetes Care- HbA1c Testing (HEDIS-NCQA)
	0063	Measure 18	Comprehensive Diabetes Care- LDL-C Screening (HEDIS-NCQA)
Mental Health	0105	Measure 20	Antidepressant Medication Management (AMM- Effective Continuation Phase) (HEDIS)

	0004	Measure 25	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-Engagement of AOD Treatment) (HEDIS-NCQA)
			Tobacco Cessation (Counseling only) – Wisconsin specific measure – the percentage of adult smokers that received tobacco cessation counseling during the calendar year
	0576	Measure 13	Follow-up After Hospitalization for Mental Illness – 30 Days After Discharge (FUH-30) (HEDIS-NCQA)
Emergency Dept.			Ambulatory Care – Emergency Department Visits (AMB) sans revenue code 0456 (HEDIS-NCQA)

Wisconsin Medicaid will explore including additional health care outcomes measures from medical record data as agreed upon with HMOs and other Medicaid providers in the state. Some additional health care outcomes could also be derived from the survey questions.

Wisconsin Medicaid will include EPSDT measures as part of health care outcomes pending further analysis of the 19 to 20 age cohort covered under the Core Plan and the new childless adult population to assess cell size.

Predictor / Explanatory Variable(s): The health outcomes measures for the childless adult population who were covered by the Core Plan before implementation of the demonstration and during the demonstration. Hence the combination of time period and benefit plan is the predictor for this analysis.

Data Analysis Method: First, the basic analysis for this research question will be calculation and comparison of different measures over time. DHS has baseline data and values for the measures in Table 3 for the BadgerCare Plus Standard Plan population; for the Core Plan population, DHS has baseline data but not specific baseline values which can be calculated through administrative data using the algorithms developed by our fiscal vendor for the Standard Plan population. The baseline measures will be used for most of the comparison purposes. We propose to adjust some of the measures by suitable control variables, though HEDIS measures as described in the table above, are not adjusted by any covariates.

A second analysis will be to examine the changes in the likelihood that a member will receive screening, preventive and primary care services over time (during the years prior to the demonstration and the five-year duration of the study) will be examined as a function of the enhanced benefit package of the Standard Plan. This explanatory variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop generalized estimation equation (GEE) models and use a logistic regression model for the binary outcome variable(s).
Sub-group analyses (i.e., separate models for different sub-sections of the population) will be performed.

For case-control analyses a split-sample method will be used to assess the assignments of individuals to the case and control groups. The samples will be determined during the first year of the Demonstration and this division of the sample will be maintained during the rest of the study period for comparison purposes.

Question 14. Will this (as described in Question 13) achieve a reduction in the incidence of unnecessary services?

Hypothesis 14.1: For childless adults who were previously (prior to April 1, 2014) enrolled in the BadgerCare Plus Core Plan there will be a reduction in the incidence of unnecessary services (such as Emergency Department visits and Inpatient Stays for Ambulatory Care Sensitive Conditions,30-Day All Cause Readmissions) during the demonstration compared to prior to the demonstration due to the enhanced benefits provided in the Standard Plan, specifically mental health and dental.

Hypothesis 14.2: Newly eligible childless adults enrolled in the Standard Plan starting on April 1, 2014 will show more efficient utilization of services compared to the childless adults enrolled in the Core Plan for a similar period of enrollment during the demonstration.

Outcome Variable: Unnecessary services and avoidable events (such as Emergency Department visits and Inpatient Stays for Ambulatory Care Sensitive Conditions, 30-Day All Cause Readmissions and unnecessary medical services and devices).

Predictor / Explanatory Variable(s): Most notable predictor as described in the question is the effect of time and the enhanced benefit package.

Data Analysis Method: Changes in the number of unnecessary services over time (during the prior year and the five-year duration of the study) will be examined as a function of the enhanced benefit package provided in the Standard Plan. This explanatory variable as well as some of the control variables (e.g., age, risk score, income level) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s) and perform sub-group analyses (i.e., separate models for different sub-sections of the population). For case-control analyses a split-sample method will be used to assign individuals to the case and control groups. The samples will be determined during the first year of the Demonstration and this division of the sample will be maintained during the rest of the study period for comparison purposes.

Question 15. Will the provision increase the cost effectiveness (Outcomes/Cost) of Medicaid services?

Hypothesis 15.1: For childless adults who were previously (prior to April 1, 2014) enrolled in the BadgerCare Plus Core Plan there will be increased cost effectiveness during the demonstration than prior to the demonstration due to the enhanced benefits provided in the Standard Plan, specifically mental health and dental.

Hypothesis 15.2: Newly eligible childless adults enrolled in the Standard Plan starting on April 1, 2014 will show higher cost effectiveness compared to the childless adults enrolled in the Core Plan for a similar period of enrollment during the demonstration.

Outcome Variables: Cost-Effectiveness will be determined as to whether changes in cost resulted in better health outcomes. In this case the cost variable(s) will be determined as total cost of care per member and the health outcomes will be that are listed in Table 3, screening / preventive measures, chronic condition management, mental health related measures and frequency of ED visits.

Predictor / Explanatory Variable(s): Most notable predictor as described in the question is the effect of time and the enhanced benefit package.

Data Analysis Method: Changes in the number of unnecessary services over time (during the prior year and the five-year duration of the study) will be examined as a function of the enhanced benefit package provided in the Standard Plan. This explanatory variable as well as some of the control variables (e.g., age, risk score, income level) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s) and perform sub-group analyses (i.e., separate models for different sub-sections of the population). For case-control analyses a split-sample method will be used to assign individuals to the case and control groups. The samples will be determined during the first year of the Demonstration and this division of the sample will be maintained during the rest of the study period for comparison purposes.

Question 16. Will the provision increase the cost effectiveness (Utilization/Cost) of Medicaid services?

Hypothesis 16.1: For childless adults who were previously (prior to April 1, 2014) enrolled in the BadgerCare Plus Core Plan there will be increased cost effectiveness during the demonstration than prior to the demonstration due to the enhanced benefits provided in the Standard Plan, specifically mental health and dental.

Hypothesis 16.2: Newly eligible childless adults enrolled in the Standard Plan starting on April 1, 2014 will show higher cost effectiveness compared to the childless adults enrolled in the Core Plan for a similar period of enrollment during the demonstration.

Outcome Variable: Cost-Effectiveness will be determined as to whether changes in cost resulted in fewer unnecessary utilization healthcare services. In this case the cost variable(s) will be determined as total cost of care per member that can be used along with the measure of unnecessary services (such as Emergency Department visits and Inpatient Stays for Ambulatory Care Sensitive Conditions (ASCs), 30-day all cause readmissions, and overall inpatient stays).

Predictor / Explanatory Variable(s): Most notable predictor as described in the question is the effect of time and the enhanced benefit package.

Data Analysis Method: The effect may vary by income level or any other demographic variables. So some adjustment by control variables are also proposed for this question. The means test will determine any significant difference in cost-effectiveness measures from before to after demonstration.

There will also be an analysis of the changes in cost-effectiveness (specifically aimed at reduction of unnecessary services), during the prior year and the five-year duration of the study, as explained by the enhanced benefit package provided in the Standard Plan. This outcome variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population) are proposed.

For the case-control matching study, the control group will be identified by propensity score matching and the split-sample technique used to determine the sensitivity of bias present in the matching method. The case and control samples will be determined during the first year of the Demonstration. This division of the sample will be maintained during the rest of the study period for comparison purposes.

Question 17. Will it demonstrate an increase in the continuity of health coverage?

Hypothesis 17.1: For childless adults who were previously (prior to April 1, 2014) enrolled in the BadgerCare Plus Core Plan there will be an increase in the continuity of coverage in the demonstration compared to prior to the demonstration due to the enhanced benefits provided in the Standard Plan, specifically mental health and dental.

Hypothesis 17.2: Newly eligible childless adults enrolled in the Standard Plan starting on April 1, 2014 will show an increased continuity of coverage compared to the childless adults enrolled in the Core Plan for a similar period of enrollment during the demonstration.

Outcome Variable: Any preferred measure of Continuity of Coverage. The measure will be calculated by combining data from claims and eligibility. Moreover, the continuity of care will be determined as part of the survey to CLAs related to usual sources of care and their experience in getting needed care before and after the demonstration.

Predictor / Explanatory Variable(s): Enrollment binary variable.

Data Analysis Method: Comparison between before and after implementation of Demonstration will be made and the measure will be analyzed over time.

A summary of the analysis plan for each of the questions is provided, below, as Table 4.

Table 6: BadgerCare Reform Demonstration Evaluation Data Analysis Plan

Research Question	Proposed Variables in analysis and/or model development			Anticipated Analysis level & Comments	Proposed Data Analysis Method
	Outcome Variable	Predictors / Independent Variable(s)	Control Variables		
For the TMA: Demonstration participants: Payment of Premiums					
1. Will the premium requirement reduce the incidence of unnecessary services?	Unnecessary ED Visits as defined in Billings et al., (2000) paper. Ambulatory Care Sensitive Visits (Non-Emergent, Primary Care Treatable, Avoidable). Also, 30-Day All Cause Readmissions and Unnecessary Medical Services & Devices.	FPL (hence sliding scale premium)	Demographics (Age[Group], Gender, Race & Ethnicity), Education, County, Region, Risk Score[ACG or CDPS], belongs to MCO or FFS, Tribal population*. Some risk scores use Age and Gender as predictors. In that case, age and gender can be dropped for modelling purposes.	Beneficiary level analysis. The control sample will be selected by split-sample method from within the TMA Adults population	Changes in the number of unnecessary services over time (during the prior year and the five-year duration of the study) will be examined as a function of the individual premium payment levels determined by the premium schedule. This explanatory variable as well as some of the control variables (e.g., age, risk score) are time- varying covariates. Therefore, it is proposed to develop longitudinal regression models for outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population).
2. Will the premium requirement lead to improved health outcomes?	The outcome variables will be recorded as member-specific data. The screening, preventive and primary care indicators are binary variables based on whether a member reported to have obtained the age, gender, and chronic condition specific services specified by NCQA for relevant HEDIS measures.	FPL (hence sliding scale premium)		Beneficiary level analysis. The control sample will be selected by split-sample method from within the TMA Adults population	The changes in the likelihood that a member will receive screening, preventive and primary care services over time (during the prior year and the five-year duration of the study) will be examined as a function of the individual premium payment levels determined by the premium schedule. This explanatory variable as well as some of the control variables (e.g., age, risk score) are time- varying covariates. Therefore, we are proposing to develop generalized estimation equation (GEE) models for the binary outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population) will be performed.
3. Will the premium requirement slow the growth in healthcare spending?	Allowed Amount will be used as the outcome variable for all cost calculations. This will be calculated as the amount paid by Wisconsin Medicaid for services based on the maximum allowable fee schedule or the capitation payments made to Medicaid HMOs.	FPL (hence sliding scale premium)		Beneficiary level analysis. The control sample will be selected by split-sample method from within the TMA Adults population	Healthcare spending over time (during the prior year and the five-year duration of the study) will be evaluated as a function of individual premium payment level. This explanatory variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population) are proposed.

4. Will the premium requirement increase the cost effectiveness (Outcomes/Cost) of Medicaid services?	Cost-Effectiveness is usually calculated as cost divided by a measure of health outcomes. In this case the cost variable(s) utilized in Question 2 can be used along with the measure of unnecessary services utilized in Question 1.	FPL (hence sliding scale premium).		Beneficiary level analysis. The control sample will be selected by split-sample method from within the TMA Adults population	The need is to analyze the changes in cost-effectiveness (specifically aimed at unnecessary services over time), during the prior year and the five-year duration of the study, as explained by the individual premium payment requirements by FPL. This outcome variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population) are proposed.
5. Will the premium requirement increase the cost effectiveness (Utilization/Cost) of Medicaid services?	Cost-Effectiveness will be determined as to whether changes in cost resulted in fewer unnecessary utilization healthcare services. In this case the cost variable(s) used in Question 2 can be used along with the measure of unnecessary services (such as Emergency Department visits and Inpatient Stays for Ambulatory Care Sensitive Conditions (ASCs), 30-Day All Cause Readmissions, and overall inpatient stays).	FPL levels defined in terms of levels on the sliding premium scale.		Beneficiary level analysis. The control sample will be selected by split-sample method from within the TMA Adults population	The need is to analyze the changes in cost-effectiveness (specifically aimed at reduction of unnecessary services), during the prior year and the five-year duration of the study, as explained by the individual premium payment requirements by FPL. This outcome variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population) are proposed. For case-control matching study, the control group will be identified by propensity score matching method and the split-sample technique used to determine the sensitivity of bias present in matching method. The case and control samples will be determined during the first year of the Demonstration. This division of the sample will be maintained during the rest of the study period for comparison purposes.
Association of Enrollment Status to Utilization and/or Costs					
6. Is there any impact on utilization and/or costs associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?	Unnecessary ED Visits as defined in Billings et al., (2000) paper. Ambulatory Care Sensitive Visits (Non-Emergent, Primary Care Treatable, Avoidable). Also, 30-Day All Cause Readmissions and Unnecessary Medical Devices. Overall PMPY Cost of Care (Medical and Pharmacy Expenditures). Allowed Amount will be considered for cost calculations.	FPL (hence sliding scale premium). Disenrollment/Re-enrollment history (Identify few frequent patterns of disenrollment / re-enrollment and create dummy variables on those patterns).	Demographics (Age[Group], Gender, Race & Ethnicity), Education, County, Region, Risk Score[ACG or CDPS], belongs to MCO or FFS, Tribal population*. Some risk scores use Age	Beneficiary level analysis. The control sample will be selected by split-sample method from within the TMA Adults population	Longitudinal regression methods are proposed for this analysis. The enrollment / disenrollment / re-enrollment information can be used multiple ways. Indicator variables can be developed to identify whether a member had any of these statuses within a certain unit of time and these variables will be added to the regression model. Alternatively, the enrollment status can be counted and categorized to discover differential effects of disenrollment/re-enrollment vs. continuous enrollment.

7. Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for individuals that have disenrolled and then re-enrolled?	Unnecessary ED Visits as defined in Billings et al., (2000) paper. Ambulatory Care Sensitive Visits (Non-Emergent, Primary Care Treatable, Avoidable). Also, 30-Day All Cause Readmissions and Unnecessary Medical Devices. Overall PMPY Cost of Care (Medical and Pharmacy Expenditures). Allowed Amount will be considered for cost calculations.	FPL (hence sliding scale premium). Disenrollment/Re-enrollment history (Identify few frequent patterns of disenrollment / re-enrollment and create dummy variables on those patterns).	and Gender as predictors. In that case, age and gender can be dropped for modelling purposes.	Beneficiary level analysis. The control sample will be selected by split-sample method from within the TMA Adults population	Longitudinal regression methods are proposed for this analysis. The enrollment / disenrollment / reenrollment information can be used multiple different ways. Indicator variable can be developed whether a member had any of these statuses within a certain unit of time and use the variable in models. Otherwise, the enrollment status can be counted and categorized to discover differential effects.
Enrollment Analysis by Payment of Premiums					
8. What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?	Disenrollment/Re-enrollment history (Identify few frequent patterns of disenrollment / re-enrollment and create dummy variables on those patterns).	FPL (hence sliding scale premium) with possible categorization into wider intervals (smaller number of buckets). Appendix 1.	Demographics (Age[Group], Gender, Race & Ethnicity), Education, County, Region, Risk Score[ACG or CDPS], belongs to MCO or FFS, Tribal population*. Some risk scores use Age and Gender as predictors. In that case, age and gender can be dropped for modelling purposes.	Beneficiary level Analysis. The control sample will be selected by split-sample method from within the TMA Adults population	Depending on the type of outcome variable that is used the analysis method will be selected. For example, if enrollment / disenrollment indicator is a categorical variable then either logistic regression analysis or generalized linear models can be employed to answer the research question.
9. How is enrollment or access to care affected by the application of new, or increased, premium amounts?	Access to care can be defined through survey questions related to whether members have a primary care physician and if they have had difficulties scheduling appointments with providers for needed care.	FPL (hence sliding scale premium) with possible categorization into wider intervals (smaller number of buckets). Appendix 1. Also, dummy variables can be created to depict if the premium payment is new or an increased amount from past payments.		Beneficiary level Analysis. The control sample will be selected by split-sample method from within the TMA Adults population	Generally 'Access To Care' can be determined as continuous or discrete variable, depending on the emphasis of the domain of care. Based on that determination appropriate regression model can be developed for longitudinal data. The source of these data will be enrollment surveys.
Payment of Premiums and 3-Month Restrictive Re-enrollment					
10. What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment?	This is a Dyad Outcome. A suitable combination category class can be created based on amount of premium and pattern of enrollment / disenrollment. The categories will be created so that variability are observed based on 3-month restrictive enrollment.	This is a Binary variable and determined whether any member had experienced this condition or not.	Demographics (Age[Group], Gender, Race & Ethnicity), Education, County, Region, Risk Score[ACG or CDPS], belongs to MCO	Beneficiary level analysis. The control sample will be selected by split-sample method from within the TMA Adults population	The categorization of dual outcome variables will create a nominal variable since there may not be a logical ordering between the categories. The logistic regression method for nominal variables may be applied to answer this research question.

11. Does this impact vary by income level?	This is a Dyad Outcome. A suitable combination category class can be created based on amount of premium and pattern of enrollment / disenrollment. The categories will be created so the variability are observed based on 3-month restrictive enrollment.	As income level is associated with premium payment, which is the outcome variable, the predictor must be carefully defined so that it is separated form outcome.	or FFS, Tribal population*. Some risk scores use Age and Gender as predictors. In that case, age and gender can be dropped for modelling purposes.	Beneficiary level analysis. The control sample will be selected by split-sample method from within the TMA Adults population	The categorization of dual outcome variables will create a nominal variable since there may not be a logical ordering between the categories. The logistic regression method for nominal variables may be applied to answer this research question.
12. If there is an impact, explore the break-out by income level.	This is a Dyad Outcome. A suitable combination category class can be created based on amount of premium and pattern of enrollment / disenrollment. The categories will be created so that variability is observed based on 3-month restrictive enrollment.	As income level is associated with premium payment, which is the outcome variable, the predictor must be carefully defined so that it is separated form outcome.		Beneficiary level analysis. The control sample will be selected by split-sample method from within the TMA Adults population	To find the break-out point(s) in the income level that makes significant difference in outcome variable, exploratory analyses can be employed using different cut-off points of the income scale.
For Childless Adults: Effects of the Benefit Plan for demonstration expansion group					
13. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries result in improved health outcomes?	Health Outcome Measures as shown in Table 2.	Groups that will be predictors are: CLA population and Core Plan Group.	Demographics (Age[Group], Gender, Race & Ethnicity), Education, County, Region, Risk Score[ACG or CDPS], belongs to MCO or FFS, Tribal population*. Some risk scores use Age and Gender as predictors. In that case, age and gender can be dropped for modelling purposes.	Aggregate level analysis: Baseline measures are calculated for the start of the study period and compared with similar measures from before and after the implementation. Beneficiary level analysis. The control sample will be selected by split-sample method from within the CLA Adults population.	The basic analysis for this research question will be calculation and comparison of different measures over time. The baseline measures will be used for most of the comparison purposes. We propose to adjust some of the measures by suitable control variables, though HEDIS measures as described in the table above, are not adjusted by any covariates. A second analysis will be to examine the changes in the likelihood that a member will receive screening, preventive and primary care services over time (during the years prior to the demonstration and the five-year duration of the study) will be examined as a function of the enhanced benefit package of the Standard Plan. This explanatory variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop generalized estimation equation (GEE) models and use a logistic regression model for the binary outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population) will be performed. For case-control analyses a split-sample method will be used to assess the assignments of individuals to the case and control groups. The samples will be determined during the first year of the Demonstration and this division of the sample will be maintained during the rest of the study period for comparison purposes.

14. Will this achieve a reduction in the incidence of unnecessary services?	Unnecessary ED Visits as defined in Billings et al., (2000) paper. Ambulatory Care Sensitive Visits (Non-Emergent, Primary Care Treatable, Avoidable). Also, 30-Day All Cause Readmissions and Unnecessary Medical Devices.	Before and after implementation comparison.		Beneficiary level analysis. The control sample will be selected by split-sample method from within the CLA Adults population	: Changes in the number of unnecessary services over time (during the prior year and the five-year duration of the study) will be examined as a function of the enhanced benefit package provided in the Standard Plan. This explanatory variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s) and perform sub-group analyses (i.e., separate models for different sub-sections of the population). For case- control analyses a split-sample method will be used to assign individuals to the case and control groups. The samples will be determined during the first year of the Demonstration and this division of the sample will be maintained during the rest of the study period for comparison purposes.
15. Will the provision increase the cost effectiveness (Outcomes/Cost) of Medicaid services?	Cost-Effectiveness will be determined as to whether changes in cost, even though increment, resulted in better health outcomes. In this case the cost variable(s) will be determined as total cost of care per member and the health outcomes will be that are listed in Table 4.2, screening / preventive measures, chronic condition management, mental health related measures and frequency of ED visits.	Before and after implementation comparison.		Beneficiary level analysis. The control sample will be selected by split-sample method from within the CLA Adults population	Changes in the number of unnecessary services over time (during the prior year and the five-year duration of the study) will be examined as a function of the enhanced benefit package provided in the Standard Plan. This explanatory variable as well as some of the control variables (e.g., age, risk score, income level) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s) and perform sub-group analyses (i.e., separate models for different sub-sections of the population). For case-control analyses a split-sample method will be used to assign individuals to the case and control groups. The samples will be determined during the first year of the Demonstration and this division of the sample will be maintained during the rest of the study period for comparison purposes.

16. Will the provision increase the cost effectiveness (Utilization/Cost) of Medicaid services?	Cost-Effectiveness will be determined as to whether changes in cost, even though increment, resulted in fewer unnecessary utilization healthcare services. In this case the cost variable(s) will be determined as total cost of care per member that can be used along with the measure of unnecessary services (such as Emergency Department visits for Ambulatory Care Sensitive Conditions (ASCs), 30-day all cause readmissions, and overall inpatient stays).	Most notable predictor as described in the question is the effect of time.		Beneficiary level analysis. The control sample will be selected by split-sample method from within the CLA Adults population	The effect may vary by income level or any other demographic variables. So some adjustment by control variables are also proposed for this question. The means test will determine any significant difference in cost-effectiveness measures from before to after demonstration. There will also be an analysis of the changes in cost-effectiveness (specifically aimed at reduction of unnecessary services), during the prior year and the five-year duration of the study, as explained by the enhanced benefit package provided in the Standard Plan. This outcome variable as well as some of the control variables (e.g., age, risk score) are time-varying covariates. Therefore, we are proposing to develop longitudinal regression models for outcome variable(s). Sub-group analyses (i.e., separate models for different sub-sections of the population) are proposed. For the case-control matching study, the control group will be identified by propensity score matching and the split-sample technique used to determine the sensitivity of bias present in the matching method. The case and control samples will be determined during the first year of the Demonstration. This division of the sample will be maintained during the rest of the study period for comparison purposes.
17. Will it demonstrate an increase in the continuity of health coverage?	Measure of Continuity of Coverage.	Before and after implementation comparison.		Beneficiary level analysis. The control sample will be selected by split-sample method from within the CLA Adults population	The effect may vary by income level or any other demographic variables. So some adjustment by control variables are also proposed for this question.

5. Data Collection Methods

Data will be collected from 3 main sources over the course of the evaluation. The two basic sources are the interChange System enrollment and claims data (captured and maintained by HP Enterprise Services, hereinafter identified as 'Enrollment and Claims/Encounter Data') and the Eligibility CARES data (captured and maintained by Deloitte, hereinafter mentioned as 'Eligibility Data'). A periodic data collection schedule will be developed by the evaluator according to analytical and reporting needs. The data fields needed to answer research questions and to create the measure to report to CMS periodically will be determined by the evaluator.

These two data sources are updated on a regular basis and hence the periodic data extraction will capture all the latest updates. To develop the baseline data, the evaluator will use Medicaid eligibility and claims data extracted at the beginning of the demonstration. All claims and eligibility data for those members will be collected twenty-four months prior to the implementation start date (April 2, 2014). These data will be archived for the exclusive use of the evaluation project, and the data format and storage location will be determined by the evaluator.

For all case-control matching analyses, since the income level (FPL) is a major matching variable, we propose to adopt a split-sample approach to define the control group. The cohort of new members joining the segments will be included into the segments for analysis purposes. The new members may be treated separately for the case-control study since those members will not have sufficient data from before implementation date.

In the middle of the demonstration and at the end of the study period, the enrollment / disenrollment / reenrollment survey will be administered by the evaluator. The survey information will be augmented with enrollment and claims data and eligibility data to provide a deeper understanding of the member perspective about premium payments, 3-month restrictive reenrollment and its' effect on health outcomes, continuity of coverage and cost of providing health care.

6. Quarterly Progress Report Contribution

Where appropriate and practical, summary statistics will be broken out by the levels of covariates such as FPL, gender, etc. to provide consistent indicators of program performance throughout the Demonstration period, however, no inferential statistics will be calculated until the second yearly report—at which time interim findings pertaining to sub-group differences in process outcomes, health outcomes, and cost-savings may be included in the quarterly progress reports.

7. Estimated Evaluation Budget

As noted previously DHS intends to contract with an independent evaluator during the second year of the demonstration and will conduct two surveys during the course of the demonstration. DHS will produce an evaluation budget as part of the contracting process,. DHS contracted with the University of Wisconsin (UW) Population Health Institute to complete the evaluation for the Wisconsin Medicaid Section 1115 Health Care Reform Demonstration (BadgerCare) (11-W-00125/5) and Childless Adults Section 1115 Demonstration (11-W-00242/5).

The UW Population Health Institute conducted one survey (at the end of the demonstrations) along with the data evaluation. The total cost for the survey and evaluation for the two expiring waivers is $400,000. DHS anticipates that the costs to conduct the evaluation for the current demonstration will be higher than the expiring demonstrations due to the additional survey and evaluation in demonstration year 3. DHS estimates the cost to be between $500,000 and $800,000.

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ATTACHMENT B: UW EVALUATION DESIGN REPORT
Recommended Changes and Crosswalk to DHS Evaluation

EVALUATION OF WISCONSIN'S BADGERCARE PLUS HEALTH COVERAGE

for

PARENTS & CARETAKER ADULTS AND FOR CHILDLESS ADULTS

2014 CMS Section 1115 Waiver Provision

Design Report: Analytic Methods

Submitted to the
WISCONSIN DEPARTMENT OF HEALTH SERVICES
December, 2015

by the
Health Policy Research Team
UW Population Health Institute

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I. INTRODUCTION/BACKGROUND

The UW Population Health Institute (The Institute) is conducting an evaluation of the Wisconsin BadgerCare Reform Demonstration Project, as outlined by the Wisconsin Department of Health Services (DHS) and approved by the federal Centers for Medicare and Medicaid Services (CMS). The evaluation uses rigorous methods to arrive at an understanding of how the changes implemented under Wisconsin's 2014 Medicaid 1115 Waiver Demonstration affect two Medicaid populations —(1) those individuals who are eligible for Medicaid through Transitional Medical Assistance (TMA Adults) and (2) those childless adults (CLAs) with an effective income level at, or below, 100% of the federal poverty level (FPL).

The evaluation will address the 17 evaluation questions defined by DHS in the "BadgerCare Reform Demonstration Draft Evaluation Design" of 10/31/2014. Building on this draft design, the Institute's team will utilize state-of-the art social scientific methods to rigorously answer each question. This design report outlines the selected methodological and statistical approaches, fulfilling the first deliverable for the project.

The design report proceeds as follows. We first summarize the proposed methods according to each evaluation question in Table 1 and then describe the data sources required for this evaluation. Our detailed explanation of the methodological approaches specific to each evaluation question is organized according to the programmatic changes authorized by the 1115 Waiver: Premium changes; 3-month RRP; and Standard Plan coverage for CLAs. Finally, an attachment at the end of this document provides a cross-walk between the evaluation team's plans and the DHS' Draft design, to clarify how this design report aligns with and meets the DHS and CMS evaluation objectives.

Table 1 Evaluation Questions and Associated Data Analysis Methods

Evaluation Question	Evaluation Method			
	Administrative Data		Survey Data	
	Descriptive Analysis	Causal Analysis	Descriptive Analysis	Causal Analysis
For TMA demonstration participants: Payment of Premiums				
1: Will the premium requirement reduce the incidence of unnecessary services?	X	DD & WP		
2: Will the premium requirement lead to improved health outcomes?	X	DD & WP		
3: Will the premium requirement slow the growth in healthcare spending?	X	DD & WP		
4: Will the premium requirement increase the cost effectiveness (Outcomes/Cost) of Medicaid services?	X	DD & WP		
5: Will the premium requirement increase the cost effectiveness (Utilization/Cost) of Medicaid services?	X	DD & WP		
Association of enrollment status to utilization and costs				
6: Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?	X	WP	X	
7: Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for beneficiaries that have disenrolled and then re-enrolled?	X	DD		
Enrollment analysis by payment of premiums				
8: What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?	X	ITS & RD		
9: How is access to care affected by the application of new, or increased, premium amounts?		RD[a]	X	RD[a]
Payment of Premiums and Three Month Restrictive Re-enrollment				
10: What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment?	X	HZ		
11: Does the RRP impact vary by income level?	X			
12: If there is an impact from the RRP, explore the break-out by income level.	X			
For CLA Adults: Effects of the Benefit Plan for Demonstration Expansion Group				
13. Will the provision of a benefit plan that is the same as the one provided to all	X	DD		

other BadgerCare adult beneficiaries result in improved health outcomes?				
14. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries achieve a reduction in the incidence of unnecessary services?	X	DD		
15. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Outcomes/Cost) of Medicaid services?	X	DD		
16. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Utilization/Cost) of Medicaid services?	X	DD		
17. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?	X	DD	X	WP[b]

Legend:
DD = Differences-in-Differences
ITS = Interrupted Time Series
RD= Regression Discontinuity
WP = Longitudinal within-person analysis
HZ = Hazard modeling

[a] Contingent on approval and feasibility of matching survey data to CARES data.
[b] Continent upon sufficient sample size for panel compo

II. DATA SOURCES

The evaluation will require administrative data from the Wisconsin DHS on (a) claims and encounters, (b) diagnostic codes, (c) enrollment, and disenrollment reason codes, and (d) premium payment information. We will also conduct a survey, in 2016 and 2018, of current and disenrolled members, assessing measures of utilization, health, and response to premiums.

A. Administrative Data from Wisconsin DHS

1. Enrollment Data

We will use longitudinal administrative data from the CARES system to measure enrollment. CARES also contains demographic information, including age, sex, educational attainment, county of residence, income, and income sources. The CARES data may contain data about an applicant's health insurance status at the time of application, although we have found previously that these fields are only regularly filled for the subset of enrollees for which this question is applicable (i.e., those for whom crowd-out provisions pertain.)

From these data, we will ascertain, where relevant, the month a person disenrolled from BadgerCare Plus (BC+). We will utilize reason codes associated with disenrollment. Further, these data contain "premium payment files" that contain monthly information on the dollar amount of premium owed, whether it was paid, and the date of payment.

2. Unemployment Insurance Earnings Data

We will use longitudinal administrative data from the Unemployment Insurance earnings reporting system to augment the enrollment data with individual measures of reported quarterly employment, wages, and firm industry code. In addition to these measures of individual-specific employment and wages (which are only available at case-level in CARES) and industry of employment, the unemployment insurance earnings data will allow us to assess the employment dynamics of individuals who transition from standard BadgerCare Plus into TMA.

3. Claims/Encounter Data

We will obtain claims and encounter data from the State's MMIS claims database. These data files include detailed ICD-9 diagnostic codes. We will draw claims data for the period from February 2008 (the beginning of the BC+ program) throughout the end of the current 1115 demonstration period. The claims and encounter data contain detailed information on diagnoses, procedure, and billing codes from which we will construct outcomes measures of health care use including health-related measures, general care use, and unnecessary care use as summarized in Table 2. Our health care use measures will include all-cause emergency department (ED) visits, inpatient hospitalizations, and outpatient visits. We will further categorize ED and inpatient measures of utilization into visits/admissions for ambulatory care sensitive conditions (ACSC) and preventable hospitalizations. Likewise, we will examine types of outpatient visits (e.g., primary, specialty and dental care).

ED visits will be measured as a day with an ED claim, identified using procedure billing codes. ACSC ED visits will be defined following Billings et al., (2000) and using the corresponding algorithm. Using this method, an ED visit is classified on a probabilistic basis into one of five categories, with the first three considered ACSC: (1) non-emergent, (2) emergent/primary care treatable, (3) emergent but preventable, and (4) emergent not preventable, (5) injuries, mental health, drug or alcohol, other.

Hospitalizations will be measured as the number of hospital stays, using bed day revenue codes to identify them in the claims. This analysis will distinguish between new admissions and transfers between hospitals, as transfers should not be considered new hospitalizations. Since transfers cannot be observed directly, any gap of less than two days between an admission and a discharge or last bed day will be considered a transfer.

Table 2 Health and health care outcome measures derived from MMIS data

Focus	Data Source	Description	Evaluation Question
Health-related			
Preventive health			
Breast cancer screening (BCS)	MMIS	NQF measure 0031; CMS adult core set #3;	1-7, 9, 13,15
Influenza immunization	MMIS	NQF measure 0041	1-7, 9, 13,15
Chronic health			
Diabetes care HBA1c testing	MMIS	NQF measure 0057; CMS adult core set #19	1-7, 9, 13,15
Diabetes care-LDL-C screening	MMIS	NQF measure 0063; CMS adult core set #18	1-7, 9, 13,15
Mental health & substance use disorder			1-7, 9, 13,15
Antidepressant medication management	MMIS	NQF measure 0105; CMS adult core set #20	1-7, 9, 13,15
Follow-up within 30 days after hospitalization for mental illness	MMIS	NQF measure 0576; CMS adult core set #13	1-7, 9, 13,15
Tobacco cessation counseling	MMIS		1-7, 9, 13,15
Initiation and engagement of alcohol and other drug dependence treatment	MMIS	NQF measure 0004; CMS adult core set #25	1-7, 9, 13,15
Health care use, general			
Office-based visits	MMIS	Non-emergency department outpatient and office-based visits, total and defined by type (e.g., dental, primary, specialty)	1-7, 9, 13,15
Emergency department visits	MMIS	ED visits, all cause	1-7, 9, 13,15
Inpatient admissions	MMIS	Inpatient admissions, all cause	1-7, 9, 13,15

Potentially avoidable/unnecessary health care use			
30-day all cause hospital readmission	MMIS		1-5, 9, 14,16
Emergency department visit for ambulatory care sensitive condition (ACSC)	MMIS		1-5, 9, 14,16
Inpatient stay for ACSC	MMIS		1-5, 9, 14,16
Preventable hospitalization	MMIS		1-5, 9, 14,16

Preventable hospitalizations will be measured using AHRQ (2010) Preventive Quality Indices (PQIs). PQIs indicate conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The PQIs considered here will be hospital admissions due to the following: (1) short-term complications from diabetes, (2) perforated appendix, (3) long-term complications from diabetes, (4) chronic obstructive pulmonary disease (COPD), (5) hypertension, (6) congestive heart failure, (7) dehydration, (8) bacterial pneumonia, (9) urinary tract infection, (10) angina without procedure, (11) asthma.

Outpatient visits will be measured as the number of provider-day visits. Total outpatient visits will be defined using a procedure code that is used only for outpatient visits (which includes skilled nursing visits). We will follow HEDIS, CMS, and NQF technical specifications as appropriate to construct the measures of health-related care use identified in Table 2.

Health care costs will be estimated by using FFS allowable charges for FFS visits and by imputing costs for Medicaid managed care encounters using the same FFS schedule of allowable charges. Monthly costs per member will be calculated by summing the total amount spent on visits in all service categories by each member, and then dividing by the number of months enrolled.

B. Survey Data

We will utilize the UW Survey Center to conduct surveys for this project. We will conduct a mixed-mode mail and telephone survey to reach a statistically valid sample of the three study cohorts:

- BadgerCare TMA current
- BadgerCare RRP – both those currently in an RRP and those returned from an RRP
- BadgerCare Childless Adults- both currently enrolled and those who were enrolled prior to March 2014

In order to develop a longitudinal panel that can facilitate over-time comparisons, where possible the survey will resample from the 1,054 respondents from the Spring 2014 survey that was fielded under the prior BadgerCare waiver evaluation. We anticipate that more than half of the new survey sample will be comprised of resampled respondents.

The survey design and process will be based on and informed by that utilized by the Oregon Health Study[4], the Urban Institute's Health Reform Monitoring Survey[5],the RAND Patient Satisfaction Survey[6] , and lessons learned administering the national Medicaid CAHPS[7] and elsewhere[8]. The survey will include questions pertaining to health care coverage and utilization during enrollment and during the time not enrolled in BadgerCare, about health status, and about the effect of premiums on enrollment decisions.

The survey will be fielded in Spring 2016 and Spring 2018. It will include an initial mailing with two follow-up letters, and then a telephone follow-up interview to selected respondents and non-respondents. Tracking methods will be utilized to locate individuals no longer BadgerCare-enrolled who are not reached through state-provided addresses information.

[4] Finkelstein A, et al. The Oregon Health Insurance Experiment: Evidence from the First year.. National Bureau of Economic Research, NBER Working Paper No. 17190, July 2011.

[5] Urban Institute. Health Reform Monitoring Survey. Available at http://hrms.urban.org/about.html

[6] Patient Satisfaction Questionnaire from RAND Health. Available at http://www.rand.org/health/surveys_tools/psq.html

[7] CMS Technical Assistance Brief Number 3.Guidance for Conducting the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H Child Survey. December 2012.

[8] Beebe TJ, Davern ME, McAlpine DD, Call KT, Rockwood TJ. (2005) Increasing Response Rates in a Survey of Medicaid Enrollees: The Effect of a Prepaid Monetary Incentive and Mixed Modes (Mail and Telephone. Medical Care.Vol 43(4).

III. METHODOLOGICAL & STATISTICAL APPROACH

Payment of Premiums and The Effect of Premiums: Questions 1-5, 8,9

Question 1: Will the premium requirement reduce the incidence of unnecessary services?

A. DHS proposed: "Case Study", "Administrative Data Analysis", and "Case-Control Matching" by statistically matching those who drop out of TMA within 12 months of premium implementation to those who do not drop out.

B. Evaluation Team Proposes:

1. Method

a. Descriptive analysis of administrative data. We will provide rates of unnecessary service use over time by TMA status, income, premium payment status, and other demographic characteristics available through CARES. We will include tabulations as well as a graphical and regression analysis.

b. *Causal analysis of administrative data*. We will use a difference-in-differences study design to compare rates of unnecessary service use for those affected by the policy (Treatment Group 1) to those not affected by the policy (Comparison Group 1 and Comparison Group 2 in separate analyses), over time. A purely descriptive analysis would not account for secular changes that might affect unnecessary service use nor the potential for selection into TMA status. This design allows us to identify the causal effect of premiums by assuming that the unnecessary service use for the treatment group would have evolved similarly over time as that of the comparison group(s) in the absence of the implementation of the premium requirement. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable. We will also perform a within-person analysis that considers whether outcomes change over time for those affected by the policy conditional on remaining enrolled.

2. Study Population

Among adults eligible to qualify for TMA, we will use two comparison groups common to Questions 1-5, 8 and 9 in order to isolate the effect of the premium requirements on the outcomes of interest. Comparison Group 1 is defined as all BadgerCare adults below 100% FPL beginning at least 2 years prior to the July 2012 original premium. Because this group never experienced any change in their premium requirements, they provide a good benchmark for general trends in health care usage, costs, and program enrollment. However, since the treatment group (TMA adults) were all originally members of MA adults, it is possible that the composition of Comparison Group 1 changes over time due to the new TMA premium policies. While we will study this directly under Question 8, we will also use an alternative comparison group, parents and caretakers who entered with incomes higher than 100% FPL and so are not eligible for TMA (Comparison Group 2).

Comparison Group 2 was subject to the same policy as TMA from July 2012 – March 2014 and may provide a better match for the TMA group after the time of their transition, as they have

similar income levels. The use of Comparison Group 2 will only be historical since Comparison Group 2 lost eligibility effective April 2014.

For the time dimension of the study, we will consider the outcomes of the treatment and comparison groups across three time periods: first, prior to any premium requirements; second, under the July 2012-April 2014 conditions; and finally, under the April 2014 – present conditions. (Table 3, below)

Table 3: Study Population 1, Premium Requirements for Treatment and Comparison Groups			
Timeline	Comparison Group 1	Comparison Group 2	Treatment Group
	MA adults (<100% FPL)	Higher-income parents/caretakers (100-200% FPL)	TMA adults
Prior to premium introduction (Feb 2008- June 2012)	Not required to pay premiums	Parents who enrolled at >150% FPL were required to pay premiums; those 100-150% were not	Not required to pay premiums
First premium policy (July 2012- March 2014)	Not required to pay premiums	Premiums introduced for 133-150%; increased for >150%	Premiums introduced for 133-200%
Current waiver premium policy (April 2014 – present)	Not required to pay premiums	No longer eligible	Premiums introduced for 100-133%

3. Data Requirements

Source:	Time	Purpose:
CARES	(February 2008 – present)	Identification of study population during and prior to TMA period
MMIS Claims	(February 2008 – present)	Identification of outcome measures for study population (Necessary/unnecessary emergency department visits, ambulatory care sensitive inpatient stays, 30 day all cause readmissions)

4. Expected Limitations

a. *Outcome measure.* While we will use empirically validated measures of the outcome, identification of "unnecessary" visits through claims data algorithms is an imperfect process and will inevitably misclassify some visits that were "necessary" as "unnecessary" and vice versa.
b. *Parallel trends assumption.* This assumption is required for the difference-in-differences analysis but is fundamentally untestable. If something other than the premium requirement changes for Treatment Group 1 but not the comparison groups at the same time as the premium requirement was implemented, the design would be invalid. While we are not aware of any obvious violations in this context, it should be noted as a potential limitation.

Question 2: Will the premium requirement lead to improved health outcomes?

A. **DHS proposed**: "Case Study", "Administrative Data Analysis", and "Case-Control Matching" by statistically matching those who drop out of TMA within 12 months of premium implementation to those who do not drop out.

B. **Evaluation Team Proposes**:

1. Method

a. Descriptive analysis of administrative data. Description of health-related outcomes over time by TMA status, income, premium payment status, and other demographic characteristics available through CARES. We will include tabulations and a graphical and regression analysis.

b. *Causal analysis of administrative data*. We will use a difference-in-differences study design to compare health-related outcomes for those affected by the policy (Treatment Group 1) to those not affected by the policy (Comparison Group 1 and Comparison Group 2 in separate analyses), over time. A purely descriptive analysis would not account for secular changes that might affect health-related outcomes nor the potential for selection into TMA status. This design allows us to identify the causal effect of premiums by assuming that the health-related outcomes for the treatment group would have evolved similarly over time as that of the comparison group(s) in the absence of the implementation of the premium requirement. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable. We will also perform a within-person analysis that considers whether outcomes change over time for those affected by the policy conditional on remaining enrolled.

2. **Study Population:** Same as Question 1

3. **Data Requirements**

Source	Time Frame	Purpose
CARES	(February 2008 – present)	Identification of study population during and prior to TMA period
MMIS Claims	(February 2008 – present)	Identification of health-related outcomes (Table 2)

4. Expected Limitations

a. *Outcome measure.* While we will use empirically validated measures as described in Table 2, identification of health-related outcomes through claims data algorithms is an imperfect process as it requires the enrollee to utilize the health care system in order to appear unhealthy.

b. *Parallel trends assumption.* This assumption is required for the difference-in-differences analysis but is fundamentally untestable. If something other than the premium requirement changes for Treatment Group 1 but not the comparison groups at the same time as the premium requirement was implemented, the design would be invalid. While we are not aware of any obvious violations in this context, it should be noted as a potential limitation.

Question 3: Will the premium requirement slow the growth in healthcare spending?

A. **DHS proposed**: "Case Study", "Administrative Data Analysis", and "Case-Control Matching" by statistically matching those who drop out of TMA within 12 months of premium implementation to those who do not drop out.

B. **Evaluation Team Proposes**:

1. Method

a. Descriptive analysis of administrative data. Description of healthcare spending over time by TMA status, income, premium payment status, and other demographic characteristics available through CARES. We will include tabulations and a graphical and regression analysis.

b. *Causal analysis of administrative data*. We will use a difference-in-differences study design to compare healthcare spending for those affected by the policy (Treatment Group 1) to those not affected by the policy (Comparison Group 1 and Comparison Group 2 in separate analyses), over time. A purely descriptive analysis would not account for secular changes that might affect healthcare spending nor the potential for selection into TMA status. This design allows us to identify the causal effect of premiums by assuming that the healthcare spending for the treatment group would have evolved similarly over time as that of the comparison group(s) in the absence of the implementation of the premium requirement. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable. We will also perform a within-person analysis that considers whether outcomes change over time for those affected by the policy conditional on remaining enrolled.

2. **Study Population:** Same as Questions 1 and 2

3. **Data Requirements**

Source	Time Frame	Purpose
CARES	(February 2008 – present)	Identification of study population during and prior to TMA period
MMIS Claims	(February 2008 – present)	Identification of healthcare spending outcomes

4. Expected Limitations

Parallel trends assumption. This assumption is required for the difference-in-differences analysis but is fundamentally untestable. If something other than the premium requirement changes for Treatment Group 1 but not the comparison groups at the same time as the premium requirement was implemented, the design would be invalid. While we are not aware of any obvious violations in this context, it should be noted as a potential limitation.

Question 4: Will the premium requirement increase the cost effectiveness (Outcomes/Cost) of Medicaid services?

A. **DHS proposed**: "Case Study", "Administrative Data Analysis", and "Case-Control Matching" by statistically matching those who drop out of TMA within 12 months of premium implementation to those who do not drop out.

B. **Evaluation Team Proposes**:

1. Method

a. *Descriptive analysis of administrative data.* Description of cost-effectiveness over time (as defined by the ratio of health-related outcomes to spending) by TMA status, income, premium payment status, and other demographic characteristics available through CARES. We will include tabulations and a graphical and regression analysis.

b. *Causal analysis of administrative data*. We will use a difference-in-differences study design to compare the health-related outcomes/spending ratio for those affected by the policy (Treatment Group 1) to those not affected by the policy (Comparison Group 1 and Comparison Group 2 in separate analyses), over time. A purely descriptive analysis would not account for secular changes that might affect the ratio of health-related outcomes to spending nor the potential for selection into TMA status. This design allows us to identify the causal effect of premiums by assuming that the health outcomes/spending ratio for the treatment group would have evolved similarly over time as that of the comparison group(s) in the absence of the implementation of the premium requirement. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable. We will also perform a within-person analysis that considers whether outcomes change over time for those affected by the policy conditional on remaining enrolled.

2. Study Population: Same as Questions 1-3

3. Data Requirements

Source	Time Frame	Purpose
CARES	(February 2008 – present)	Identification of study population during and prior to TMA period
MMIS Claims	(February 2008 – present)	Identification of health-related outcomes (Table 2) and healthcare spending

4. Expected Limitations

a. ***Outcome measure.*** While we will use empirically validated measures as described in Table 2, identification of health-related outcomes through claims data algorithms is an imperfect process as it requires the enrollee to utilize the health care system in order to appear unhealthy. We note that Outcomes/Cost is also not a typical measure of "cost-effectiveness", which is normally expressed as a denominator of a gain in health and a numerator of the cost associated with the health gain. Regardless, we will not be able to directly identify the specific costs of any particular change in health outcomes, only "changes in costs" and "changes in health outcomes" induced by the premium requirement.

b. ***Parallel trends assumption.*** This assumption is required for the difference-in-differences analysis but is fundamentally untestable. If something other than the premium requirement changes for Treatment Group 1 but not the comparison groups at the same time as the premium requirement was implemented, the design would be invalid. While we are not aware of any obvious violations in this context, it should be noted as a potential limitation.

Question 5: Will the premium requirement increase the cost effectiveness (Utilization/Cost) of Medicaid services?

A. **DHS proposed**: "Case Study", "Administrative Data Analysis", and "Case-Control Matching" by statistically matching those who drop out of TMA within 12 months of premium implementation to those who do not drop out.

B. **Evaluation Team Proposes**:

1. **Method**
   a. *Descriptive analysis of administrative data.* Description of cost-effectiveness over time (as defined by the ratio of healthcare utilization to spending) by TMA status, income, premium payment status, and other demographic characteristics available through CARES. We will include tabulations and a graphical and regression analysis.
   b. *Causal analysis of administrative data*. We will use a difference-in-differences study design to compare the ratio of healthcare utilization to spending for those affected by the policy (Treatment Group 1) to those not affected by the policy (Comparison Group 1 and Comparison Group 2 in separate analyses), over time. A purely descriptive analysis would not account for secular changes that might affect the ratio of healthcare utilization to spending nor the potential for selection into TMA status. This design allows us to identify the causal effect of premiums by assuming that the ratio of healthcare utilization to spending for the treatment group would have evolved similarly over time as that of the comparison group(s) in the absence of the implementation of the premium requirement. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable. We will also perform a within-person analysis that considers whether outcomes change over time for those affected by the policy conditional on remaining enrolled.

2. **Study Population:** Same as Questions 1-4

3. **Data Requirements**

Source	Time Frame	Purpose
CARES	(February 2008 – present)	Identification of study population during and prior to TMA period
MMIS Claims	(February 2008 – present)	Identification of healthcare utilization (emergency department use, hospitalizations, and outpatient use) and healthcare spending

4. Expected Limitations

a. ***Outcome measure.*** While we will use empirically validated measures as described in Table 2, identification of health outcomes through claims data algorithms is an imperfect process as it requires the enrollee to utilize the health care system in order to appear unhealthy. We note that Utilization/Cost is also not a typical measure of "cost-effectiveness", which is normally expressed as a denominator of a gain in health and a numerator of the cost associated with the health gain. Regardless, we will not be able to directly identify the specific costs of any particular change in health outcomes, only "changes in costs" and "changes in healthcare utilization" induced by the premium requirement.

b. ***Parallel trends assumption.*** This assumption is required for the difference-in-differences analysis but is fundamentally untestable. If something other than the premium requirement changes for Treatment Group 1 but not the comparison groups at the same time as the premium requirement was implemented, the design would be invalid. While we are not aware of any obvious violations in this context, it should be noted as a potential limitation.

Question 8: What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?

A. **DHS proposed**: "Case Study", "Administrative Data Analysis", and "Case-Control Matching" by statistically matching those who drop out of TMA within 12 months of premium implementation to those who do not drop out.

B. **Evaluation Team Proposes**:

1. Method

a. Descriptive analysis of administrative data. We will provide a description of TMA enrollment over time, including the probability of transitioning to TMA, by TMA status, income, premium payment status, and other demographic characteristics available through CARES.

b. Causal analysis of administrative data. We will use an interrupted time series study design to compare the rate of transitions from MA adult to TMA status in order to understand whether premium requirements affect the incentive to take up TMA and/or experience the types of transitions that would lead to a qualifying event. We will also use this design to study the probability of exit from TMA. This design allows us to identify the causal effect of premiums by assuming that enrollment behavior in the TMA population would have evolved similarly over time if not for the premium requirements. We will use econometric modeling techniques that appropriately account for serial correlation.

Second, we will use a regression discontinuity design within the TMA population in order to study the effect of premium amounts. This design involves comparing the enrollment behavior of those who transition and have incomes just low enough to qualify them for a particular premium amount relative to those who transition and have incomes just higher, qualifying them for a higher premium amount. The strength of this design is that it ensures populations are highly similar (as both transitioned from MA) rather than relying on a comparison of adults who did not transition, who may be different from those who did in unobservable ways that are predictive of the enrollment outcome. We will perform this analysis for each level of the required premium.

2. **Study Population:** Same as Questions 1-5

3. **Data Requirements**

Source	Time Frame	Purpose
CARES	February 2008 – present	Identification of study population during and prior to TMA period. Identification of premium amounts and payment status.
UI Earnings reports	First quarter 2008 - present	Verification of changes in earnings

4. Expected Limitations

a. *Interrupted time series assumption*. This analysis relies on the idea that no other programmatic changes occurred at the same time as the premium changes. To this end, we will not be able to separate the effects of the premium from other simultaneously implemented policies.

b. *Regression discontinuity assumption.* This analysis requires the assumption that TMA adults are not purposefully selecting into their premium-paying group (for example, by influencing their reported income). This assumption is somewhat testable and will be addressed by studying transition probabilities at the premium margins.

3. *Income as a confounder.* Because premiums are higher as income increases, it is not completely possible to separate the effect of the premium from the effect of income on average. In particular, we will not be able to conclude whether the effects may differ for higher income groups due to the amount of the premium or due to the beneficiaries' higher incomes.

Question 9: How is access to care affected by the application of new, or increased, Premium amounts?

A. **DHS proposed**: "Case Study", "Administrative Data Analysis", "Case-Control Matching", and "Enrollment/Disenrollment Survey"

B. **Evaluation Team Proposes**:

1. Method

a. *Descriptive analysis of survey data.* : The survey that will be fielded in Spring 2016 will include questions that will provide measures of access to care (e.g., usual source of care and experience of any unmet need for medical care), which is not well measured from administrative claims data. The survey will include both current TMA enrollees as well as those who have been placed in an RRP, so that both those who are and are not currently paying premiums are represented. We will summarize survey measures of beneficiary access to care stratified by TMA and premium-requirement status, providing tabular, graphical, and regression-adjusted analyses.

b. *Matched analysis of administrative data*. If feasible, we will enhance the survey by matching the survey data to the administrative data. This will allow us to observe more precise measures of income and enrollment, which will facilitate a causal analysis. In particular, we will use a regression discontinuity design within the TMA population in order to study the effect of premium amounts. This design involves comparing the surveyed access to care responses of those who transition and have incomes just low enough to qualify them for a particular premium amount relative to those who transition and have incomes just higher, qualifying them for a

higher premium amount. The strength of this design is that it ensures populations are highly similar rather than relying on a comparison of adults who did not transition, who may be different from those who did in unobservable ways that are predictive of the enrollment outcome. We will perform this analysis for each level of the required premium using appropriate econometric techniques.

2. **Study Population:** Same as Questions 1-5,8

3. **Data Requirements**

Source	Time Frame	Purpose
CARES	February 2008 – present	Identification of study population during and prior to TMA period. Identification of premium amounts and payment status.
Survey	Point-in-time measures valid at time of survey implementation	Measuring access to care

4. **Expected Limitations**
   a. ***Survey data sample.*** While the survey team will follow best practices in design, feasible limitations in limitations will not allow the identification of very small differences in access to care.
   b. ***Regression discontinuity assumption.*** This analysis requires the assumption that TMA adults are not purposefully selecting into their premium-paying group (for example, by influencing their reported income). This assumption is somewhat testable and will be addressed by studying transition probabilities at the premium margins.
   c. ***Income as a confounder.*** Because premiums are higher as income increases, it is not completely possible to separate the effect of the premium from the effect of income on average. In particular, we will not be able to conclude whether the effects may differ for higher income groups due to the amount of the premium or due to the beneficiaries' higher incomes.

Restrictive Reenrollment Period for Failure to Pay Premium: Questions 6-7, 10-12

The 2014 waiver introduced a 3-month restrictive reenrollment period (RRP) for TMA beneficiaries who failed to pay the required premium after a 30-day grace period. Unlike the 12-month RRP that had previously been in place for BadgerCare+ members, the RRP included in the 2014 waiver allows beneficiaries to re-enter the program before the end of the RRP period if they repay previously owed premiums. TMA members with incomes between 100%-133% FPL are exempted from premiums in their first six months of enrollment and are therefore not subject to the RRP during this time.

For those beneficiaries who experience an RRP, the period of disenrollment may affect both outcomes related to service use (utilization, cost, and access) as well as outcomes related to enrollment. Relative to patterns of utilization before entering an RRP, beneficiaries may decrease their use of health services while in an RRP since they are temporarily uninsured, but then increase their service use in the

immediate period after returning to the program due to "pent-up" demand for care (Question 6). Over longer-periods of time, these may lead to differences in spending and service utilization between those who experience RRPs versus those who remain continuously enrolled (Question 7). The presence of an RRP may also be hypothesized to reduce the likelihood that beneficiaries fail to make premium payments, at least insofar as beneficiaries are concerned about losing benefits for an extended period of time (Question 10). The impact of the RRP penalty may also differ depending on the member's income level (Questions 11-12), but the direction of the association has not yet been hypothesized.

Question 6: Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?

A. DHS proposed: "Case Study", "Administrative Data Analysis", "Case-Control Matching", and "Enrollment/Disenrollment Survey"

B. Evaluation Team Proposes:

1. Method

Question 6 will be addressed through (1) an analysis of administrative data (claims and enrollment from CARES and MMIS) and (2) through an analysis of survey data. The survey will contribute to assessment of both questions 6 and 7, which has several new questions designed to focus on the experiences of being in an RRP.

a. Administrative data analysis: A key analytical challenge in measuring the impact of the RRP is to identify the impact of being placed in an RRP on post-RRP outcomes independent of other individual-level factors that may drive utilization changes. For example, a beneficiary may experience a health event that causes both a temporary inability to work (increasing financial strain) and which leads to greater than average utilization in the pre-RRP period. Risk of entering an RRP may also be influenced by changes in the environment, such as the secular trends in the state economy. To account for these factors, we will estimate a regression model that compares pre- and post-RRP trends taking advantage of repeated measures of utilization within the same beneficiary, and also taking advantage of data from other beneficiaries who experience RRPs at different times. In this estimation strategy, beneficiaries in pre-RRP periods can serve as controls for themselves in the post-RRP period as well as for other beneficiaries who experience RRPs at different times.

The regression equation measuring the impact of the RRP can be expressed as:

$$Y_{it} = \beta_0 + \beta_1 Post\text{-}RRP_{it} + \beta_2 Pre\text{-}RRP_{it} + \beta_3 Demographics_i + \beta_4 Month_t + \beta_5 Person_i + \varepsilon_{it}$$

Where *Y* represents any outcome measure, for person *i* observed at time *t*. *Post-RRP* is an indicator for being observed in a post-RRP period and *Pre-RRP* is an indicator for being observed in a pre-RRP period. The omitted time period in these models are periods of "regular enrollment." *Demographics* represents time-invariant individual-level demographics. *Month* is a monthly indicator for time point where the individual is observed (in order to adjust for secular time trends). *Person* is an individual-level random effect, which allows the model to apply a different intercept term to each beneficiary. Standard errors will be adjusted to account for the auto-correlation of individual-level data across months and the clustering of multiple RRPs

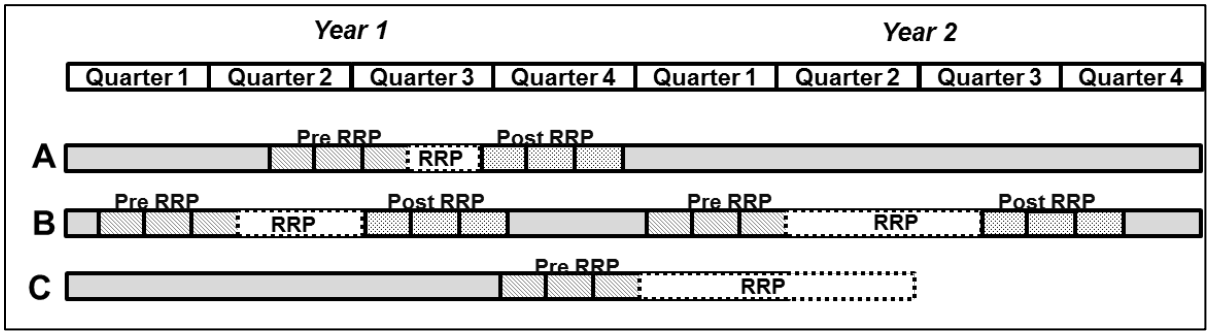
within the same beneficiary. This regression approach can be adapted for a variety of outcomes using generalized linear models. These models will allow us to specify the appropriate functional form for the outcome (e.g., probit models for binary outcomes and negative binomial or Poisson models for number of visits).

b. Survey Data Analysis**:** The survey that will be fielded in Spring 2016 and Spring 2018 will provide a special module of questions specifically designed to capture the experiences of beneficiaries who have experienced a recent RRP. To ensure that an adequate sample of these beneficiaries are captured in the data collection process, we will allocate approximately 20% of the sample (~200 interviews) to beneficiaries whom the state indicates have been recently placed in an RRP. Comparison of responses will be conducted within the RRP sample between those that return to BadgerCare and those that do not return, and between the RRP and non-RRP samples (especially other TMA beneficiaries). The analysis will adjust for other differences in income and demographics. This comparison will reveal whether beneficiaries in an RRP experience a greater prevalence of access problems than do other demographically similar BadgerCare enrollees.

2. **Study Population**

For the administrative data analyses we will identify all beneficiaries who were placed in an RRP at any point from January 1, 2014-December 31, 2015. The maximum length of an RRP is 3 months, but we expect that many members will have RRPs less than 3 months (as they can rejoin the program after paying owed premiums). We also assume that some beneficiaries will remain disenrolled beyond the length of the RRP. We will test the sensitivity of several sample restrictions, such as limiting the sample to beneficiaries who have disenrollment periods of 1-6 months.

Figure 1. Measuring RRPs for Hypothetical TMA Beneficiaries



For each beneficiary who is placed in an RRP, we will define two adjacent time periods: the pre-RRP period and post-RRP period. We can define these periods in terms of monthly segments (e.g., 3 months pre and 3 months post RRP). All time periods that are outside of the window of time adjacent to the RRP will be considered "regular enrollment" periods.

Figure 1 illustrates this approach for 3 hypothetical beneficiaries (A, B, and C). Person A experiences a brief RRP in year 1; person B experiences two separate RRPs in years 1 and 2; person C enters an RRP in year 2, but does not re-join the program for a period of at least 6 months. Other time periods, shown in light gray comprise regular enrollment periods.

3. Data Requirements

Source	Time Frame	Purpose
CARES	January 1, 2014-December 31, 2015	Identification of study population: beneficiaries during and prior to three-month RRP
MMIS Claims	January 1, 2014-December 31, 2015	Measures of cost, utilization, and access to care created using claims data
Survey	Point-in-time measures valid at time of survey implementation	Identification of study population: beneficiaries that experience RRP and return; beneficiaries that experience RRP and do not return; beneficiaries that do not experience an RRP; Measures of utilization

4. Expected Limitations

a. ***Selection Bias from Life Events:*** entry into an RRP is not a random process – it is more likely to occur to individuals that experience "life events" that precede non-payment of premiums. Failure to control for these life events can bias the interpretation of the "RRP effect" since these events can influence utilization independent of the RRP. However, it is difficult to know what the direction of bias will be since life events can be either negative (e.g., loss of employment, marital dissolution) or positive (e.g., new coverage options through a job gain or spousal employment). We will address this issue in regression models by controlling for individual-level variables that may be associated with greater risk of life events (such as demographics). We will also, where possible, attempt to identify whether the RRP coincides with life events that are observed through other state databases (such as gains or losses in employment).

b. ***Survey Response Bias:*** respondents to the RRP survey may be different than the population experiencing the RRP (for example, individuals who agree to complete a survey may have a greater likelihood of rejoining the program). To address this survey response bias, we will use survey weights to adjust the sample closer to the overall population of RRP individuals (e.g., adjusting by demographic factors that may influence both survey response and RRP experiences).

Question 7: Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for beneficiaries that have disenrolled and then re-enrolled?

A. DHS Proposed: "Case Study", "Administrative Data Analysis", "Case-Control Matching", and "Enrollment/Disenrollment Survey"

C. Evaluation Team Proposes:

1. Methods

To examine the effects of experiencing a disruption in coverage due to an RRP relative to being continuously enrolled on utilization, cost, and health care outcomes, we will use a difference-in-differences design to compare the longer-term trends in outcomes between the population of TMA beneficiaries that experience RRPs to several alternative groups that do not experience RRPs.

The first comparison is a within-group comparison for TMA with incomes 100-133% FPL in their first six months (when they are not subject to RRP) versus their second six months when they are subject to RRPs. The advantage of this comparison is that we observe the group during a time period when they are not at risk of losing coverage due to an RRP compared to a time period when the policy changes and they are exposed to an RRP. Second, we can look at TMA populations who remain continuously enrolled (i.e. never experience an RRP), but are otherwise similar to those who do experience an RRP (using a propensity score matching process with baseline demographic characteristics). Third, we can compare TMA beneficiaries with an RRP to similar beneficiaries in the CLA population, which is not subject to RRPs, and is therefore less likely to experience enrollment gaps.

Matching: A challenge with such a comparison is that differences between RRP and non-RRP beneficiaries may also reflect unmeasured differences in underlying preferences for insurance, need for care, and access to alternative health care resources. If these differences are not accounted for, comparisons will provide biased estimates of the effect of being in the RRP group. One strategy to address the comparability problem is to apply propensity score matching to the sample. A propensity score reflects the degree to which beneficiaries in the non-RRP group are like beneficiaries in the RRP group based on a set of observable characteristics taken from some baseline period (such as the first two months of coverage). The propensity score can be derived using demographic information (race, age, sex), income category, and health service utilization measures. This method can be implemented using a regression model that assigns each individual in the non-RRP group a probability of being similar to an RRP individual. Examining whether the matched samples are similar on observable covariates can test balance between the RRP and non-RRP groups.

Estimation Approach: After matching, we can estimate a regression model of the following form:

$$Y_{it} = \beta_0 + \beta_1 RRP\text{-}Group_{it} + \beta_2 Year_t + \beta_3 Person_i + \varepsilon_{it}$$

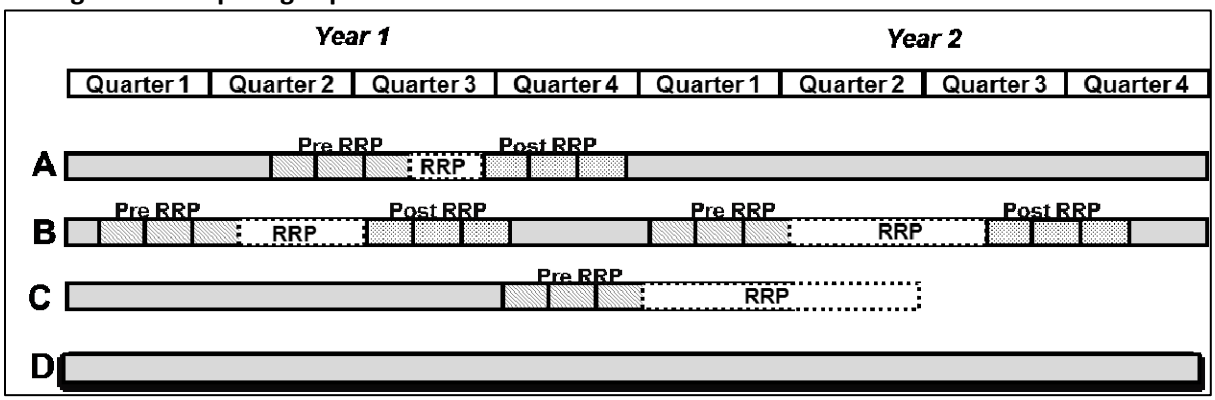
Where *Y* represents any study outcome related to either spending or utilization (for example, in 6 month increments) for person *i* observed at year *t*. *RRP-Group* is an indicator for whether an individual is in the TMA population that experienced an RRP versus the matched group that did not experience an RRP. *Year* is an indicator for the calendar year of data (to account for secular trends).

Person represents an individual-level random effect. Since beneficiaries can contribute data from multiple years, data will be clustered at the level of the beneficiary.

2. Study Population

Whereas Question 6 is focused on changes in utilization and spending that occur after an RRP within the population that experiences an RRP, Question 7 is focused on overall trends in costs and utilization in the RRP population versus the non-RRP population. This is represented in Figure 2 where the comparison is now between beneficiaries A, B, and C to beneficiary D (and others like him/her). The simplest way to conduct this comparison is to sum all utilization and spending over defined time periods (e.g., six month increments) and compare averages in the TMA subgroup that experienced RRPs versus the TMA group that did not experience RRPs.

Figure 2. Comparing experience of RRP and non-RRP TMA beneficiaries



3. Data Requirements:

Source	Time Frame	Purpose
CARES	January 1, 2014-December 31, 2015	Identification of study population: beneficiaries in TMA who experience an RRP versus CLA or TMA individuals who don't experience an RRP
MMIS Claims	January 1, 2014-December 31, 2015	Measures of cost, utilization, and access to care created using claims data

4. Expected Limitations:

Matching Bias: With the exception of the first comparison that focuses on the same population at two different time periods, this research question will be addressed by matching groups with RRP experience to groups that do not experience an RRP. Matching is most effective if the observable variables used to create the comparison group are closely related to selection into the treatment group. While this assumption cannot be directly tested, we can examine the robustness of the matching method by comparing different matching and weighting strategies.

Question 10: What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment?

A. DHS Proposed: "Case Study", "Administrative Data Analysis", "Case-Control Matching", and "Enrollment/Disenrollment Survey"

B.Evaluation Team Proposes:

1. Methods

For both analyses described below, we will measure the payment of premiums as a function of two processes: the average length of total enrollment and, conditional on being enrolled in the program, the amount of premiums owed that are paid to the program during the time enrolled in the program.

Analysis 1: The Effect of Premiums and RRP on Enrollment:

This first analysis will address the question of how much enrollment duration changes after the imposition of premiums with RRP (without further disentangling the effect of premiums from the RRP). We will compare enrollment patterns among TMA individuals with incomes 100%-133% FPL in their first six months in the program (when they are not subject to premiums or RRP) to TMA beneficiaries in this same income group (100%-133% FPL) in their second six months in the program (when they are submit to premiums) and to TMA beneficiaries in income groups above 133% FPL in their first six months of enrollment. Using both comparison groups is necessary because the group of TMA beneficiaries that persist in the program after six months may be more highly selected toward individuals with a long-term demand for public insurance.

Estimating Enrollment Trends: We will apply hazard modeling to compare the relative risk of disenrollment in the first six months for TMA individuals with income 100%-133% FPL to disenrollment rates in the comparison groups over the six month segments noted above. The hazard model assumes that every individual has some underlying probability of leaving the program, whether or not they are subject to premiums and/or an RRP, and that this risk can be modeled as a function of time spent in the program, demographics, and policy variables. The population 100%-133% FPL in their first six months provides a baseline rate with which to compare disenrollment rates in segments of the program with higher incomes or with longer periods of enrollment. The hazard model will allow us to calculate the rate of leaving the program comparing a baseline (no premiums or RRP) to the rate with premiums and RRP, conditional on a set of time invariant person-level covariates.

Analysis 2: Historical Comparison with the 12 Month RRP

This analysis will consider the differences in both disenrollment rate and total premiums paid between individuals subject to the 3 month RRP 2016 versus the effect of 12 month RRP among demographically similar individuals in the past. The time periods will be July 2012-December 2013 (12 month RRP) versus July 2014-December 2015 (3 month RRP).

The two populations will first be matched on demographic and income covariates. Once comparable cohorts have been created, the analysis will calculate the mean length of an enrollment spell and the amount paid per month of enrollment, conditional on being in the program. These two parameters can be combined to estimate the unconditional predicted amount of money paid to the program during a time of enrollment.

Average total amount paid = (Mean number of months of enrollment)(Amount paid per month during enrollment)*

2. Study Population

This question considers how the RRP for the TMA population would affect the rate of premium payments relative to a situation in which beneficiaries are subject to premiums but are not locked-out through the RRP. Because there is no segment of the Wisconsin program that currently is required to pay premiums and is not subject to an RRP, there is no readily available comparison group. It is also important to note that the 3 month RRP is different than the previously existing 12 month RRP not only because it is shorter but also because it is less binding (i.e., beneficiaries are allowed to re-enter the program before the end of 3 months as long as they pay owed premiums).

3. **Data Requirements:**

Source	Time Frame	Purpose
CARES	January 1, 2014-December 31, 2015	Comparing TMA enrollees 100-133% FPL before and after premium requirement begins (after first six months of enrollment)
CARES	July 2012-December 2013; July 2014-December 2015	Comparing TMA enrollees subject to the 3 month RRP versus TMA enrollees subject to the 12 month RRP

4. **Expected Limitations**
   - **a.** ***Generalizability (Approach 1):*** The first approach focuses on the disenrollment effect of being subject to a premium plus RRP on a specific income group (100-133% FPL). This effect may not apply to higher income levels. Addressing heterogeneity by income is a key objective of Questions 11 and 12, below.
   - **b.** ***Identifying Premium Effect (Approach 1):*** As noted above, the first approach does not allow us to disentangle the effect of being subject to premiums versus being subject to RRP. Therefore, these estimates are understood to represent the combined effect of these two policies on the relevant income group where we have the ability to clearly identify over-time variation in the implementation of the policy.
   - **c.** ***Secular Trends (Approach 2):*** The second approach, comparing the historical 12 month RRP to the current 3 month RRP is challenging because these two policies unfolded against different time varying trends that could independently influence enrollment dynamics (e.g., the implementation of the Affordable Care Act and changes in the state economy). As a possible way to address this, we will explore using enrollment dynamics in a third group (such as parents and caretakers) that is less affected by these premium policy changes but is likely to be influenced by the same secular trends.

Question 11: Does the RRP impact vary by income level?
&
Question 12: If there is an RRP impact, explore the break-out by income level.

A. DHS Proposed: "Case Study", "Administrative Data Analysis", and "Case-Control Matching"

B. Evaluation Team Proposes:

1. Methods

Testing for heterogeneity in the effect of the RRP by income level can be accomplished by comparing subgroup effects within the 3 month RRP to the 12 month RRP (i.e., examining whether the average rate of premium payment is higher or lower among beneficiaries with higher income after the switch). This can be operationalized by interacting a variable for income category with the variable for policy group in a model that reports average differences in mean number of months of enrollment (e.g., by looking at whether the enrollment effect is greater for individuals above 200% FPL) and carrying out a similar analysis for estimates of amount paid per month during enrollment. Formal testing of statistical significance for interaction can indicate whether any variation identified is likely to reflect variation that cannot be explained simply by chance differences in the income groups.

2. **Study Population:** same as for Question 10

3. **Data Requirements:** Same as 10

4. **Expected Limitations**

As indicated in Question 8, there is no way to fully disentangle the effect of premiums from higher income since the two increase together. We will descriptively compare differences in enrollment trends by income level and will attribute those differences to some combined effect of income and premium levels.

Childless Adult Beneficiary Enrollment in the Medicaid Standard Plan: Questions 13-17

The objective of evaluation questions 13-17 is to understand whether and to what extent the provision of standard Medicaid benefits to childless adult (CLAs) beneficiaries improved health, health care, and resource use-related outcomes for CLAs. The WI Department of Health Services is specifically interested in measuring CLA Standard Plan enrollees' outcomes relative to the two comparators, A and B, described below. We will implement both comparisons for each of the research questions related to childless adult enrollment in the Standard Plan. In the following paragraphs, we describe the general samples and research designs that we will deploy across questions 13-17. We then provide additional analytical detail that is specific to each research question.

A. A comparison of CLA beneficiaries' outcomes while enrolled in the Standard Plan relative to their outcomes while enrolled in the Core Plan; and

B. A comparison of outcomes for newly eligible CLA beneficiaries enrolled in the Standard Plan relative to outcomes for CLA beneficiaries enrolled in the Core Plan for a similar period of enrollment during the demonstration.

A. Research Design and Sample

Design. We will implement a difference-in-differences (DD) design to estimate the change in outcomes for CLA beneficiaries before enrollment in the Standard Plan and after Standard Plan enrollment relative to the change in outcomes over the same time periods in a propensity-score matched comparison group of parent/caretaker beneficiaries. As illustrated in Table 4, a comparison group of parents/caretakers who were continuously enrolled in the Standard Plan controls for any trends that may have affected the health care use of publicly-insured low-income adults during this period that were not otherwise related to the introduction of Standard Plan coverage for CLA beneficiaries. The DD design with a well-matched comparison group increases our capacity to make causal inferences from the evaluation findings by isolating the impact of the coverage change on the affected population.

Table 4. Difference-in-Differences Research Design for Evaluation of Childless Adult Enrollment in Standard Plan

	Pre-Period *April 2012 - March 2014		**Post-Period *April 2014-March 2016**
Treatment Group	Core Plan (A) Cohort of childless adults < =100%FPL	**=>**	Standard Plan (B) Same cohort of childless adults <=100%FPL
Comparison Group	Standard Plan (C) Propensity-score matched cohort of parents/caretakers <=100%FPL	**=>**	Standard Plan (D) Same cohort of parents/caretakers <=100%FPL
Difference-in-Differences:			**[(B-A) - (D-C)]**

**Time segments for the 'pre' and 'post' periods may be adjusted based on enrollment continuity of sample and data availability.*

Sample. We will use the CARES data to identify the sample of CLA beneficiaries that transitioned from the Core Plan to the Standard Plan. Each individual that meets the following criteria will be included in the "transitioner," sample: income that is at or below 100% FPL; enrollment in the Core Plan in March 2014; and enrollment for at least 1 month after the April 1, 2014 transition to the Standard Plan.

Because childless adult and parent/caretaker beneficiaries may differ on observable characteristics, we will employ propensity score methods to construct a statistically matched comparison group of parents/caretakers using CARES and MMIS claims data. The comparison sample of parents/caretakers will include subjects who can be statistically matched to the childless adult beneficiary sample in terms of their administrative characteristics (e.g., month and duration of enrollment, income level, age, gender, county of residence), past utilization (measures of visits in the pre-period), and health history (measured by diagnostic codes in the MMIS data in the pre-period). A large literature has demonstrated that matching on past outcome measures, as we propose here, is an exceptionally strong propensity score matching design.[9]

[9] See for example: Heckman J, Ichimura H, Todd P. (1997) Matching as an Econometric Evaluation Estimator: Evidence from Evaluating a Job Training Programme. Review of Economic Studies, Vol. 64, pp. 605-654; Card D and Sullivan D. (1988) Measuring the Effect of Subsidized Training Programs on Movements into

B. Research Design and Sample

Design. We will describe the differences in study outcomes between two groups of CLA Standard Plan enrollees: individuals who enrolled on or after April 1, 2014; and individuals who transitioned from the Core Plan to the Standard Plan in April 2014. The observational study design is illustrated in Figure 3.

Figure 3. Comparing the experience in the Standard Plan of new CLA enrollees to CLA enrollees that transitioned from the Core Plan

CLA Beneficiaries	April 2014-March 2015				April 2015 – March 2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
New Enrollees	=> ----------							
Transitioners	=> ----------							

This design will yield important insight into the effects on study outcomes of Standard Plan coverage for CLAs who experienced a richer set of benefits from the start of their Medicaid enrollment (i.e., new enrollees) relative to CLAs who initially experienced a more limited set of Medicaid benefits (i.e., transitioners.) We note that the design does not allow us to distinguish between several plausible explanations for potential outcome differences between new enrollees and transitioners. These explanations include prior health insurance coverage and differences across groups in unobserved characteristics related to study outcomes such as care-seeking preferences, health history, etc.

Sample. We will use CARES data to identify two groups of CLA beneficiaries between the ages of 19-64: new enrollees; and transitioners. New enrollees will include CLA beneficiaries with at least 1 month of Standard Plan enrollment beginning on or after 4/1/2014 and no Core Plan enrollment in the prior 12 months. The new enrollee population will thus include both individuals on the Core Plan wait list and individuals that were not on the Core Plan wait list. Each individual that meets the following criteria will be included in the "transitioner," sample: income that is at or below 100% FPL; enrollment in the Core plan in March 2014; and enrollment for at least 1 month after the April 2014 transition to the Standard Plan.

and out of Employment. Econometrica, Vol. 56, pp. 497-530; Deheija R and Wahba S. (1999) Causal Effects in Nonexperimental Studies: Reevaluating the Evaluation of Training Programs. Journal of the American Statistical Association, Vol, 94, pp. 1053-1062; Deheija R and Wahba S. (2002) Propensity Score Matching Methods for Nonexperimental Causal Studies. Review of Economic Studies, Vol. 84, pp. 151-161; Heckman J, Ichimura H, Smith J, Todd P. (1996) Sources of Selection Bias in Evaluating Programs: An Interpretation of Conventional Measures and Evidence on the Effectiveness of Matching as a Program Evaluation Method. Proceedings of the National Academy of Sciences, Vol. 93, pp. 13416-13420. Heckman J and Smith J. (1999) The Pre-Program Earnings Dip and the Determinants of Participation in a Social Program: Implications for Simple Program Evaluation Strategies. NBER Working Paper 6983, National Bureau of Economic Research, Cambridge: MA; and Smith J and Todd P. (2005) Does Matching Overcome LaLonde's Critique of Nonexperimental Estimators? Journal of Econometrics, Vol. 125, pp. 305-353.

Question 13. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries result in improved health outcomes?

A. DHS Proposed: "Case Study;" "Administrative Data Analysis;" and "Case-Control Matching."

B. Evaluation Team Proposes:

1. Method

a. *Descriptive analysis of administrative data*. We will describe health-related outcomes over time for CLA beneficiaries by sample membership (i.e., new enrollees and transitioners), and for CLA transitioners relative to the matched parent/caretaker comparison group. We will include tabulations as well as a graphical and regression analysis. Study outcomes for Q.13 are summarized in Table 2.

b. *Causal analysis of administrative data*. We will use a difference-in-differences study design to compare health-related outcomes for those affected by the change to Standard Plan coverage (CLA transitioners) to those not affected by the coverage change (matched parents and caretakers), over time. A purely descriptive analysis would not account for secular changes that might affect health-related outcomes. This design allows us to identify the causal effect of Standard Plan coverage relative to Core Plan coverage by assuming that the health-related outcomes for the treatment group would have evolved similarly over time as that of the comparison group in the absence of the change in coverage. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable.

1. **Study Population:** CLA transitioners; CLA new enrollees; and matched parent/caretaker sample as described above.

2. Time period

a. We will compare health-related outcomes for new enrollees relative to transitioners from April 1, 2014 through March 30, 2016.

b. The pre and post-periods for our DD analyses will include up to 24 months each, April 2012-March 2014 and April 2014-March 2016 respectively.

3. Data Requirements

Source	Time Frame	Purpose
CARES	April 2012 – March 2016	Identification of study samples and the specific months observed for each subject. Provides the demographic data for use in construction of propensity-score matched parent/caretaker group.
MMIS Claims	April 2012 – March 2016	Identification of health-related outcomes. Provides the diagnostic and health care data for use in construction of propensity-score matched parent/caretaker group.

5. Expected Limitations

a. *Outcome measures.* We will use empirically validated measures whenever possible as described in Table 2. However, identification of health-related outcomes through claims data algorithms is an imperfect process as it requires the enrollee to utilize the health care system in order to appear unhealthy.

b. *Outcome measures*. The technical specifications for some of the outcomes noted in Table 2 require 18-24 months of continuous enrollment for inclusion in the denominator. This restriction will limit the available sample for measure construction and may affect the generalizability of the finding to the relevant WI Medicaid population. When feasible, we will modify the definition and technical specifications of some measures to balance sample size limitations and evaluation objectives. .

c. *Parallel trends assumption.* This assumption is required for the difference-in-differences analysis but is fundamentally untestable. If something other than coverage changes for CLA transitioners (that is also related to the outcome) but not the comparison group in April 2014, the design would be invalid. While we are not aware of any obvious violations in this context, it should be noted as a potential limitation.

Question 14. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries achieve a reduction in the incidence of unnecessary services?

A. DHS Proposed: "Case Study;" "Administrative Data Analysis;" and "Case-Control Matching."

B. Evaluation Team Proposes:

1. Method

a. Descriptive analysis of administrative data. We will describe rates of unnecessary service use over time for CLA beneficiaries by sample membership (i.e., new enrollees and transitioners), and for CLA transitioners relative to the matched parent/caretaker comparison group. We will include tabulations as well as a graphical and regression analysis. Outcome measures for Q.14 are summarized in Table 2.

b. Causal analysis of administrative data. We will use a difference-in-differences study design to compare rates of unnecessary service use for those affected by the change to Standard Plan coverage (CLA transitioners) to those not affected by the coverage change (matched parents and caretakers), over time. A purely descriptive analysis would not account for secular changes that might affect health outcomes. This design allows us to identify the causal effect of Standard Plan coverage relative to Core Plan coverage by assuming that the use of unnecessary services for the treatment group would have evolved similarly over time as that of the comparison group in the absence of the change in coverage. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable.

2. Study Population: CLA transitioners; CLA new enrollees; and matched parent/caretaker sample as described above.

3. **Time period**

a. We will compare unnecessary service use for new enrollees relative to transitioners from April 1, 2014 through March 30, 2016.

b. The pre and post-periods for our DD analyses will include up to 24 months each, April 2012-March 2014 and April 2014-March 2016 respectively.

4. **Data Requirements**

Source	Time Frame	Purpose
CARES	April 2012 – March 2016	Identification of study samples and the specific months observed for each subject. Provides the demographic data for use in construction of propensity-score matched parent/caretaker group.
MMIS Claims	April 2012 – March 2016	Identification of outcome measures. Provides the diagnostic and health care data for use in construction of propensity-score matched parent/caretaker group.

5. Expected Limitations

a. *Outcome measure.* Identification of "unnecessary" visits through claims data algorithms is an imperfect process and will inevitably misclassify some visits that were "necessary" as "unnecessary" and vice versa.

b. *Parallel trends assumption.* This assumption is required for the difference-in-differences analysis but is fundamentally untestable. If something other than coverage changes for CLA transitioners (that is also related to the outcome) but not the comparison group in April 2014, the design would be invalid. While we are not aware of any obvious violations in this context, it should be noted as a potential limitation.

Question 15. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Outcomes/Cost) of Medicaid services?

A. DHS Proposed: "Case Study;" "Administrative Data Analysis;" and "Case-Control Matching."

B. Evaluation Team Proposes:

1. Method

a. *Descriptive analysis of administrative data*. We will describe the cost-effectiveness over time (as defined by the ratio of health-related outcomes to spending) for CLA beneficiaries by sample membership (i.e., new enrollees and transitioners), and for CLA transitioners relative to the matched parent/caretaker comparison group. We will include tabulations as well as a graphical and regression analysis. Outcome measures for Q.15 are summarized in Table 2.

b. *Causal analysis of administrative data*. We will use a difference-in-differences study design to compare the health-related outcomes/spending ratio for those affected by the change to Standard Plan coverage (CLA transitioners) to those not affected by the coverage change (matched parents and caretakers), over time. A purely descriptive analysis would not account for secular changes that might affect the ratio of health outcomes to spending. This design allows us to identify the causal effect of Standard Plan coverage relative to Core Plan coverage by assuming that the outcome/spending ratio for the treatment group would have evolved similarly over time as that of the comparison group in the absence of the change in coverage. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable.

c. Expenditures estimation. Health care expenditures will be computed using an algorithm that maps encounter data to a fee-for-service schedule of allowable charges for the Wisconsin Medicaid population.[10]

2. Study Population: CLA transitioners; CLA new enrollees; and matched parent/caretaker sample as described above.

3. Time period

a. We will compare the ratio of health-related outcomes to spending for new enrollees relative to transitioners from April 1, 2014 through March 30, 2016.
b. The pre and post-periods for our DD analyses will include up to 24 months each, April 2012-March 2014 and April 2014-March 2016 respectively.

4. **Data Requirements**

Source	Time Frame	Purpose
CARES	April 2012 – March 2016	Identification of study samples and the specific months observed for each subject. Provides the demographic data for use in construction of propensity-score matched parent/caretaker group.
MMIS Claims	April 2012 – March 2016	Identification of outcome measures. Provides the diagnostic and health care data for use in construction of propensity-score matched parent/caretaker group.

5. Expected Limitations

a. *Outcome measure.* We will use empirically validated measures whenever possible as described in Table 2. Identification of health-related outcomes through claims data algorithms is an imperfect process as it requires the enrollee to utilize the health care system in order to appear unhealthy. We note that outcomes/spending is also not a typical measure of "cost-effectiveness," which is normally expressed as a denominator of a gain in health and a numerator of the cost associated with the health gain. Regardless, we will not be able to directly identify the specific costs of any particular change in health outcomes, only "changes in costs" and "changes in health-related outcomes" induced by the introduction of Standard Plan coverage.
b. *Parallel trends assumption.* This assumption is required for the difference-in-differences analysis but is fundamentally untestable. If something other than coverage changes for CLA transitioners (that is also related to the outcome) but not the comparison group in April 2014, the design would be invalid. While we are not aware of any obvious violations in this context, it should be noted as a potential limitation.

Question 16. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost (Utilization/Cost) of Medicaid services?

A. DHS Proposed: "Case Study;" "Administrative Data Analysis;" and "Case-Control Matching."

[10] Leininger L, Friedsam D., Voskuil K., DeLeire T. (2014) Predicting high-need cases among new Medicaid enrollees. *American Journal of Managed Care*. 20(9):e399-e407.

B. Evaluation Team Proposes:

1. Method
   a. *Descriptive analysis of administrative data*. We will describe the cost-effectiveness over time (as defined by the ratio of health care use to spending) for CLA beneficiaries by sample membership (i.e., new enrollees and transitioners), and for CLA transitioners relative to the matched parent/caretaker comparison group. We will include tabulations as well as a graphical and regression analysis. Outcome measures for Q.16 are summarized in Table 2.
   b. *Causal analysis of administrative data*. We will use a difference-in-differences study design to compare the health care use/spending ratio for those affected by the change to Standard Plan coverage (CLA transitioners) to those not affected by the coverage change (matched parents and caretakers), over time. A purely descriptive analysis would not account for secular changes that might affect the ratio of health care use to spending. This design allows us to identify the causal effect of Standard Plan coverage relative to Core Plan coverage by assuming that the care use/spending ratio for the treatment group would have evolved similarly over time as that of the comparison group in the absence of the change in coverage. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable.
   c. Expenditures estimation. Health care expenditures will be computed using an algorithm that maps encounter data to a fee-for-service schedule of allowable charges for the Wisconsin Medicaid population.

2. Study Population: CLA transitioners; CLA new enrollees; and matched parent/caretaker sample as described above.

3. Time period

   a. We will compare the ratio of health care use to spending for new enrollees relative to transitioners from April 1, 2014 through March 30, 2016.
   b. The pre and post-periods for our DD analyses will include up to 24 months each, April 2012-March 2014 and April 2014-March 2016 respectively.

4. Data Requirements

Source	Time Frame	Purpose
CARES	April 2012 – March 2016	Identification of study samples and the specific months observed for each subject. Provides the demographic data for use in construction of propensity-score matched parent/caretaker group.
MMIS Claims	April 2012 – March 2016	Identification of outcome measures. Provides the diagnostic and health care data for use in construction of propensity-score matched parent/caretaker group.

5. Expected Limitations

   a. *Outcome measure.* We note that utilization/cost is also not a typical measure of "cost-effectiveness", which is normally expressed as a denominator of a gain in health and a numerator of the cost associated with the health gain. Regardless, we will not be able to directly identify the

specific costs of any particular change in health outcomes, only "changes in costs" and "changes in healthcare utilization" induced by the premium requirement.

b. *Parallel trends assumption.* This assumption is required for the difference-in-differences analysis but is fundamentally untestable. If something other than coverage changes for CLA transitioners (that is also related to the outcome) but not the comparison group in April 2014, the design would be invalid. While we are not aware of any obvious violations in this context, it should be noted as a potential limitation.

Question 17. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?

A. DHS Proposed: "Case Study;" "Administrative Data Analysis;" "Case-Control Matching," and "enrollment/disenrollment survey."

B. Evaluation Team Proposes:

1. Method

a. *Descriptive analysis of administrative data*. We will describe the continuity of health insurance coverage and the continuity of health care over time for CLA beneficiaries by sample membership (i.e., new enrollees and transitioners), and for CLA transitioners relative to the matched parent/caretaker comparison group. We will include tabulations as well as a graphical and regression analysis.

b. *Causal analysis of administrative data*. We will use a difference-in-differences study design to compare the continuity of coverage and care for those affected by the change to Standard Plan coverage (CLA transitioners) to those not affected by the coverage change (matched parents and caretakers), over time. A purely descriptive analysis would not account for secular changes that might affect continuity of coverage. This design allows us to identify the causal effect of Standard Plan coverage relative to Core Plan coverage by assuming that the continuity of coverage and care for the treatment group would have evolved similarly over time as that of the comparison group in the absence of the change in coverage. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable.

c. *Descriptive and causal analysis of survey data*. In addition to the 2014 survey of BadgerCare beneficiaries, the 2016 and 2018 surveys will provide repeated cross-sectional measures of health care continuity for CLA beneficiaries with income at or below 100%FPL. Using these data we will describe the continuity of health care over time for CLA beneficiaries. The planned surveys will also include a panel component, a subset of respondents that is surveyed up to three times (i.e., 2014, 2016, and 2018). This panel of respondents enables person-level, fixed effects analyses to estimate the effect of the transition to the Standard Plan from Core Plan coverage on health care continuity. In this fixed effects framework, each person serves as his/her own control. Implementation of this causal analysis is contingent upon retention of a sufficient sample of CLA panel respondents.

2. Study Population: CLA transitioners; CLA new enrollees; and matched parent/caretaker sample as described above.

3. Time period

a. We will compare continuity of coverage and care for new enrollees relative to transitioners from April 1, 2014 through March 30, 2016.
b. The pre and post-periods for our DD analyses will include up to 24 months each, April 2012-March 2014 and April 2014-March 2016 respectively.
c. For survey-based measures, we will describe continuity of care across and within CLA beneficiaries at three time points (2014, 2016, and 2018).

4. Data Requirements

Source	Time Frame	Purpose
CARES	April 2012 – March 2016	Identification of study samples and the specific months observed for each subject. Provides the demographic data for use in construction of propensity-score matched parent/caretaker group. Identification of outcome measures related to coverage continuity (i.e., number and duration of enrollment and disenrollment spells; re-enrollment at renewal; transition to non-CLA Medicaid eligibility category.)
MMIS Claims	April 2012 – March 2016	Provides the diagnostic and health care data for use in construction of propensity-score matched parent/caretaker group.
Survey	Point-in-time measures valid at time of survey implementation	Identification of outcome measures for continuity of care: usual source of care; usual provider of care; receipt of all needed care in the past 12 months.

5. Expected Limitations

a. *Survey data sample.* While the survey team will follow best practices in design and implementation, it is possible that the resulting sample size will not allow identification of small differences in continuity of care or support within-subject analyses.
b. *Parallel trends assumption.* This assumption is required for the difference-in-differences analysis but is fundamentally untestable. If something other than coverage changes for CLA transitioners (that is also related to the outcome) but not the comparison group in April 2014, the design would be invalid. While we are not aware of any obvious violations in this context, it should be noted as a potential limitation.

University of Wisconsin Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Crosswalk: UW Research Team Evaluation Methods and DHS Proposed Evaluation Methods

Hypotheses	Evaluation Team Planned Approach	DHS Proposal
Payment of Premiums and The Effect of Premiums: Q 1-5; 8,9		
1: Will the premium requirement reduce the incidence of unnecessary services?	1. Descriptive analysis of administrative data. Report the effect of the premium on 5 outcome measures: 1) rates of unnecessary service use, 2) rate on various health outcomes, 3) health spending, 4) cost-effectiveness over time (as defined by the ratio of health outcomes to spending), and 5) cost-effectiveness (as defined by the ratio of healthcare utilization to spending), over time by TMA status, income, premium payment status, and other demographic characteristics available through CARES. We will include tabulations as well as a graphical and regression analysis. 2. Causal analysis of administrative data using a difference-in-differences study design. Compare the 5 outcome measures for those affected by the policy (Treatment Group 1) to those not affected by the policy (Comparison Group 1 and Comparison Group 2 in separate analyses), over time. A purely descriptive analysis would not account for secular changes that might affect the 5 outcome measures nor the potential for selection into TMA status. This design allows identification of the causal effect of premiums by assuming that the 5 outcome measures for the treatment group would have evolved similarly over time as that of the comparison group(s) in the absence of the implementation of the premium requirement. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable. 3. We will also perform a within-person analysis that considers whether outcomes change over time for those affected by the policy conditional on remaining enrolled.	"Case Study", "Administrative Data Analysis", and "Case-Control Matching" by statistically matching those who drop out of TMA within 12 months of premium implementation to those who do not drop out.
2: Will the premium requirement lead to improved health outcomes?		
3: Will the premium requirement slow the growth in healthcare spending?		
4: Will the premium requirement increase the cost effectiveness (Outcomes/Cost) of Medicaid services?		
5: Will the premium requirement increase the cost effectiveness (Utilization/Cost) of Medicaid services?		
8: What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?	1. Descriptive analysis of administrative data. We will provide a description of TMA enrollment over time, including the probability of transitioning to TMA, by TMA status, income, premium payment status, and other demographic characteristics available through CARES. 2. Causal analysis of administrative data using an interrupted time series study design. Compare the rate of transitions from MA adult to TMA status in order to understand whether premium requirements affect the incentive to take up TMA and/or	

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	experience the types of transitions that would lead to a qualifying event. We will also use this design to study the probability of exit from TMA. This design allows us to identify the causal effect of premiums by assuming that enrollment behavior in the TMA population would have evolved similarly over time if not for the premium requirements. We will use econometric modeling techniques that appropriately account for serial correlation. 3. Regression discontinuity design within the TMA population to study the effect of premium amounts. This design involves comparing the enrollment behavior of those who transition and have incomes just low enough to qualify them for a particular premium amount relative to those who transition and have incomes just higher, qualifying them for a higher premium amount. The strength of this design is that it ensures populations are highly similar (as both transitioned from MA) rather than relying on a comparison of adults who did not transition, who may be different from those who did in unobservable ways that are predictive of the enrollment outcome. We will perform this analysis for each level of the required premium.	
9: How is access to care affected by the application of new, or increased, premium amounts?	1. Descriptive analysis of survey data: The survey that will be fielded in Spring 2016 will include measures of access to care (e.g., usual source of care and experience of any unmet need for medical care), which is not well measured from administrative claims data. The survey will include both current TMA enrollees as well as those who have been placed in an RRP, so that both those who are and are not currently paying premiums are represented. We will summarize survey measures of beneficiary access to care stratified by TMA and premium-requirement status, providing tabular, graphical, and regression-adjusted analyses. 2. Matched analysis of administrative data. If feasible, we will enhance the survey by matching the survey data to the administrative data. This will allow us to observe more precise measures of income and enrollment, which will facilitate a causal analysis. In particular, we will use a regression discontinuity design within the TMA population in order to study the effect of premium amounts. This design involves comparing the surveyed access to care responses of those who transition and have incomes just	"Case Study", "Administrative Data Analysis", "Case-Control Matching", and "Enrollment/Disenrollment Survey"

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	low enough to qualify them for a particular premium amount relative to those who transition and have incomes just higher, qualifying them for a higher premium amount. The strength of this design is that it ensures populations are highly similar rather than relying on a comparison of adults who did not transition, who may be different from those who did in unobservable ways that are predictive of the enrollment outcome. We will perform this analysis for each level of the required premium using appropriate econometric techniques.	
Restrictive Reenrollment Period for Failure to Pay Premium: Q6-7; 10-12		
6: Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?	Regression model that compares pre- and post-RRP trends taking advantage of repeated measures of utilization within the same beneficiary, and also taking advantage of data from other beneficiaries who experience RRPs at different times. In this estimation strategy, beneficiaries in pre-RRP periods can serve as controls for themselves in the post-RRP period as well as for other beneficiaries who experience RRPs at different times.	"Case Study", "Administrative Data Analysis", "Case-Control Matching", and "Enrollment/Disenrollment Survey"
7: Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for beneficiaries that have disenrolled and then re-enrolled?	Difference-in-differences design to compare the longer-term trends in outcomes between the population of TMA beneficiaries that experience RRPs to several alternative groups that do not experience RRPs. 1. The first comparison is a within-group comparison for TMA with incomes 100-133% FPL in their first six months (when they are not subject to RRP) versus their second six months when they are subject to RRPs. The advantage of this comparison is that we observe the group during a time period when they are not at risk of losing coverage due to an RRP compared to a time period when the policy changes and they are exposed to an RRP. 2. Second, we can look at TMA populations who remain continuously enrolled (i.e. never experience an RRP), but are otherwise similar to those who do experience an RRP (using a propensity score matching process with baseline demographic characteristics). Third, we can compare TMA beneficiaries with an RRP to similar beneficiaries in the CLA population, which is not subject to RRPs, and is therefore	"Case Study", "Administrative Data Analysis", "Case-Control Matching", and "Enrollment/Disenrollment Survey"

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	less likely to experience enrollment gaps.	
10: What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment?	1. Hazard modeling to compare the relative risk of disenrollment in the first six months among TMA individuals with incomes 100%-133% FPL to disenrollment rates in other groups over similar amounts of time. The hazard model assumes that every individual has some underlying probability of leaving the program, whether or not they are subject to premiums and/or an RRP, and that this risk can be modeled as a function of time spent in the program, demographics, and policy variables. 2. Comparison of differences in both disenrollment rate and total premiums paid between individuals subject to the 3 month RRP 2016 versus the effect of 12 month RRP among similar individuals from prior time period, using propensity score matching.	"Case Study", "Administrative Data Analysis", "Case-Control Matching", and "Enrollment/Disenrollment Survey"
11: Does the RRP impact vary by income level? 12: If there is an impact from the RRP, explore the break-out by income level.	1. Comparison of subgroup effects within the 3 month RRP to the 12 month RRP (i.e., examining whether the average rate of premium payment is higher or lower among beneficiaries with higher income after the switch). This can be operationalized by interacting a variable for income category with the variable for policy group in a model that reports average differences in mean number of months of enrollment and carrying out a similar analysis for estimates of amount paid per month during enrollment. 2. Formal testing of statistical significance for interaction to indicate whether any variation identified is likely to reflect variation that cannot be explained simply by chance differences in the income groups.	"Case Study", "Administrative Data Analysis", and "Case-Control Matching"
Childless Adult Beneficiary Enrollment in the Medicaid Standard Plan: Q13-17		
13. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries result in improved health outcomes?	1. Descriptive analysis of administrative data. We will descriptively analyze 3 outcome measures: 1) health-related outcomes over time, 2) rates of unnecessary service use, and 3) the cost-effectiveness over time (as defined by the ratio of health-related outcomes to spending) for CLA beneficiaries by sample membership (i.e., new enrollees and transitioners), and for CLA transitioners relative to the matched parent/caretaker comparison group. We will include tabulations as well as a graphical and regression analysis.	"Case Study;" "Administrative Data Analysis;" and "Case-Control Matching."

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14. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries achieve a reduction in the incidence of unnecessary services?	2. Causal analysis of administrative data. We will use a difference-in-differences study design to compare 3 outcome measures -- 1) health-related outcomes, 2) rates of unnecessary service use, 3) health-related-outcomes/spending ratio -- for those affected by the change to Standard Plan coverage (CLA transitioners) to those not affected by the coverage change (matched parents and caretakers), over time. This design allows us to identify the causal effect of Standard Plan coverage relative to Core Plan coverage by assuming that each of the 3 measures for the treatment group would have evolved similarly over time as that of the comparison group in the absence of the change in coverage. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable. 3. Expenditures estimation. Health care expenditures will be computed using an algorithm that maps encounter data to a fee-for-service schedule of allowable charges for the Wisconsin Medicaid population.	
15. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Outcomes/Cost) of Medicaid services?		
16. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase in the cost effectiveness (Utilization/Cost) of Medicaid services?	1. Descriptive analysis of administrative data. We will describe 2 outcome measures -- 1) the cost-effectiveness over time (as defined by the ratio of health care use to spending) and 2) the continuity of health insurance coverage and the continuity of health care over time -- for CLA beneficiaries by sample membership (i.e., new enrollees and transitioners), and for CLA transitioners relative to the matched parent/caretaker comparison group. We will include tabulations as well as a graphical and regression analysis. 2. Causal analysis of administrative data. We will use a difference-in-differences study design to compare the health care use/spending ratio and the continuity of coverage and care for those affected by the change to Standard Plan coverage (CLA transitioners) to those not affected by the coverage change (matched parents and caretakers), over time. This design allows us to identify the causal effect of Standard	"Case Study;" "Administrative Data Analysis;" "Case-Control Matching," and "enrollment/disenrollment survey."
17. Will the provision of a benefit plan that is the same as the one		

provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?	Plan coverage relative to Core Plan coverage by assuming that the each of the outcomes for the treatment group would have evolved similarly over time as that of the comparison group in the absence of the change in coverage. For estimation, we will use an appropriate econometric model that incorporates the nature and distribution of the outcome variable. 3. Expenditures estimation. Health care expenditures will be computed using an algorithm that maps encounter data to a fee-for-service schedule of allowable charges for the Wisconsin Medicaid population. 4. Descriptive and potential causal analysis of survey data. In addition to the 2014 survey of BadgerCare beneficiaries, the 2016 and 2018 surveys will provide repeated cross-sectional measures of health care continuity for CLA beneficiaries with income at or below 100%FPL. Using these data we will describe the continuity of health care over time for CLA beneficiaries. The planned surveys will also include a panel component, a subset of respondents that is surveyed up to three times (i.e., 2014, 2016, and 2018). This panel of respondents enables person-level, fixed effects analyses to estimate the effect of the transition to the Standard Plan from Core Plan coverage on health care continuity. In this fixed effects framework, each person serves as his/her own control. Implementation of this causal analysis is contingent upon retention of a sufficient sample of CLA panel respondents.	

ATTACHMENT C: CMS Comments and UW/DHS Responses

Wisconsin BadgerCare Reform Evaluation Design changes
UW Response to CMS Review, V2

CMS comments in Font Times Roman
UW Comments in *Font Calibri italics*

The revised plan represents a set of robust evaluation methodologies, including elements like the proposed difference-in-difference study design, in conjunction with a within-person longitudinal analysis, and interrupted time series and regression discontinuity designs. **The main limitations that need to be clarified or addressed are listed below. Items in bold are considered priorities.**

We appreciate CMS' careful and thoughtful review of our Design Report. We had submitted that report to the Wisconsin Department of Health Services under our contract to evaluate Wisconsin's 2014 BadgerCare waiver. The State had provided to us an evaluation plan, titled "BadgerCare Reform Demonstrate Evaluation Plan" (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/Badger-Care-Reform/wi-badgercare-demo-eval-plan-20141031.pdf), that had been prepared by a separate consulting firm and pre-approved by CMS, and asked that we use that plan, including its measures and methods, for our evaluation.

Our team, after reviewing that plan, met with Wisconsin DHS, noted concerns about the plan and asked that we propose a revision. DHS understood our perspective, particularly with regard to the scientific methods, and asked that, in preparing a revision, we adhere to the existing 17 study questions as outlined in its existing pre-approved plan and within the existing budget and timeline limits for the evaluation.

We welcome an ongoing discussion about how to best answer questions of importance to both Wisconsin DHS and to CMS. Toward that end, we offer the following responses to the CMS comments.

Effect of Premium Requirements and Payment of Premiums Q 1-5; 8-9

- The proposed evaluation outcome measures listed in Table 2 do not adequately assess whether enrollees are forgoing any necessary care. Evaluators may want to consider adapting additional national standards for preventive care outcome measures for the evaluation such as: adult access to ambulatory care (NCQA), tobacco use cessation (NCQA, NQF #0028), body mass index screening and follow-up (NQF #0421), cervical cancer screening (NQF #0032), screening for clinical depression (NQF #0418), and practitioner follow-up after hospitalization (NQF #0567).

The current evaluation reflects the outcome measures that the WI DHS selected in its CMS-approved "BadgerCare Reform Demonstrate Evaluation Plan," (see pages 25 and 35-36 in that original plan) along with additional measures that the UW PHI team suggested to the DHS based on the data available.

We are happy to consider additional variables as outcomes to the extent that we may construct them with the data available and within the current budget and project timeline. For example, time and resources permitting, using the available claims and enrollment data it may be possible to assess access to ambulatory care, cervical cancer screening, and practitioner follow-up after hospitalization. However, the additional measures requested above are beyond the scope of the current project because they require access to clinical information (e.g., electronic medical records) that is not available to the evaluation team.

- **The first comparison population of MA Adults <100% FPL are not exposed to the premium policy because their income requirements do not qualify them. We can expect systematic differences between the treatment population (TMA Adults) and this proposed comparison group on key variables, such as income level, that influence both selection into the groups and subsequent outcomes. Propensity score methods are used with a difference-in-difference framework to balance the groups on these key observable variables. Do the evaluators propose to use propensity score methods in this case, as proposed for the CLA comparison group in Q 13-17?**

  Propensity score matching is unnecessary if the common trends assumption is satisfied. If matching appears to be needed, we will use this method. It is important to note that TMA adults were previously members of the MA adults <100% FPL group. In addition, we have planned analyses as indicated that involve only comparisons within the TMA population.

- **The evaluators note that the second comparison group of parents/caretakers was exposed to the premium policy for a limited time period, and can only serve as a historical comparison since they do not have Medicaid coverage in the post-policy period for the treatment group (Table 3). Do the evaluators propose to conduct a difference-in-difference analysis with this comparison population as well? If so, how are the different time periods of exposure to premium payments for the two groups going to be aligned? Alternately, what study design will be used to compare the two groups?**

  We plan to use this comparison group in a cohort study (so the timelines would be aligned, for example, 1 year prior). The relevant assumption would be that the outcomes would have evolved similarly for this population in the prior time period so that they provide a good counterfactual for the post-policy period for the treatment group.

- It is possible that the treatment and comparison groups may not be mutually exclusive, meaning that someone may have qualified as an MA adult in earlier years, and may now

qualify as a TMA adult who has to pay a premium. How will the evaluation handle such beneficiaries?

The analysis is planned to be spell-level. Therefore, if the enrollment represents a distinct spell, the individuals will be treated as distinct. We will explore whether controlling for prior enrollment spells is important for the analysis.

- In assessing the impact of premiums on enrollment, the evaluators rightly note that income effects cannot be separated from premium effects. Evaluators may however want to consider stratifying the ITT and RDD analyses by specific income levels to assess if the impact of premiums on enrollment varies by income. The proposed design currently does not get at this question.

  The analysis plan states: "We will perform this analysis for each level of the required premium." This means that at each income level at which the premium changes, we will provide separate estimates. Since the ITT/RDD analyses can only be done at the margins at which the premiums change, and these are also different income levels, the design of the waiver does not allow us to directly assess the question of whether any differing effects are due to higher premiums or higher incomes.

- Does the survey sample of 1,054 refer to respondents with completed surveys? In fielding the survey, and using it to facilitate over-time comparisons, evaluators may want to consider the low response rate of <25% for the adult Medicaid population on mixed-mode mail and phone surveys, to determine their target sample.

  The 2014 evaluation surveyed 2,000 total members, with 1,084 total respondents with completed surveys, yielding a (very high) 54% response rate. We have previously conducted extensive research on the response rates of various Medicaid surveys and our project partner, the UW Survey Center has extensive and longstanding expertise in the various methods available to increase response rates, as well as with weighting and oversampling techniques.

- Can the evaluator provide more clarity on how they plan to link survey data to claims?
  Each survey instrument has a code on it that allows connection back to unique assigned identifier at the UW Survey Center. That Survey Center identifier is connected in a separate secure data file to each respondent's Medicaid ID number, which is what is used to connect the responses to the Medicaid claims.

- **What survey questions will adequately capture whether premiums affect disenrollment and access to care as consequence of disenrollment? Will the evaluators consider conducting interviews or focus groups with disenrolled beneficiaries to obtain qualitative insights to how premiums affect disenrollment?**

  We have attached a copy of the full survey instrument here. Several questions within the instrument address premiums, their relationship to enrollment, and access to care as a consequence to disenrollment. On the "Non-RRP" survey version, these concerns are specifically addressed in questions 2,4,8-19, 23, 27, 40-44. The "RRP" survey version specifically addresses these concerns in questions 3-19, 23, 27, 40-44.

  We have opted not to conduct focus groups given our very limited evaluation resources. Instead, are conducting enhanced telephone follow-up within the survey protocol, with respondent interviews, to achieve a high survey response rate and to gain robust understanding across all survey elements.

Restrictive Reenrollment Period for Failure to Pay Premiums Q6-7; 10-12

- In assessing Q6, are outcomes to be estimated every beneficiary-month, while additionally including calendar-month in the models to control for time trends?

  Yes, that is the current plan.

- As noted previously, evaluators may want to consider oversampling beneficiaries experiencing RRPs to allow for pre-post comparisons in Q6. Longitudinal survey response rates for Medicaid beneficiaries can be greatly improved by providing incentives upon completion of the follow-up survey.

  We are oversampling beneficiaries experiencing RRPs.

- To evaluate Q7, evaluators propose using a difference-in-difference design, but the model specification on Page 20 seems to compare just differences in cost/utilization (calculated over a 6-month periods) between the groups. Please clarify.

  Here is our anticipated model for the DD design that involves subjects 100-133% FPL versus those higher income 134%+:

  $$Y_{it} = \beta_0 + \beta_1 After\_transition_{it} + \beta_2 High\_Income_{it} + \beta_3 After\_transition * High\_Income_{it} + \beta_4 Demographics_{it} + \beta_5 CalendarMonth + \varepsilon_{it}$$

  Where Y is some outcome measured for individual i at time t (which is constrained to be in the first six months of TMA). "After transition" is being observed in the time period after April 2014 when the RRP policy changed, "High Income" is being 133%+ FPL and thus subject to the requirements, β_3 is the key DD coefficient which identifies the differences in continuity of coverage and service use outcomes in the post-transition period in the targeted group compared to the untargeted group 100-

133% FPL. Demographics are person-level fixed characteristics and CalendarMonth is a seasonality control for the calendar month in which the RRP began.

- For Q7, it will be important to match RRP and non-RRP beneficiaries by their health status. Hence, evaluators may want to consider including Chronic Illness Disability Payment System (CDPS) risk score computed using all diagnoses on claims/encounters over the baseline period in the propensity score model.

  We agree that propensity score matching will be important for matching RRP and non-RRP subjects, and we hope to develop an approach that encompasses a variety of health status/utilization measures. Our team has not previously worked with the CDPS algorithm. It does appear to be available for free to research teams such as ours, and may be feasible with the structure of claims that we have available, but we are not prepared to commit to implementing this algorithm on the claims until we are confident that it can be done with high reliability and within the limited resources our team has available. We can also explore alternative methods for health stratification such as the Charlson Comorbidity Index.

- **In Analysis 1 for Q10-12, evaluators may want to consider conducting a sensitivity analysis comparing disenrollment rates for TMA beneficiaries with varying income levels in the first two months to their respective disenrollment rates in their last two months of TMA eligibility to assess the impact of premiums alone. Since the RRP locks out a beneficiary for three-months, the marginal rate of disenrollment between these first and last TMA eligibility months will capture the burden of premiums alone on disenrollment. Evaluators may want to consider to something similarly unique to assess the effect of RRP alone on disenrollment.**

  Thank you for this good suggestion. This is a creative approach that we will certainly explore, as we agree that the potential loss of months of eligibility are much greater for an RRP in months 1 and 2 than they are in months 11 and 12. Offhand, the only concern we have about this approach is that individuals who persist to months 11 and 12 may be a more selected group that is likely to persist in their coverage and pay premiums regularly than those who attrit from coverage earlier, but we can explore approaches to reduce potential bias.

- **In Analysis 2 for Q 10, evaluators propose using a historical comparison group of beneficiaries who experienced the 12 month RRP in a previous policy version. Would this not bias the findings in favor of the 3 month RRP because of the increased opportunity for beneficiaries to pay premiums? What survey questions will adequately capture the impact of RRP on access to care? Will the evaluators consider conducting interviews or focus groups with beneficiaries with RRPs to obtain qualitative insights on the consequences of RRP?**

Our study design is conditional, so we don't only look at total months. We look at disenrollment rate/RRP rate from period of TMA entry, and then conditional on exiting TMA, we separately look at length of time out of the program.

We have survey items that ask people where they go for care during the RRP. For example:

[RRP only]During the period of time you could not be enrolled because of Restrictive Reenrollment, which of the following statements applied to your health care needs? Select *all* that apply.	**Yes**	**No**
a. I did not need any health care	◯	◯
b. I needed health care, but I decided to delay until I had health care coverage again [# Skip to Q7, place usually go]	◯	◯
c. I received health care in the hospital emergency room	◯	◯
d. I received health care at a community health center or clinic	◯	◯
e. I received health care from a private doctor or clinic	◯	◯
f. I received health care where I usually do when I have health care coverage	◯	◯
[RRP only] How did you pay for the health care you got during the period of time you could not be enrolled in BadgerCare Plus? Select all that apply.		
a. I, or a friend or family member, paid directly (out-of-pocket)	◯	◯
b. I was able to get free/charity care	◯	◯
c. I used a different health insurance plan	◯	◯
d. I still owe money/have debt for those bills	◯	◯

We have opted not to conduct focus groups given our very limited evaluation resources. Instead, we are conducting enhanced telephone follow-up within the survey protocol, with respondent interviews, to boost the response rate to the surveys and gain robust understanding across these elements.

Childless Adult Beneficiary Enrollment Q 13-17

To capture the impact of transitioning into a more comprehensive plan on beneficiary outcomes, evaluators may want to consider adapting additional nationally recognized preventive care outcome measures such as: adult access to ambulatory care (NCQA), tobacco use cessation (NCQA, NQF #0028), body mass index screening and follow-up (NQF #0421), cervical cancer

screening (NQF #0032), screening for clinical depression (NQF #0418), and practitioner follow-up after hospitalization (NQF #0567).

The current evaluation reflects the outcome measures that the WI DHS selected in its CMS-approved "BadgerCare Reform Demonstrate Evaluation Plan," (see pages 25 and 35-36 in that original plan) along with additional measures that the UW PHI team suggested to the DHS based on the data available.

We are happy to consider additional variables as outcomes to the extent that we may construct them with the data available and within the existing budget and project timeline. For example, time and resources permitting, using the available claims and enrollment data it may be possible to assess access to ambulatory care, cervical cancer screening, and practitioner follow-up after hospitalization . However, the additional measures requested above are beyond the scope of the current project because they require access to clinical information (e.g., electronic medical records) that is not available to the evaluation team.

- It will be important to match beneficiaries in the treatment and comparison group by their health status. Hence, evaluators may want to consider including Chronic Illness Disability Payment System (CDPS) risk score computed using all diagnoses on claims/encounters over a baseline period in the propensity score model.

  Propensity score matching of the treatment and comparison group is unnecessary if the common trends assumption is satisfied. We appreciate the CMS' suggestion of the CDPS as a potential matching variable and will consider it if matching appears to be needed. (See also the response to Q7 on page 5.)

- Systematic differences between childless adults and parents/caretakers are likely. While propensity score methods ensure balance between the two groups on measured confounders, are there contingency plans in place if there is no balance observed between the treatment and comparison group on these observed confounders?

  In the context of the diff-in-diff design, systematic differences between the groups are only problematic to the extent that they violate the common trends assumption.

  If matching appears to be necessary, we will select our matching method based on the degree of overlap in observables between the two groups. If there is insufficient overlap, we will implement a single series interrupted time series model. This design has the capacity to yield causal findings in the absence of a comparison group assuming no concurrent event related to the outcome in April 2014 and a sufficient number of data points before and after April 2014. We have a sufficient number of data points to implement this design and are not aware of any confounding concurrent events.

Additional suggestions for evaluators to consider:

- We suggest rewording the "cost-effectiveness" to either "efficiency" or "smarter spending" since the evaluation measures do not get at true cost-effectiveness.

  Our UW evaluation team did not select the content or wording of the State of Wisconsin's evaluation measures. This language was laid out in the State of Wisconsin's document that had previously been approved by CMS and provided to our UW team to follow as part of our evaluation contract.

  In our Design Report that we submitted to DHS, we provided clarifying text in the "limitations" section that follows each of the State's cost -effectiveness questions. This text recognizes the CMS' point. The representative text from Q15 is included below:

  > *We note that outcomes/spending is also not a typical measure of "cost-effectiveness," which is normally expressed as a denominator of a gain in health and a numerator of the cost associated with the health gain. Regardless, we will not be able to directly identify the specific costs of any particular change in health outcomes, only "changes in costs" and "changes in health-related outcomes" induced by the introduction of Standard Plan coverage.*

  If the DHS and CMS would like to alter the language, we propose the text below. These questions are identical to the original DHS questions except for the underlined text.

  Q.4. Will the premium requirement increase the ratio of outcomes to spending for Medicaid services?

  Q5. Will the premium requirement increase the ratio of health care utilization to spending for Medicaid services?

  Q.15 Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase the ratio of outcomes to spending for Medicaid services?

  Q.16. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries increase the ratio of health care utilization to spending for Medicaid services?

- There are multiple diagnoses associated with an ED visit claim/encounter. In applying the Billings Algorithm to determine whether an ED visit is for an ambulatory care sensitive condition, we suggest that evaluators consider the ED diagnoses on the claim with the highest with the highest likelihood of being truly emergent. This allows for consistency in classifying ED visits as avoidable/unavoidable.

  We will apply the Billings algorithm in a consistent and transparent manner as in our prior work. See, for example:

DeLeire T, Dague L, Leininger L, Voskuil K, Friedsam D. 2013. Wisconsin experience indicates that expanding public insurance to low-income childless adults has health care impacts. Health Affairs. 32(6):1037-1045.

- We suggest adding a discussion on the completeness and accuracy of the Wisconsin encounter data.

  We will include this assessment in our annual and final reports, as we have in our previous evaluation projects with Wisconsin DHS.

ATTACHMENT D: Workplan Timeline

	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Status
Project Start-Up							
Attain needed BAA and DUA							completed
Secure IRB certification							completed
Attain sub-agreements with collaborating investigators, UW Survey Center, IRP, and CHSRA							completed
Survey 1							
Draft Survey Instrument							completed
Submit for DHS and CMS Review/Approval							completed
Identify and Select Cohort							completed
Attain mailing information from DHS							completed
Field Survey							completed
Survey Data Collection							completed
Survey Data Analysis and Reporting							completed
Telephone Interviews							completed
Administrative Data Analysis							
Attain enrollment files for both TMA and CLA samples							completed
Conduct matching to identify Pre- and Post-Tx samples							partially completed
Match enrollment file to claims and encounter data							partially completed
Refresh data at six month intervals							completed
Identify and construct relevant outcome measures (eg - 30-day readmission)							Moved to 2017 Workplan
Conduct analyses - for interim and final reporting							
Unnecessary Services							Moved to 2017 Workplan
Improved Health Outcomes							Moved to 2017 Workplan
Effect of premiums							Interim analyses completed
Continuity of health coverage							Interim analyses completed

Slow growth in Healthcare Spending			Begin in 2017 as planned
Cost Impact Analysis			Begin in 2017 as planned
Effect of RRP		Start 2017	Interim analyses completed
Create price/cost measure for cost impact analysis			Begin in 2017 as planned
Reports			
Design Report - Methodological and Statistical Approach			completed
Interim Annual Reports			completed

ATTACHMENT E: SURVEY INSTRUMENT

University of Wisconsin
Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Current or Former
BadgerCare Plus Member Survey

Thank you for taking the time to answer the questions on the following pages. This survey is about your health care coverage through Wisconsin Medicaid or BadgerCare Plus. Your answers will help the Wisconsin Department of Health Services understand how changes to these programs affect your health and health care.

Taking part in this survey is voluntary. You can skip questions that you do not want to answer. If you choose not to take this survey, it will not affect any health care benefits you are getting right now or might get in the future. All information is private and confidential. You will not be individually identified with your responses.

For each question, please fill in the circle next to the answer you choose, or write your answer in the box provided. When you are finished, please place the completed survey into the postage-paid envelope provided, and put it in the mail.

If you have questions about the survey, you can contact one of the people listed below:

Bob Cradock at the University of Wisconsin Survey Center
608-265-9885
cradock@ssc.wisc.edu

Donna Friedsam at the UW Population Health Institute
608-263-4881
dafriedsam@wisc.edu

Thank you again for your help!

Your Health Care Coverage

1. In the past 12 months, how many months did you have some kind of health care coverage? Select *one* answer only.

- ○ No health care coverage during the last 12 months
- ○ 1 to 2 months of health care coverage
- ○ 3 to 5 months of health care coverage
- ○ 6 to 8 months of health care coverage
- ○ 9 to 11 months of health care coverage
- ○ Covered for all of the last 12 months → **Go to Question 3**

2. If you did not have health care coverage in some or all of the past 12 months, what are the reasons you did not have coverage? Select *all* that apply.

	Yes	No
a. I did not qualify for Medicaid/BadgerCare Plus anymore	○	○
b. I could not afford payments to remain on Medicaid or BadgerCare Plus	○	○
c. I could not afford payments for private health care coverage, an employer's insurance, or from the federal Marketplace/Healthcare.gov/ACA/Obamacare	○	○
d. I was not offered health care coverage from an employer	○	○
e. I was not able to afford the health care coverage an employer offered	○	○
f. I did not have access to any health care coverage	○	○
g. I did not want health care coverage	○	○
h. I did not know how to find information on available health care coverage options	○	○
i. I did not have the time to get health care coverage	○	○

3. What type of health care coverage do you *currently* have? Select *all* that apply.

	Yes	No
a. Wisconsin Medicaid Program	○	○
b. BadgerCare Plus	○	○
c. Medicare	○	○
d. Employer or family member's employer	○	○
e. A private plan I pay for myself	○	○
f. A health plan from Healthcare.gov, the federal Affordable Care Act (ACA/Obamacare) Marketplace	○	○
g. Other coverage. Please specify:	○	○
h. None - no coverage/insurance	○	○

If you *currently* have coverage from Medicaid or BadgerCare Plus, please skip to Question 7.

4. For those who no longer have Medicaid/BadgerCare coverage: What are the reasons you no longer have that coverage? Select *all* that apply.

	Yes	No
a. I am not eligible anymore because I have access to other health care coverage.	○	○
b. I am not eligible anymore because my income has changed.	○	○
c. I am not eligible anymore for other reasons.	○	○
d. The premiums increased and so I dropped my Medicaid/BadgerCare Plus coverage.	○	○
e. I missed a premium payment, so the Medicaid/BadgerCare Plus program temporarily removed me from coverage.	○	○
f. Other reason. Please specify:	○	○

5. Have you ever looked for information on health care coverage available from the federal Health Insurance Marketplace (healthcare.gov)? Select *one* answer only.

- ○ Yes
- ○ No, but I plan on looking for information → **Go to Question 7**
- ○ No, and I do not plan on looking for information → **Go to Question 7**
- ○ I have not heard about this kind of health care coverage → **Go to Question 7**
- ○ I do not know how to look for health care coverage → **Go to Question 7**

6. How did the health care coverage available from the federal Health Insurance Marketplace (healthcare.gov) seem to you? Select *one* answer only.

- ○ There are some good options for me
- ○ I can't afford the required premium payments
- ○ The plans don’t cover/include the doctors and providers that I need to see
- ○ I’m not sure

Your Health Care

7. Is there a place you *usually* go to get health care? Select *one* answer only.

- ◯ Yes
- ◯ No → **Go to Question 9**

8. Where do you usually go to get health care? Select *one* answer only.

- ◯ A private doctor's office or clinic
- ◯ A public health clinic, community health center, or tribal clinic
- ◯ A walk-in clinic in a store, such as Walmart or a pharmacy
- ◯ A hospital-based clinic
- ◯ A hospital emergency room
- ◯ An urgent care clinic
- ◯ Some other place. Please specify: _____
- ◯ I don't have a usual place
- ◯ I don't know

9. Do you have at least one person you think of as your personal doctor or health care provider? Select *one* answer only.

- ◯ Yes, more than one person
- ◯ Yes, only one person
- ◯ No, no one
- ◯ I don't know

10. If you needed health care in the past 12 months, did you get all the care you needed?

- ◯ Yes → **Go to Question 12**
- ◯ No
- ◯ I did not need care in the last 12 months → **Go to Question 12**

11. Think about the *most recent time* you went *without* needed health care in the last 12 months. What were the main reasons you went without care at that time? Select *all* that apply.

	Yes	No
a. It cost too much	◯	◯
b. I didn't have health care coverage	◯	◯
c. The doctor wouldn't take my insurance	◯	◯
d. I owed money to the doctor	◯	◯
e. I couldn't get an appointment quickly enough	◯	◯
f. The office wasn't open when I could get there	◯	◯
g. I didn't have a doctor	◯	◯
h. Other reason. Please specify:	◯	◯

12. Was there a time in the *last 12 months* when you needed *prescription medication*?

- ◯ Yes
- ◯ No → **Go to Question 15**

13. If you needed prescription medications in the past 12 months, did you get all the medications you needed? Select *one* answer only.

- ◯ Yes → **Go to Question 15**
- ◯ No
- ◯ I did not need medications in the last 12 months → **Go to Question 15**

14. Think about the *most recent time* you went *without* prescription medications that you needed in the last 12 months. What were the main reasons you went without prescription medications at that time? Select *all* that apply.

	Yes	No
a. They cost too much	◯	◯
b. I didn't have health care coverage	◯	◯
c. I didn't have a doctor	◯	◯
d. I couldn't get a prescription	◯	◯
e. I couldn't get to the pharmacy	◯	◯
f. Some other reason. Please specify:	◯	◯

15. How long has it been since you last visited a dentist or a dental care provider for any reason? *Include visits to dental specialists, such as orthodontists.*

- ◯ Less than 12 months ago
- ◯ Between 1 and 5 years ago
- ◯ More than 5 years ago
- ◯ I have never visited a dentist or dental care provider
- ◯ Not sure

16. In the *last 12 months*, how many times did you visit a doctor's office, an urgent care or walk-in clinic, or other health care provider to get care for yourself? *Do not include hospital and emergency room visits or dental care. Please give your best guess.*

- ◯ 0 times
- ◯ 1 time
- ◯ 2 times
- ◯ 3 or 4 times
- ◯ 5 or more times

17. In the *last 12 months*, how many times did you go to an emergency room to get care for yourself? *Please give your best guess.*

- ◯ 0 times → **Go to Question 19**
- ◯ 1 time
- ◯ 2 times
- ◯ 3 or 4 times
- ◯ 5 or more times

18. Think about the *most recent time* you went to the emergency room in the last 12 months. What were the main reasons you went to the emergency room instead of somewhere else for health care at that time? Select *all* that apply.

	Yes	No
a. I needed emergency care	◯	◯
b. I didn't have health insurance	◯	◯
c. The doctors' office/clinic was closed	◯	◯
d. I couldn't get an appointment to see a regular doctor soon enough	◯	◯
e. I didn't have a personal doctor	◯	◯
f. I couldn't afford the copay to see a doctor	◯	◯
g. I needed a prescription drug	◯	◯
h. I didn't know where else to go	◯	◯
i. Some other reason. Please specify: _____	◯	◯

19. In the *last 12 months*, how many different times were you a patient in a hospital for at least one overnight? *Do not include hospital stays to deliver a baby.*

[ ] times

20. Overall, how would you rate the quality of the medical care you have received in the *last 12 months*?

◯ Excellent
◯ Very good
◯ Good
◯ Fair
◯ Poor

◯ I did not receive medical care in the last 12 months

21. How satisfied or dissatisfied are you with the following aspects of your current health care?

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
a. The range of health care services available	◯	◯	◯	◯
b. The choice of doctors and other providers	◯	◯	◯	◯

Your Health Care Costs

22. In the past 12 months, did you have problems paying any medical bills, including bills for doctors, dentists, hospitals, therapists, medical equipment, nursing home, or home care?

◯ Yes
◯ No

23. In the past 12 months, did you need any of the following at any time but not get it because of how much it cost? Select *all* that apply.

	Yes	No
a. Prescription drugs	◯	◯
b. Medical care	◯	◯
c. To see a general doctor	◯	◯
d. To see a specialist	◯	◯
e. To get medical tests, treatment, or follow-up care	◯	◯
f. Dental care	◯	◯
g. Mental health care or counseling	◯	◯
h. Eyeglasses or vision care	◯	◯

24. Do you *currently* owe money to a health care provider, credit card company, or anyone else for medical expenses?

◯ Yes
◯ No → **Go to Question 26**

25. About how much do you owe?

$ .00 amount owed

26. In the *last 12 months*, have you had to borrow money, skip paying other bills, or pay other bills late in order to pay health insurance bills?

◯ Yes
◯ No

27. In the *last 12 months*, has a doctor, clinic, or medical service refused to treat you because you owed money to them for past treatment?

◯ Yes
◯ No
◯ I don't know

Your Health

28. In general, would you say your health is:

◯ Excellent
◯ Very good
◯ Good
◯ Fair
◯ Poor

29. How has your health changed in the *last 12 months*?

◯ My health has gotten better
◯ My health is about the same
◯ My health has gotten worse

30. Have you ever been told by a doctor or other health care provider that you have any of the health conditions listed below? Select *all* that apply.

	Yes	No
a. Diabetes or sugar diabetes	◯	◯
b. Asthma	◯	◯
c. High blood pressure	◯	◯
d. Emphysema or chronic bronchitis (COPD)	◯	◯
e. Heart disease, angina, or heart attack	◯	◯
f. Congestive heart failure	◯	◯
g. Depression or anxiety	◯	◯
h. High cholesterol	◯	◯
i. Kidney problems, kidney disease, or dialysis	◯	◯
j. A stroke	◯	◯
k. Alcoholism or drug addition	◯	◯
l. Cancer, except for skin cancer	◯	◯

31. In the past 12 months, have you done any of the following things specifically for any of those health conditions you were told that you have? Select *all* that apply.

	Yes	No
a. I have been to a doctor or clinic	◯	◯
b. I have taken medication regularly	◯	◯
c. I have been to the hospital emergency room because of the condition(s)	◯	◯
d. I have been admitted to the hospital because of the condition(s)	◯	◯
e. I have not been treated for the condition(s)	◯	◯

32. Have you had your blood cholesterol checked?

◯ Yes, within the last 12 months
◯ Yes, but it's been more than 12 months
◯ Never

33. During the past 12 months, have you had either a flu shot or a flu vaccine that was sprayed in your nose?

◯ Yes
◯ No

34. Do you currently smoke cigarettes every day, some days, or not at all?

- ◯ Every day
- ◯ Some days
- ◯ Not at all → **Go to Question 36**

35. In the *last 12 months*, have you been advised by a doctor or health professional to quit smoking?

- ◯ Yes
- ◯ No
- ◯ I haven't seen a doctor in the last 12 months

36. Does a physical, mental, or emotional condition now limit your ability to work at a job?

- ◯ Yes
- ◯ No

37. Over the past two weeks, how often have you been bothered by having little interest or pleasure in doing things?

- ◯ Not at all
- ◯ A few times
- ◯ More than half the days
- ◯ Nearly every day
- ◯ Don't know

38. Over the past two weeks, how often have you been bothered by feeling down, depressed, or hopeless?

- ◯ Not at all
- ◯ A few times
- ◯ More than half the days
- ◯ Nearly every day
- ◯ Don't know

Your Health Care Coverage Experiences

39. Some people find health care coverage and insurance difficult to understand. For each of the words below, please indicate how confident you are that you understand what the word means.

	Very Confident	Somewhat Confident	Slightly Confident	Not At All Confident
a. Premiums	◯	◯	◯	◯
b. Deductibles	◯	◯	◯	◯
c. Copayments	◯	◯	◯	◯
d. Coinsurance	◯	◯	◯	◯

40. Were you enrolled in the BadgerCare program before April 2014?

◯ Yes
◯ No → **Go to Question 45**
◯ Don't know

41. In April 2014, the BadgerCare Plus program changed its program requirements, including how people can become eligible for the program, what services are covered, and what kinds of payments might be required to participate in the program.

To the best of your knowledge were you affected by any new program requirements?

◯ Yes
◯ No
◯ Don't know

42. Did you ever lose eligibility for BadgerCare Plus and were no longer enrolled because of changes made after April 2014?

◯ Yes → **Go to Question 45**
◯ No

43. Think about changes since April 2014 in the BadgerCare Plus program. Please indicate how each of the items below affected you.

	Increased	Decreased	No Change	Not Sure
a. Monthly premium/payments for health care coverage	◯	◯	◯	◯
b. Penalties for not paying a monthly premium	◯	◯	◯	◯
c. Copayments to visit a doctor or clinic	◯	◯	◯	◯
d. Mental health or substance abuse treatment benefits	◯	◯	◯	◯

44. Overall, how satisfied or dissatisfied are you with the changes that have taken place since April 2014? Select one answer only.

- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Somewhat dissatisfied
- ◯ Very dissatisfied

About You

45. Are you male or female?

- ◯ Male
- ◯ Female

46. What is your current age?

- ◯ Younger than age 19
- ◯ Age 19 to 25
- ◯ Age 26 to 34
- ◯ Age 35 to 44
- ◯ Age 45 to 64
- ◯ Age 65 or older

47. Are you currently employed or self-employed?

- ◯ Yes, employed by someone else
- ◯ Yes, self-employed
- ◯ Not currently employed
- ◯ Retired

48. About how many hours per week, on average, do you work at your current job(s)?

- ◯ I don’t currently work
- ◯ I work less than 20 hours per week
- ◯ I work 20 to 29 hours per week
- ◯ I work 30 or more hours per week

49. What was your household's gross income (before taxes and deductions are taken out) for 2015? Include any cash assistance or unemployment benefits you may have received, and include the income of all members of your household. Select *one* answer only. If you do not know, give your best guess.

- ◯ Less than $4,999
- ◯ $5,000 to $9,999
- ◯ $10,000 to $14,999
- ◯ $15,000 to $19,999
- ◯ $20,000 to $29,999
- ◯ $30,000 to $39,999
- ◯ $40,000 to $49,999
- ◯ $50,000 to $59,999
- ◯ $60,000 to $69,999
- ◯ $70,000 to $79,999
- ◯ $80,000 to $89,999
- ◯ $90,000 to $99,999
- ◯ $100,000 or more

50. Would you describe yourself as Spanish, Hispanic, or Latino?

- ◯ Yes
- ◯ No

51. How would you describe your race? Select *all* that apply.

- ☐ White
- ☐ Black or African-American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other, please specify: _____

52. What is the *highest* level of education you have completed? Select *one* answer only.

- ◯ Less than high school
- ◯ High school diploma or General Education Development (GED) certificate
- ◯ Vocational training or 2-year degree
- ◯ Some college but no degree
- ◯ A 4-year college degree or more

53. What is your current living arrangement? *Select all that apply.*

☐ I live alone
☐ I live with my partner or spouse
☐ I live with my parents
☐ I live with other relatives (including children)
☐ I live with friends or roommates
☐ Other, please specify: _____

54. How many family members, <u>including yourself</u>, counting adults and children, are living in your home? (*For example, if you live alone, you should write "1"*.)

_____ family member(s) in my home

55. Of the family members living in your home, how many are under age 19?

_____ family member(s) in my home are under age 19

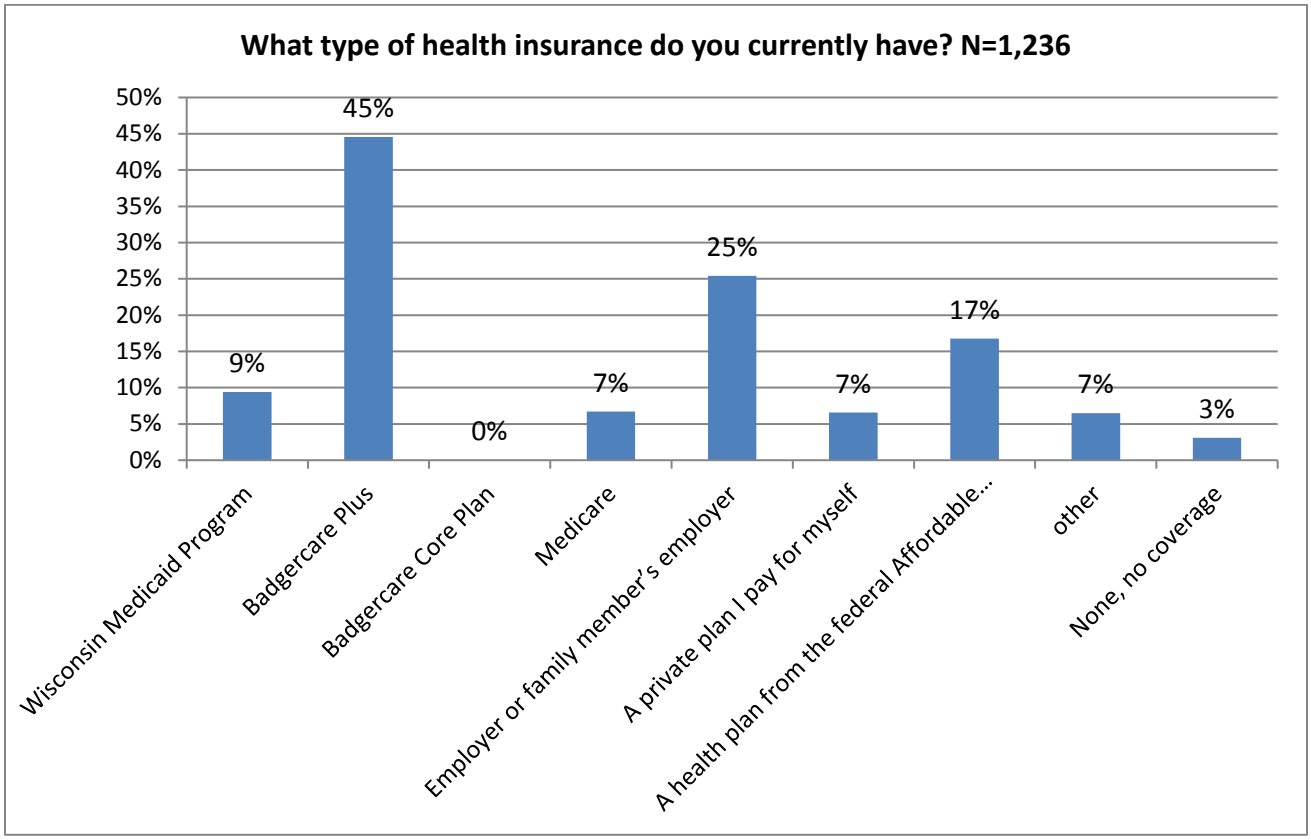
56. Do you have any children under age 19 who you financially support but that do not live in your home?

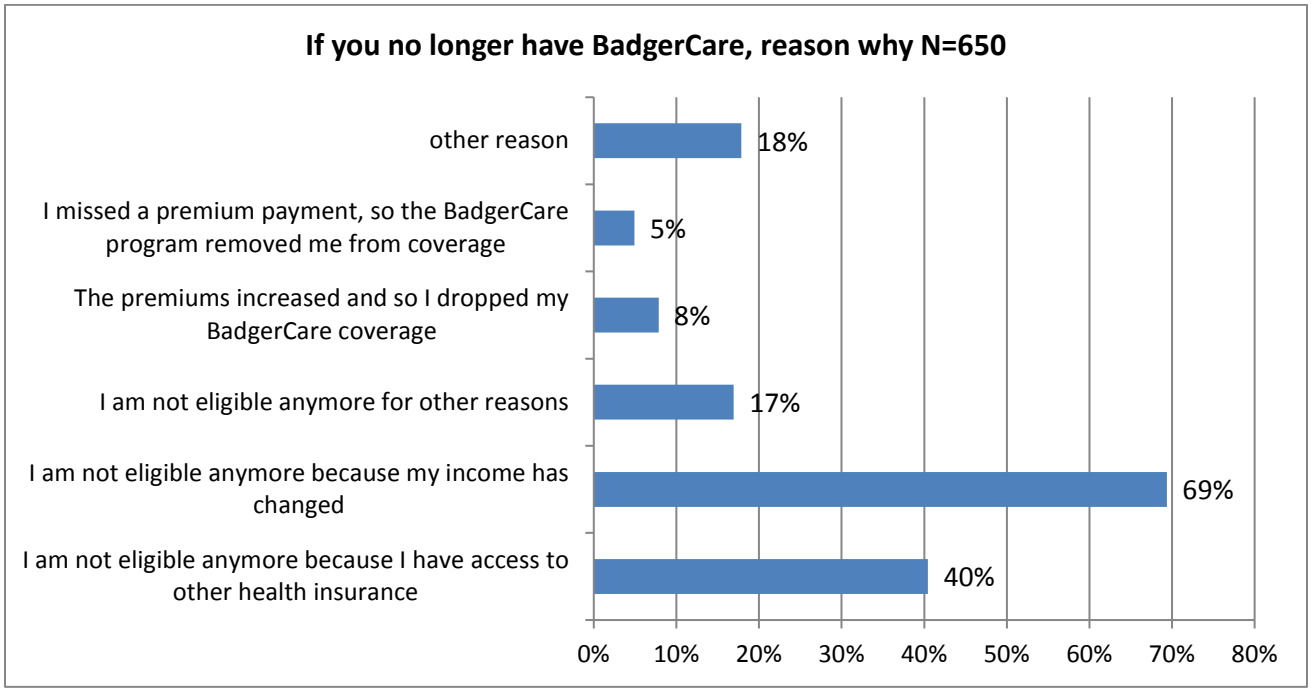
◯ Yes
◯ No

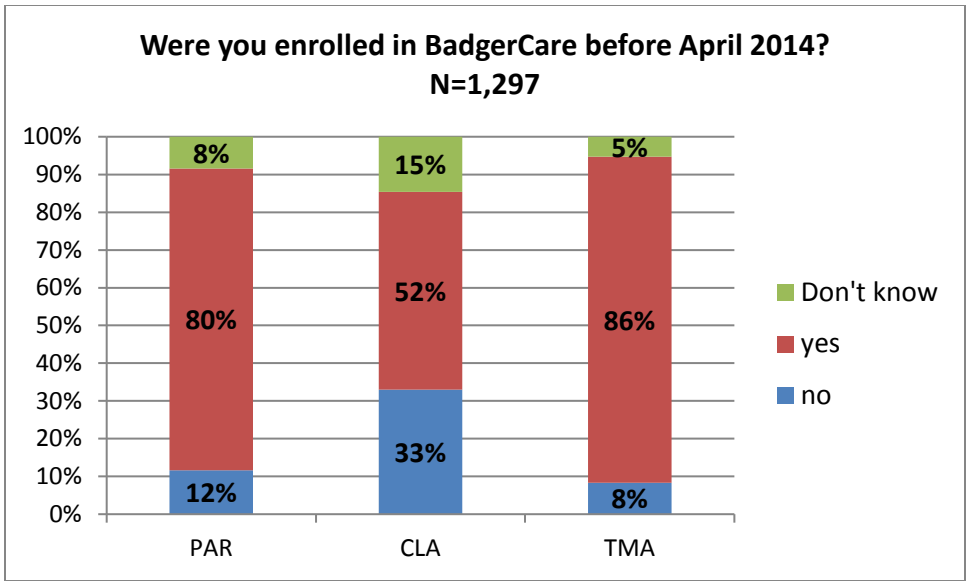
Thank you for your participation. When you have finished your survey, please place it in the included postage-paid envelope, and drop it in the mail.

ATTACHMENT F: Descriptive View of Raw Survey Responses

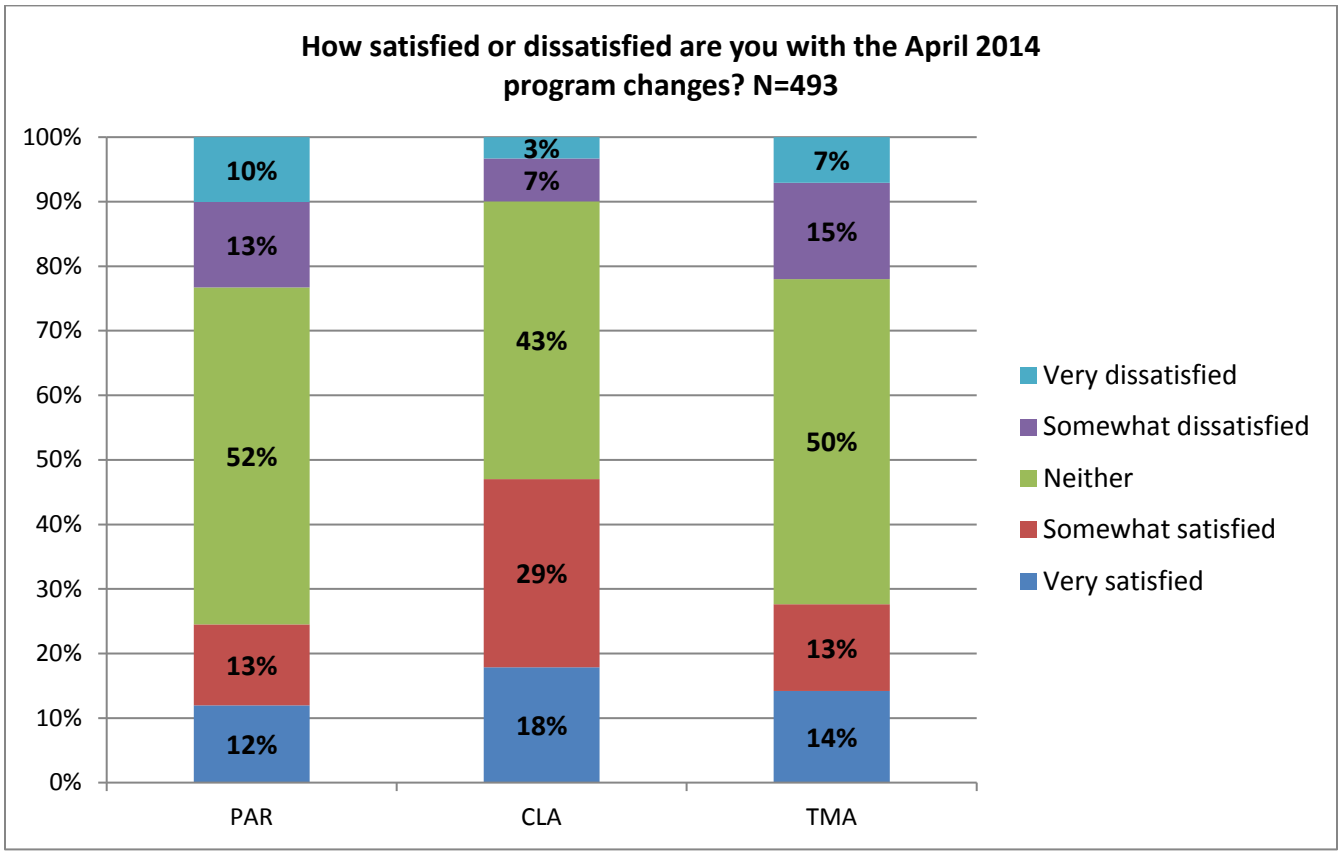
The analysis and results from the survey will be delivered in a separate scientific report. However, in order to demonstrate the progress toward meeting this workplan component, we provide here an initial descriptive view of some of the data elements. These descriptive statistics reflect raw, unweighted responses. They illustrate the kind of information that will be available in the forthcoming scientific report, but the data displayed in this attachment are not intended for drawing causal inferences or for distribution.

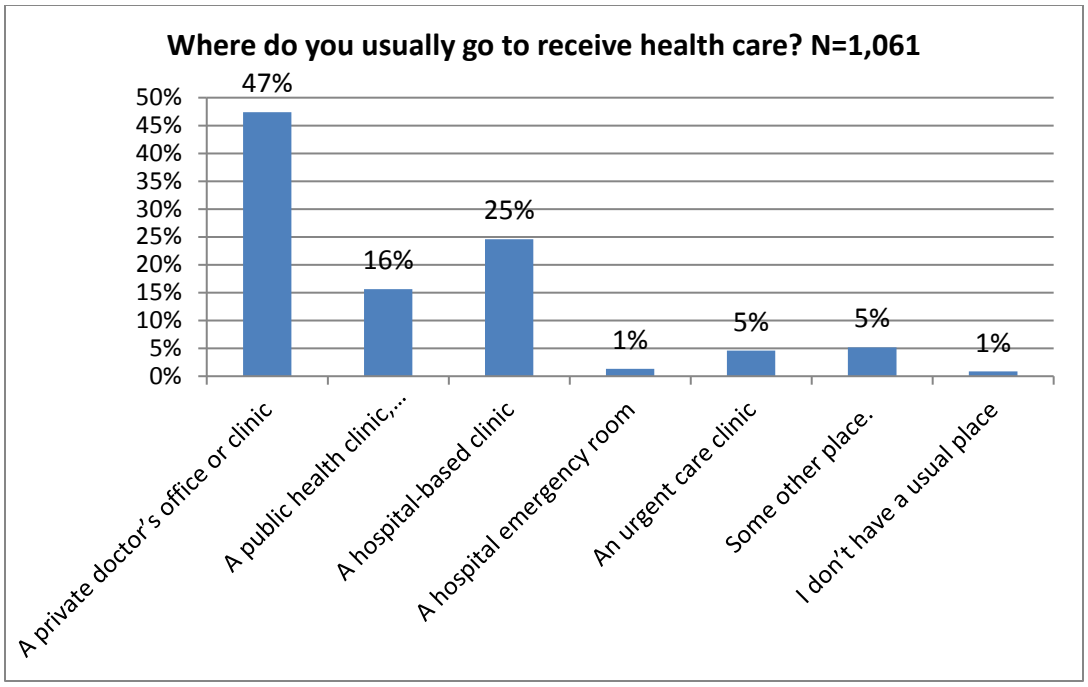

What type of health insurance do you currently have? N=1,236
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
9%
45%
0%
7%
25%
7%
17%
7%
3%
Wisconsin Medicaid Program
Badgercare Plus
Badgercare Core Plan
Medicare
Employer or family member's employer
A private plan I pay for myself
A health plan from the federal Affordable...
other
None, no coverage

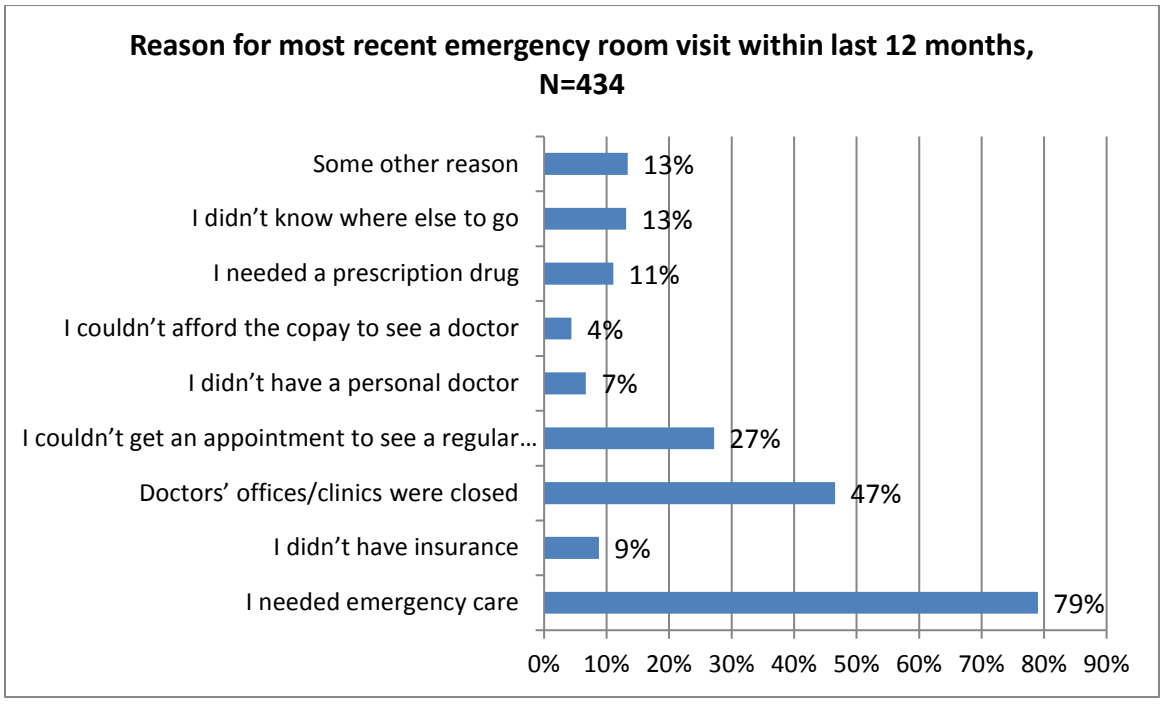

If you no longer have BadgerCare, reason why N=650
other reason
18%
I missed a premium payment, so the BadgerCare program removed me from coverage
5%
The premiums increased and so I dropped my BadgerCare coverage
8%
I am not eligible anymore for other reasons
17%
I am not eligible anymore because my income has changed
69%
I am not eligible anymore because I have access to other health insurance
40%
0%
10%
20%
30%
40%
50%
60%
70%
80%

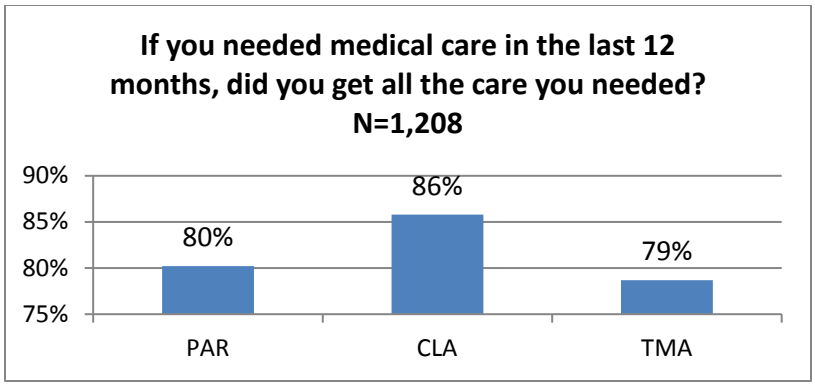


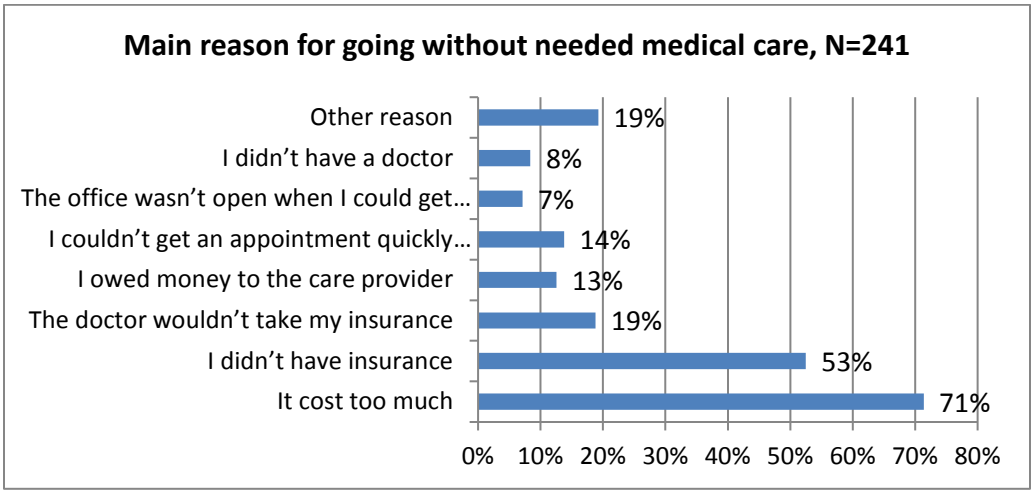
Of those who answered "Yes" indicating they were enrolled in BadgerCare prior to April 2014:

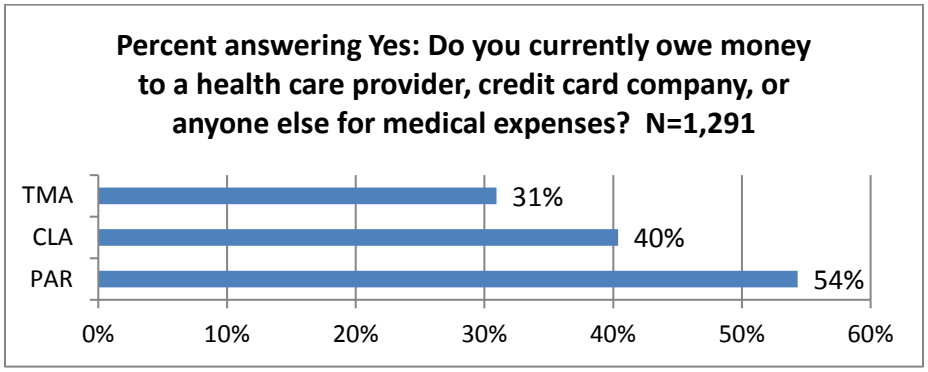


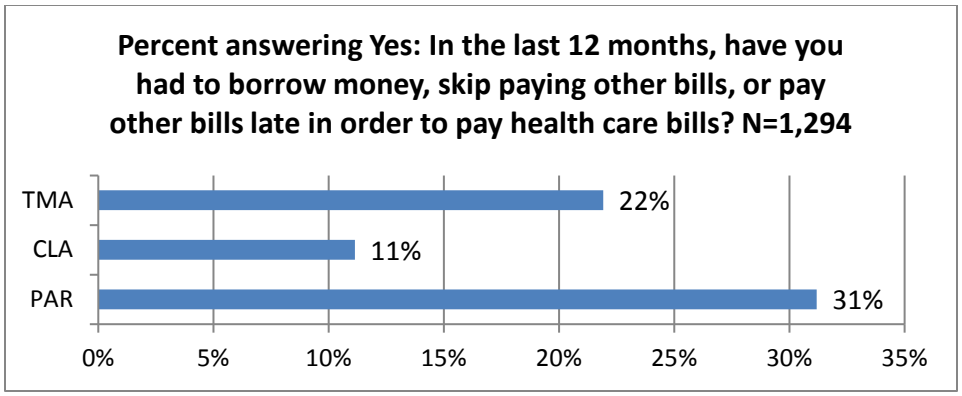

Where do you usually go to receive health care? N=1,061
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
47%
16%
25%
1%
5%
5%
1%
A private doctor's office or clinic
A public health clinic,...
A hospital-based clinic
A hospital emergency room
An urgent care clinic
Some other place.
I don't have a usual place

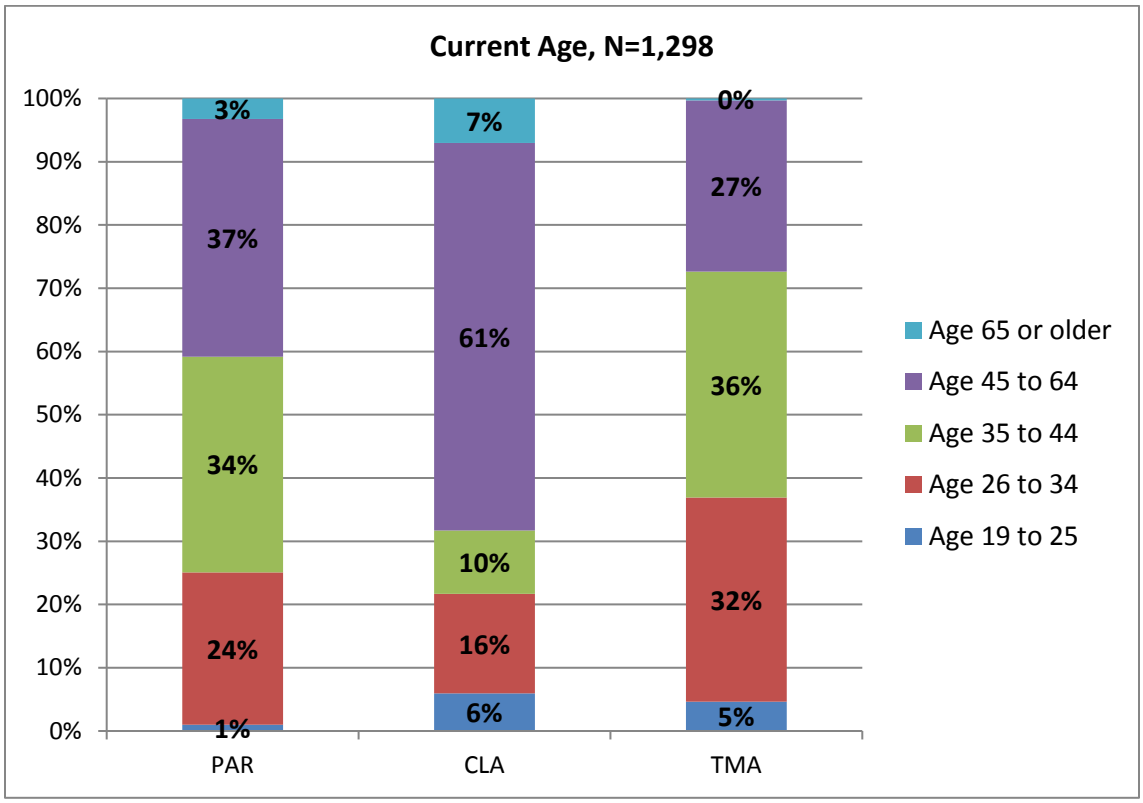

Reason for most recent emergency room visit within last 12 months, N=434
Some other reason
I didn't know where else to go
I needed a prescription drug
I couldn't afford the copay to see a doctor
I didn't have a personal doctor
I couldn't get an appointment to see a regular...
Doctors' offices/clinics were closed
I didn't have insurance
I needed emergency care
13%
13%
11%
4%
7%
27%
47%
9%
79%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%

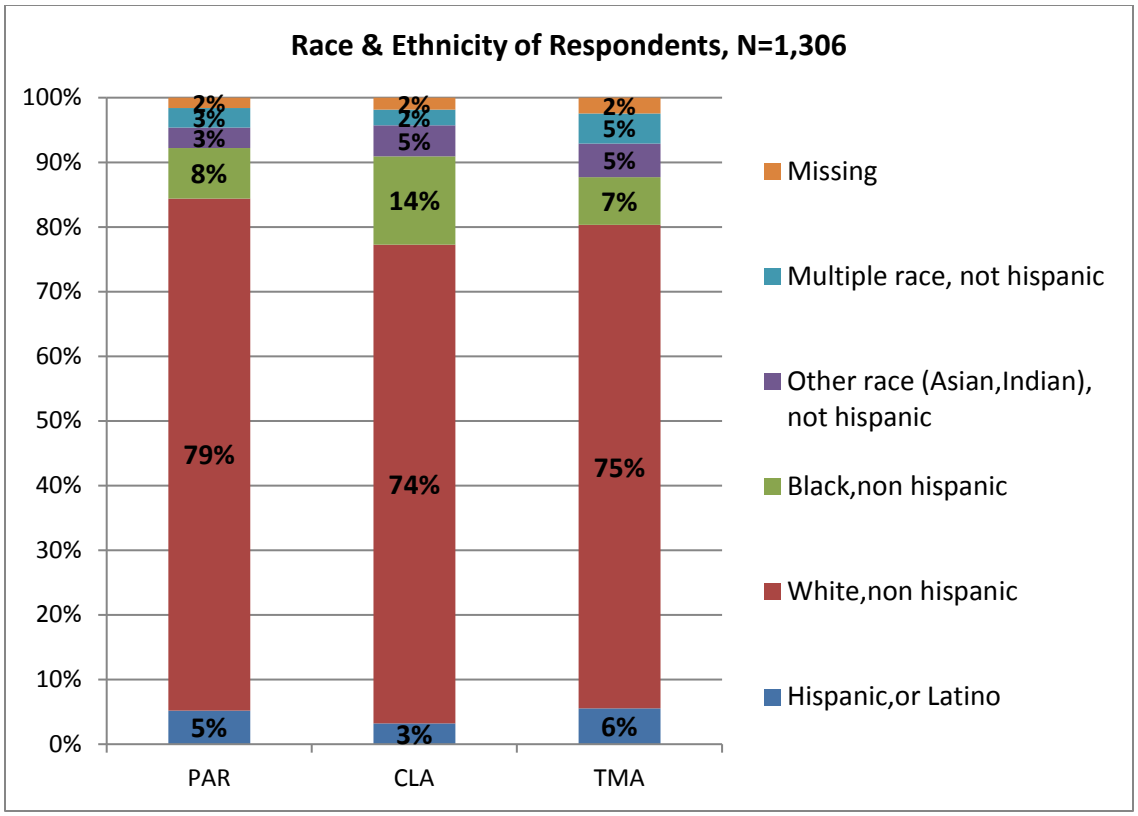

If you needed medical care in the last 12 months, did you get all the care you needed? N=1,208
90%
85%
80%
75%
80%
86%
79%
PAR
CLA
TMA

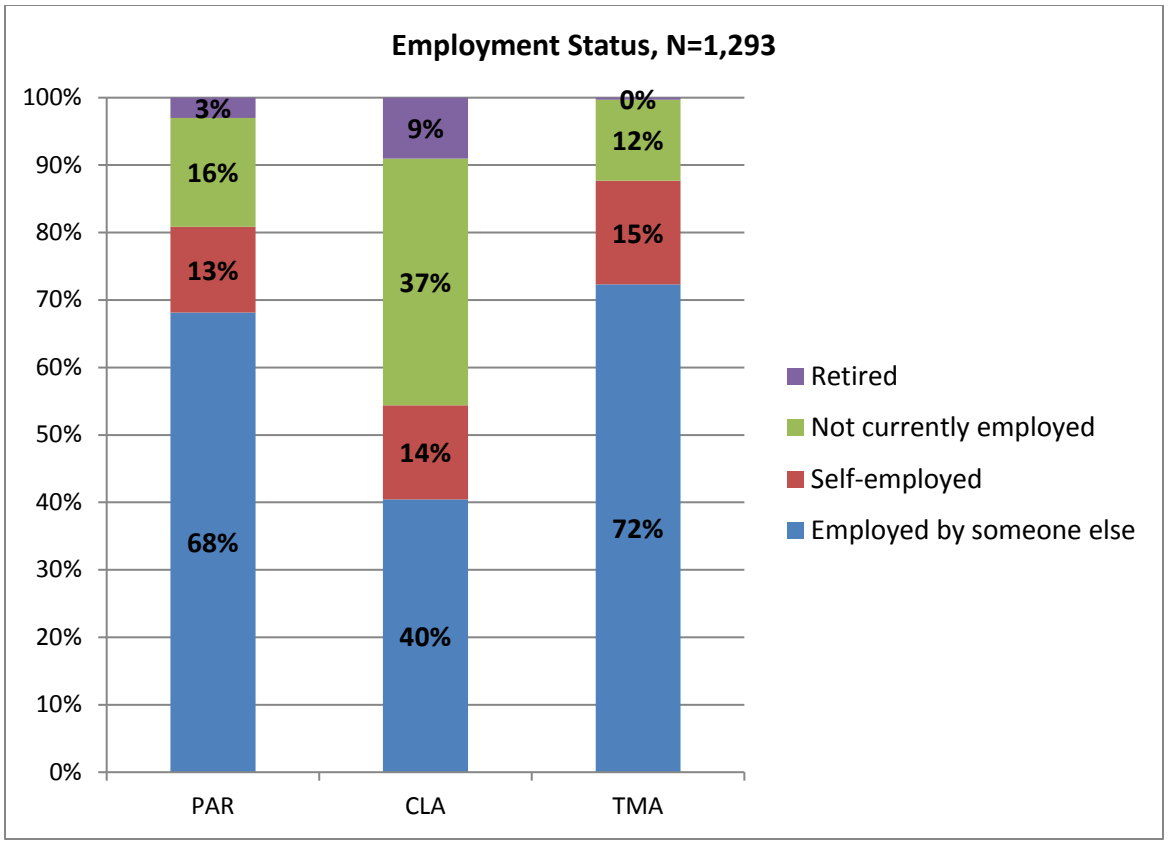

Main reason for going without needed medical care, N=241
Other reason
I didn't have a doctor
The office wasn't open when I could get…
I couldn't get an appointment quickly…
I owed money to the care provider
The doctor wouldn't take my insurance
I didn't have insurance
It cost too much
19%
8%
7%
14%
13%
19%
53%
71%
0% 10% 20% 30% 40% 50% 60% 70% 80%

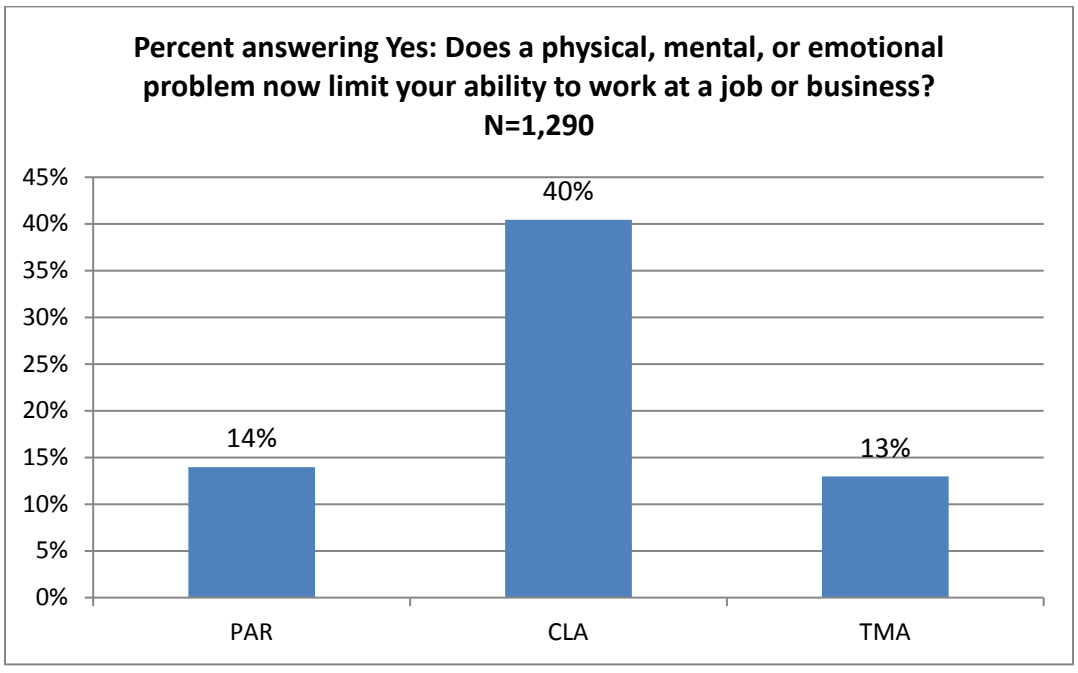

Percent answering Yes: Do you currently owe money to a health care provider, credit card company, or anyone else for medical expenses? N=1,291
TMA
CLA
PAR
31%
40%
54%
0% 10% 20% 30% 40% 50% 60%


Percent answering Yes: In the last 12 months, have you had to borrow money, skip paying other bills, or pay other bills late in order to pay health care bills? N=1,294
TMA
CLA
PAR
22%
11%
31%
0%
5%
10%
15%
20%
25%
30%
35%


Current Age, N=1,298
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3%
37%
34%
24%
1%
7%
61%
10%
16%
6%
0%
27%
36%
32%
5%
PAR
CLA
TMA
Age 65 or older
Age 45 to 64
Age 35 to 44
Age 26 to 34
Age 19 to 25


Race & Ethnicity of Respondents, N=1,306
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
PAR
CLA
TMA
2%
3%
3%
8%
79%
5%
2%
2%
5%
14%
74%
3%
2%
5%
5%
7%
75%
6%
Missing
Multiple race, not hispanic
Other race (Asian,Indian), not hispanic
Black,non hispanic
White,non hispanic
Hispanic,or Latino


Employment Status, N=1,293
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3%
16%
13%
68%
9%
37%
14%
40%
0%
12%
15%
72%
PAR
CLA
TMA
Retired
Not currently employed
Self-employed
Employed by someone else


Percent answering Yes: Does a physical, mental, or emotional problem now limit your ability to work at a job or business? N=1,290
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
14%
40%
13%
PAR
CLA
TMA

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Evaluation of Wisconsin's BadgerCare Plus Health Coverage

for

Parents & Caretaker Adults and for Childless Adults

2014 Waiver Provisions

SURVEY SCIENTIFIC REPORT

Submitted to the

Wisconsin Department of Health Services

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This work also benefited from the regular consultation, review and oversight by staff of the Wisconsin Department of Health Services, including Craig Steele, Rachel Witthoft, and Mitzi Melendez.

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A. EXECUTIVE SUMMARY

The UW Population Health Institute is conducting an evaluation of Wisconsin's 2014 Medicaid 1115 Waiver Demonstration related to populations: (1) individuals who are eligible for Medicaid through Transitional Medical Assistance (TMA Adults) and (2) childless adults (CLAs) with an effective income level at, or below, 100% of the federal poverty level (FPL). The evaluation will field a survey at two separate points in the four-year evaluation period. This report details the initial findings from the first of the two surveys, fielded in April-June 2016. A mixed-mode mail and telephone survey yielded 1,305 responses out of 2,559 individuals in the sample, for response rate of 51%. The survey was intended primarily to support understanding of three evaluation questions.

Key findings include the following:

Question 6: (RRP) Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled and re-enrolled after a 3-month restrictive re-enrollment period (RRP)?

We compared individuals who had recent RRP experience with individuals in TMA with no recent RRP experience.

- Individuals in the RRP groups and TMA groups were similar in some key demographics, but the RRP group was more likely to be racial/ethnic minority
- The groups had similar self-reported physical health status, but the RRP group reported lower levels on one measure of mental health than the TMA group
- Individuals in the RRP group were twice as likely to report being currently uninsured, and much more likely to report lacking a usual source of care and holding medical debt.
- Individuals in the RRP group were significantly more likely than the TMA group to report high levels of dissatisfaction with changes that took place in BadgerCare since April 2014.

Question 9: (TMA) How is access to care affected by the new, or increased, premium amounts?

We assessed financial burden in the TMA population and differences between individuals in TMA who were sampled from program groups with incomes between 100-133% of the federal poverty level (FPL) relative to those with incomes >133% FPL, who had more exposure to premiums.

- TMA members across in the two groups look substantially similar on almost all dimensions.
- Within the overall TMA population, among those who were enrolled in BadgerCare before the April 2014 program changes, 52% report that they were affected by the program changes, while a fifth (19%) report that they do not know if they were affected. A third were not sure if there had been a change in their premiums.
- About 80% report getting all medical care and medications they needed over the past year.
- Of those who report not getting all care of medications needed, most cite cost-related reasons.
- In summary, findings indicate much higher levels of unmet medical need and financial distress among people with recent RRP experiences.

<u>Question 17:</u> (CLA) Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?

We compared outcomes for the CLA sample in the 2016 survey to outcomes for the CLA sample in the 2014 survey of Wisconsin Medicaid/BadgerCare beneficiaries.

- The likelihood and duration of health insurance coverage increased from 2014 to 2016.
- CLAs' reported need for medical care increased as did their likelihood of obtaining all needed care under the Standard plan compared to the Core plan period.
- The likelihood of borrowing money or skipping payment of other bills in order to pay for health care decreased.
- No significant change occurred in overall self-reported health status. However, the probability of having a work-limiting health problem increased from 2014 to 2016.
- In general, the CLAs under the Standard plan period report better outcomes with respect to coverage and access than CLAs reported under the Core plan period.

These observational findings, while not causal, offer important indicators of the relative experience of BadgerCare members with the 2014 waiver. The interim findings contribute toward our overall analysis of each study hypothesis. This process continues, as we move toward fielding the second survey in 2018, deepening our analysis of the administrative data.

B. BACKGROUND

The UW Population Health Institute (the Institute) is conducting an evaluation of the Wisconsin BadgerCare Reform Demonstration Project, as outlined by the Wisconsin Department of Health Services (DHS) and approved by the federal Centers for Medicare and Medicaid Services (CMS). The evaluation uses rigorous methods to arrive at an understanding of how the changes implemented under Wisconsin's 2014 Medicaid 1115 Waiver Demonstration affect two Medicaid populations —(1) those individuals who are eligible for Medicaid through Transitional Medical Assistance (TMA Adults) and (2) those childless adults (CLAs) with an effective income level at, or below, 100% of the federal poverty level (FPL).

The evaluation addresses the 17 evaluation questions defined by DHS in the "BadgerCare Reform Demonstration Draft Evaluation Design," of 10/31/2014. The hypotheses focus on programmatic changes authorized by the 1115 Waiver: Premium changes; 3-month restrictive reenrollment period (RRP); and Standard Plan coverage for CLAs.

The evaluation design included plans to use a survey at two separate points in the four-year evaluation period. The survey was intended primarily to support understanding of three evaluation questions:

> Question 6: (RRP) Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?
>
> Question 9: (TMA) How is access to care affected by the application of new, or increased, premium amounts?
>
> Question 17. (CLA) Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of health coverage?

This report details the initial findings from the first of the two surveys, fielded in May-September 2016. The Year 01 progress report, submitted to the Wisconsin Department of Health Services in April 2017, included an initial descriptive view of some of the data elements. The data presented in that report reflected preliminary, unweighted responses, and were not intended to be representative of the state's Medicaid population.

This follow-up scientific report provides a more detailed description of the survey methodology and the responses from the 2016 survey. Additionally, the current estimates are weighted to represent the underlying populations. It links the 2016 survey's responses to the three questions noted above and identifies what this first survey contributes toward answering these questions.

The report and findings presented here represent an interim product within the context of a four-year evaluation, including a second survey and analysis of administrative data. None of the findings from a single interim product stand on their own or can be considered final conclusions about the waiver hypotheses. As the evaluation proceeds, we will place the survey findings in context with the analysis of the administrative data. Section F of this report describes next steps with the survey and further analyses.

C. Waiver Overview and Target Populations

The 2014 Wisconsin waiver concerns two beneficiary populations, adults who are eligible for Transitional Medical Assistance, and adults without dependent children (referred to as "childless adults"). In the following paragraphs, we describe these populations and provide an overview of waiver's provisions. The waiver provisions were effective on April 1, 2014.[1]

Transitional Medical Assistance (TMA). TMA extends Medicaid coverage for current beneficiaries for up to 12 months following an increase in income beyond 100% of the federal poverty level (FPL). TMA is available to qualifying adults who were enrolled in Medicaid under parent/caretaker eligibility and had an income of less than 100% FPL for 3 of the last 6 months of their enrollment. The July 2012 DHS waiver introduced a premium requirement for TMA beneficiaries with income at or above 133% FPL. The premium amount was based on a sliding scale relative to household income with a cap of 9.5% of household income. Under the 2014 waiver, these provisions remained in place. The 2014 waiver introduced a premium requirement for TMA beneficiaries with income between 100% and 133% FPL. Unlike the higher-income TMA beneficiaries, however, this requirement only takes effect after the 6th month of TMA enrollment.

The method for calculating the premium amount is the same for all TMA beneficiaries. The 2014 waiver also stipulates that TMA adults who do not make a required premium payment are disenrolled from BadgerCare at the end of their eligibility month and placed in a three-month Restrictive Reenrollment Period (RRP). During the 3-month RRP, these individuals are ineligible for TMA if and until they pay their outstanding premium balance. This RRP policy differs from the policy in place before the 2014 waiver. Specifically, from July 2012 to March 2014, TMA beneficiaries with income at or above 133% FPL who failed to pay a premium were subject to a 12-month RRP. During that 12-month RRP, these individuals were ineligible for TMA. There was no mechanism for a return to TMA within those 12 months.

Childless Adults (CLA). The 2014 waiver introduced a change in income eligibility and benefits for non-pregnant, non-disabled adults between 19 and 64 years of age, without dependent children, referred to as "childless adults" (CLAs). Previously, the DHS offered coverage under its Core Plan to a limited number of CLAs with income up to 200% FPL. These plans required enrollment fees and provided a limited set of benefits relative to standard WI Medicaid coverage, the Standard Plan. Effective April 1, 2014, DHS eliminated the Core and Basic Plans. The DHS transitioned CLAs beneficiaries with incomes at or below 100% FPL to the Standard Plan, and going forward all new childless adult applicants with incomes not exceeding 100% FPL enroll in the Standard Plan. The WI Medicaid Standard Plan has no premiums for eligible members below 100% FPL, and provides the full range of Medicaid benefits.[2] CLAs with income above 100% FPL are no longer eligible for Medicaid coverage.

[1] Additional detail regarding the 2014 WI Medicaid waiver and the Special Terms and Conditions may be found online at the following locations: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/Badger-Care-Reform/wi-BadgerCare-reform-demo-project-app-11102011.pdf; and https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-BadgerCare-reform-ca.pdf

[2] Additional detail regarding the CLA population and a comparison of benefits under the Core, Basic, and Standard plans may be found online: https://www.dhs.wisconsin.gov/BadgerCareplus/standard.htm; and https://www.forwardhealth.wi.gov/kw/pdf/2008-199.pdf

D. Survey: Process and Methods

D1. Overview

The UW Survey Center, our team's subcontracted partner on this project, conducted a mixed-mode mail and telephone survey. The survey protocol was designed to obtain a representative sample of individuals across subgroups (described below) that are of interest to different populations affected by the waivers. The 2016 survey updates a cross-sectional survey of enrollees conducted in 2014. The 2016 survey sampling frame included current beneficiaries who met our study categories (thus permitting cross-sectional analysis in 2016) and a sample of respondents from the 2014 survey, permitting us to conduct longitudinal analysis. Additional information about the 2014 survey and our longitudinal analyses is included in Section D5.

The 2016 survey samples were drawn from four groups:

1. Parents and Caretakers
    - Parents/Caretakers who remained on the program pre- and post-April 2014
    - Parents/Caretakers who joined post-2014
    - Parents/Caretakers >100% FPL who transitioned off of the BadgerCare program after the April 2014 policy change
2. Childless adults (CLA)
    - CLA who remained eligible from pre-2014 Core Plan coverage
    - CLA who gained eligibility post-2014
    - CLA who, with incomes >100% FPL, lost BC coverage post-April 2014
3. Transitional Medical Assistance (TMA)
    - Current TMA members who did not recently experience a restrictive reenrollment period (RRP) in two groups: 100-133% FPL and >133% FPL
4. TMA individuals who recently experienced a Restrictive Reenrollment Period (RRP)

The UW Survey Center conducted the mixed-mode mail and telephone survey to reach a sample size powered to detect differences between groups. The survey was fielded from May 10-September 26, 2016. It included an initial mailing with two follow-letters, and then a telephone follow-up to non-respondents.

D2. Survey Domains

Consistent with the scientific goals of the study, the survey was designed to measure demographics, health status, utilization of care, and health care experiences. Wherever possible we drew upon validated and widely used survey measures, such as those used in the National Health Interview Survey, the Urban Institute Health Reform Monitoring Survey, and the Behavioral Risk Factor and Surveillance System. Items in the survey have been validated for representative population samples, including individuals with low reading proficiency. Additionally, the survey included measures related to satisfaction with program changes, knowledge of program requirements, and health insurance literacy. The 2016 survey instrument is available in the appendix.

D3. Sample Construction and Response Rate

The 2016 survey sample includes a new sample and a resample of Medicaid beneficiaries. To obtain the new sample, the WI DHS drew a random sample of individuals from each enrollee population of interest for the current evaluation and provided this list to the UW Survey Center. The UW Survey Center

selected a random sample from this list to generate the new sample for the 2016 survey. The resample includes all respondents to the 2014 survey of WI Medicaid beneficiaries conducted as part of the 2012 section 1115 waiver evaluation. Additional detail regarding the 2014 survey is provided in section D5. Table D.1 presents the size of the enrollee population in February 2016 when the new sample was drawn. The total sample of 2,597 individuals reflects the combined total of new and resampled beneficiaries. Using administrative data, the Survey Center determined a small subgroup of these individuals were not eligible for the survey (for example, people who had moved out-of-state). The remaining eligible cases (N=2,559) comprise the effective survey sample from which the response rate is calculated.

The survey was fielded from May 10, 2016 - September 26, 2016. It included an initial mailing with a $5 incentive, two follow-up letters, and then a telephone follow-up to non-respondents. The survey attained an overall 51% response rate, with rates by specific subgroups detailed in Table D.1.

Table D.1: Enrollee Population, Survey Sample, and Response Rates by Subgroup

	Parents/ Caretaker Adults	Childless Adults	TMA	Current RRP	Total
Enrolled Population	42,271	142,003	9,812	3,830	197,916
Total Sample N	997	600	600	400	2,597
Ineligible Cases	31 total were deemed ineligible			7 ineligible	38
Respondents N	591	278	317	119	1,305
Response rate	**59%**	**46%**	**53%**	**30%**	**51%**
Mail	443	210	246	73	972
Phone	148	68	71	46	333
Notes: Ineligible cases are all individuals who met survey criteria for being interviewed and who were contacted to take the survey. Respondents are individuals in the population of eligible cases who completed the survey.					

D4. Weighting

We created a raking weight[3] for each survey respondent, allowing us to account for under-representation of some population groups in the survey sample relative to their size in the population from which they were sampled (due to differential non-response or to differential sampling of groups). These weights allow us to calculate statistics that are more representative of the underlying populations. Weights were created using a raking weight survey package in Stata that adjusts the marginal proportion of survey respondents to the underlying population using age, sex, race, and geographic location. All estimates presented in this report are weighted.

D5. Longitudinal Design

As noted in section D1, the 2016 survey was designed to facilitate both cross-sectional and longitudinal analysis. It is possible to conduct longitudinal analyses because the 2016 survey includes a planned resample of the respondents to a 2014 survey of WI Medicaid beneficiaries, and a large subset of the questions posed in the 2014 survey. The Institute conducted the 2014 survey as part of the evaluation of the 2012 section 1115 waiver that introduced changes in premium and restrictive reenrollment policies. As describe above, the 2016 total sample (Table D.1) includes all 2014 survey respondents and

[3] Deville J, Sarndal C, Sautory O. 1993. Generalized Raking Procedures in Survey Sampling. Journal of the American Statistical Association 88(423): 1013-1020.

a random sample of individuals enrolled in Medicaid in 2016. Individuals who responded to both the 2014 and 2016 surveys comprise the longitudinal cohort.

The inclusion of a common set of questions across surveys allows us to compare changes within these same individuals over this time of important programmatic changes. We define a cohort sample member's Medicaid eligibility category according to his/her 2014 sampling group, in the interest of attaining a sufficient sample size for a resample population. For example, a cohort member who was selected for the 2014 survey sample within the CLA eligibility category is included in the 2016 CLA sample. This approach allows us to examine the post-waiver experience of individuals who were enrolled in Medicaid before implementation of the 2014 waiver. We anticipate that cohort members' responses to insurance coverage and Medicaid enrollment may differ across the two surveys because of changes in Medicaid eligibility and the health insurance market more generally during this time period.

In this report, we specifically use the 2014 survey data in our analysis of CLAs' outcomes before and after implementation of the 2014 waiver. We applied the same weighting methodology to the 2014 data as was applied to the 2016 data. Additional discussion about the 2014 sample for these analyses is included in section E, question 17.

D6. Recoding and Analysis

We recoded some survey responses from their original response categories, in order to the ability to interpret the study measures. For example, we dichotomized ordinal scales where there was either an obvious cut point in the data or a justification from prior studies in the literature. We calculated means and proportions for each of the study variables, applying survey weights. To calculate statistical significance for differences between two groups, we calculated standard test statistics (i.e., *t*-statistics for proportions and *chi*-squared statistics for categorical and ordinal data). These statistics were adapted for weighted data in the survey routine in Stata. We consider $p<.05$ to indicate statistically significant differences.

All results reported here are unadjusted. Regression-adjustment can be accomplished by estimating a regression model that includes the survey outcome as the dependent variable and a predictor for group membership along with covariates for other survey-measured characteristics common to the two groups. Predicted margins can then be calculated to capture differences between samples after accounting for these covariates. Regression adjustment can be helpful in diminishing the influence of observed differences between samples due to factors like demographics, as such differences can operate as confounders (variables that independently influence membership in a particular group and the outcome, and which can bias the association between group membership and the outcome).

However, adjusting also requires care particularly in small survey samples, as there are situations in which "over-adjustment" can introduce bias. This could arise if the adjusting variables are modified by the group membership status. For example, one might consider adjusting for income between TMA and RRP groups when comparing differences in access to care because income differences can plausibly confound the association between RRP status and access. However, household income itself may also respond to the 2014 waiver-related program changes, and thus adjusting for income may diminish meaningful and important differences between the groups. We intend, in future iterations of our analyses, to select items where regression adjustment may be scientifically merited and might add to our understanding of existing findings. We believe that the unadjusted associations presented here are important as a starting point for understanding associations.

E. Data Analysis and Application to Hypotheses

The following section addresses each of the three survey-related evaluation questions in turn. It is important to note that the survey was not designed to provide stand-alone answers to any of the evaluation questions. Rather, it is designed as a complement to analysis of administrative data. We view the survey analyses as helping us to uncover dimensions related to individual experience that might not otherwise be identified with administrative data.

The tables in each section present data about survey responses to a series of questions. Some of the survey questions included multi-level responses, directing respondents to skip various questions depending on their answers to prior questions. The tables identify, for each question, the total number of respondents eligible to answer that question. In some cases, it will be the full sample, and in other cases, a subset of the sample based on responses to a previous question.

Question 6: Impact of RRP on utilization, costs, and/or health care outcomes

Is there any impact on utilization, costs, and/or health care outcomes associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?

The 2014 waiver introduced changes to the TMA program related to restrictive reenrollment periods (RRPs). The prior waiver, initiated in 2012, enforced 12-month RRPs for non-payment of premiums, with no opportunity for re-entry during that period apart from a change in income status bring the member into a new eligibility category. The 2014 waiver lowered the RRP maximum length to three months and allows individuals to reenter TMA prior to the end of the 3-month period by repaying owed premiums.

Key Findings

There are several key findings: 1) Individuals in the RRP groups and TMA groups were similar in some key demographics, but the RRP group was more likely to be racial/ethnic minority; 2) The groups self-reported similar physical health status, but the RRP group reported at least one symptom of mental health lower than the TMA group (Table 6.3); 3) Striking differences emerge in insurance coverage and access to care, with individuals in the RRP group twice as likely to report being currently uninsured, and much more likely to report having access to care challenges such as lacking a usual source of care and holding medical debt (Table 6.2); and 4) Individuals in the RRP and TMA groups generally reported similar levels of knowledge about health insurance, but individuals in the RRP group were significantly more likely to report high levels of dissatisfaction with changes that took place in BadgerCare since April 2014 (Table 6.5).

Research Design

The current evaluation considers the impact of the new form of RRP on outcomes related to access and health care use. We used the survey to contribute toward this objective, drawing a sample of current and former TMA members with recent RRP experience such that they could accurately report their experience during that short three-month period (while not enrolled in BadgerCare). This posed a survey sampling challenge, with a short three-month RRP time frame and the potential of some to

return prior to completing that full period. We thus designed a rapid-turnaround process, sampling and surveying members immediately as they were completing the second month of an RRP.

RRP individuals, by definition, were at one point enrolled in TMA, and had the option to reenroll in TMA after serving an RRP. To understand how RRP status might be associated with health care experiences, we compare them to members of the general TMA population sampled in the 2016 survey. The survey yielded data on 119 individuals with RRP experience and a comparison sample of 317 individuals in the TMA category. (Table 6.1)

Although we would ideally like to compare responses for the same members before and after an experience of RRP, the demographic similarities of the TMA population to the RRP population provides a plausible comparison group for considering the access and health care outcomes of the RRP population. Additionally, assessing program knowledge and satisfaction (questions added to the 2016 survey) allow us to understand how individuals with recent RRP experience may differ in their understanding of program changes or experiences with these changes compared to the overall TMA population.

Description of Sample (Table 6.1)

Overall, 56% of eligible TMA respondents completed the survey and 35% of eligible RRP respondents completed the survey (Table D.1.). The lower response rate among RRP respondents is perhaps not surprising as this population is likely to have lower attachment to the program. As noted, our weighting strategy enables us to account for differential non-response by characteristics like race/ethnicity, age, and sex. Table 6.1 compares the demographic and socioeconomic characteristics of the TMA and RRP samples. The TMA sample was more likely to be 35 or older (60%) relative to the RRP sample (44%). About three-quarters of both groups were female (76% for TMA and 75% for RRP). The TMA sample was significantly different than the RRP sample by race/ethnicity: they were more likely to be white (71% versus 47%) and less likely to be black (8% versus 38%). The groups were similar in terms of educational attainment and income: about half had high school degrees or less and two thirds were in households with annual incomes <$30,000. They were similar in terms of household composition and presence of children in the household.

Analysis

We calculated means and proportions for each of the study variables, applying survey weights. To calculate statistical significance for differences between two groups, we calculated standard test statistics (i.e., *t*-statistics for proportions and *chi*-squared statistics for categorical and ordinal data). These statistics were adapted for weighted data in the survey routine in Stata. We consider $p<.05$ to indicate statistically significant differences between groups. Unless otherwise noted, all between-group differences reported in this section are statistically significant.

Results

The findings detailed below underscore that those TMA members who fall into an RRP differ from the general TMA population on several salient dimensions. They are much more likely to report a lack of current insurance coverage and a lack of coverage over the prior year. They are also more likely to report problems with access to care, such as not having a usual source of care and financial burden. They are also more likely to report being dissatisfied with changes that occurred in BadgerCare since April 2014. These findings are consistent with the hypothesis that experiencing an RRP leads to greater

periods of being uninsured and to worse access to health care. These findings are useful to consider alongside preliminary analyses conducted with the state CARES data that indicated substantially greater risk of disenrollment after the April 2014 policy (albeit for shorter spells of RRP on average).[4]

Coverage, Service, and Access to Care (Table 6.2 and Table 6.3)
Table 6.2 reports findings on health insurance coverage. TMA is a time-limited program, and so we would expect that significant proportions from both the TMA and RRP groups would be observed in non-Medicaid/BadgerCare coverage status. However, individuals in the RRP group were much more likely to report being currently uninsured than the TMA group (18% versus 9%). People in the RRP group were also significantly more likely than the TMA group to report being uninsured for the entire prior year (11% versus 1%). Overall, 45% of TMA respondents reported currently being in Medicaid/BadgerCare compared to 24% of RRP respondents. Conversely, 11% of TMA respondents reported being currently enrolled in employer sponsored insurance compared to 32% of RRP respondents. Coverage under the ACA/Obamacare exchanges was reported by 15% of TMA respondents and 4% of RRP respondents. Other forms of coverage such as private and Medicare were less frequently reported.

While no significant differences emerge between TMA and RRP respondents in reported need for medical care and prescription drugs, large and significant differences appear in ability to access care (Table 6.3). While 78% of TMA respondents said they got "all needed care" in the prior year, only 62% of RRP respondents said the same. While 86% of TMA respondents said their usual source of care was a doctor's office, only 71% of RRP respondents said the same. RRP respondents were much more likely to report receiving care in the emergency department in the prior year (15% of TMA versus 32% of RRP). While 65% of TMA respondents said their medical care in the prior year was "excellent" or "very good" only 41% of RRP respondents said the same. Finally, RRP respondents were much more likely to report medical financial burden: for example, 69% said they had current medical debt compared to 30% of TMA respondents. No significant differences emerged in unmet mental health care need or in receipt of dental care.

Self-Reported Health Status (Table 6.4)
No significant differences appear in self-reported general health status (Table 6.4). For example, 43% of individuals in both groups reported excellent or very good general health, and 13% of TMA and 17% of RRP respondents reported a work-limiting disability. However, RRP respondents were significantly more likely to report mental health problems related to being bothered or not being able to experience pleasure in the last month (a symptom of depression or anxiety): 50% of the TMA sample reported that they experienced these symptoms "at least a few times" compared to 63% of the RRP sample.

Insurance Knowledge and Attitudes About Program Changes (Table 6.5)
No significant differences emerge in self-reported confidence about health insurance terminology between the TMA and RRP group, except that individuals in the RRP group were significantly less likely to report confidence in the term "deductible" (6% of TMA reported "not at all confident" compared to 16% of RRP). (Table 9.6) In terms of self-reported understanding of program changes, individuals in the TMA group were more likely to state that they were enrolled in the program before April 2014 (88% versus 71%). (Table 9.5) No significant differences appear in self-reporting that the respondent was affected by changes in program requirements, and specifically there was no difference in reporting

[4] Evaluation of Wisconsin's BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2014 Waiver Provisions Interim Evaluation Report – Year 01. UW Population Health Institute. Submitted to the Wisconsin Department of Health Services. April 20, 2017.

being affected by penalties for not paying a premium. However, RRP respondents were significantly more likely to report dissatisfaction with changes that have taken place since April 2014: whereas 7% of TMA respondents said they were “very dissatisfied” 25% of RRP respondents said the same.

Limitations

These findings are subject to several important limitations. First, although the RRP population is a subsample of individuals with TMA experience, they may differ from the TMA subjects surveyed here due to factors unrelated to being in RRP. For example, this group is different in its racial/ethnic composition and in some measures of socioeconomic status. In future analysis, we will add some limited set of controls to adjust for potential confounding -- although such adjustment will not necessarily allow us to interpret these differences causally. As noted, while it would be better to track the same individuals before and after entry into an RRP, doing so using a survey approach under current resource constraints is not feasible. Our approach thus represents the best attempt to understand how the health and health care access experiences differ between individuals with RRP experiences and other TMA enrollees (or individuals who were at one point eligible for the TMA survey).

Table Q6.1. Demographic and Socioeconomic Characteristics of TMA and RRP Sample

	TMA	RRP	
AGE	N=317	N=319	
Younger than 35	0.40	0.54	*
35 and above	0.60	0.44	
Missing	0	0.01	
SEX	N=317	N=319	
Female	0.76	0.75	
Male	0.24	0.25	
RACE	N=317	N=319	
Spanish, Hispanic or Latino	0.07	0.08	**
White , Non-Hispanic	0.71	0.47	
Black, Non-Hispanic	0.08	0.38	
Other race (Asian, Indian), not Hispanic	0.07	0.05	
Mixed Race, not Hispanic	0.05	0.02	
Missing	0.02	0.01	
EDUCATION	N=317	N=319	
High school diploma or Less than high school	0.50	0.50	
More than high school	0.50	0.48	
Missing	0.01	0.02	
INCOME	N=317	N=319	
< $30000	0.61	0.67	
>= $30000	0.39	0.33	
PARENTAL STATUS	N=317	N=319	
No	0.88	0.89	
Yes	0.11	0.10	
Missing	0.01	0.02	
HOUSEHOLD COMPOSITION	N=317	N=319	
Living alone	0.07	0.05	
Living with partner or spouse	0.27	0.15	
Living with Others	0.63	0.77	
Missing	0.03	0.04	
HOUSEHOLD SIZE	N=317	N=319	
>2 members	0.82	0.79	
<=2 members	0.18	0.21	
HOUSEHOLD AGE	N=317	N=319	
>=Two HH members below 19	0.58	0.61	
0-1 HH member below 19	0.42	0.39	

*Indicates a difference between outcomes that is statistically significant at p< 0.05.
**Indicates a statistically significant different at p <0.01

Table 6.2 Health Insurance Status TMA v RRP

	TMA	RRP	
Currently Have Health Insurance	N=317	N-119	
No	0.09	0.18	*
Yes	0.91	0.82	
Some kind of health care coverage in past 12 months	N=317	N-119	
Full year uninsured	0.01	0.11	**
1-11 months	0.27	0.44	
all 12 months	0.71	0.45	
Missing	0.01	0	
Current health care coverage	N=317	N-119	
Medicaid, BC, BC core	0.45	0.24	**
Employer or family member's employer	0.11	0.32	
Private (I pay for myself), Other	0.07	0.06	
Medicare	0.04	0.08	
ACA/Obamacare	0.15	0.04	
Uninsured	0	0	
Missing	0.18	0.27	
For those who no longer have BadgerCare coverage: Reasons why	N=104	N=50	
Not eligible	0.69	0.40	**
Premium related	0.03	0.37	
Other reasons	0.09	0.13	
Missing	0.2	0.1	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01			

Table 6.3 Utilization and Access, TMA v RRP

	TMA	RRP	
Needed medical care in past 12 months	N=317	N-119	
No	0.04	0.01	
Yes	0.95	0.97	
Missing	0.01	0.01	
Among those who needed care in the past 12 months: Got all the treatment needed	N=297	N=116	
No	0.21	0.37	**
Yes	0.79	0.63	
Missing	0	0	
Among those who went without needed medical care: Main reasons[a]	N=60	N=41	
Non-cost related reasons	0.10	0.03	
Cost related reasons	0.88	0.95	
Missing	0.02	0.02	
Needed prescription medication in past 12 months	N=317	N-119	
No	0.22	0.24	
Yes	0.78	0.74	
Missing	0	0.02	
Among those who needed prescription medications in the past 12 months: Got all medications needed?	N=249	N=89	
No	0.16	0.27	
Yes	0.83	0.72	
Missing	0.02	0.02	
Among those who went without needed prescription medications you needed: Reasons why	N=42	N=29	
Non-cost related reasons	0.16	0.07	
Cost related reasons	0.73	0.87	
Missing	0.1	0.06	
Usual source of care	N=263	N=96	
Doctor's office, health center, clinic	0.86	0.72	**
Urgent care	0.05	0.2	
No usual place, don't know	0.01	0	
Other	0.04	0.06	
Missing	0.04	0.02	
ER visit in the last 12 months	N=317	N-119	
Zero times	0.64	0.51	**
1 time	0.21	0.16	
2 or more times	0.15	0.31	
Missing	0	0.01	

Among those with an ER visit in last 12 months: Main reason[b]	N=109	N=56	
Other reasons	0.73	0.77	
Needed ER only	0.26	0.17	
Missing	0.01	0.06	
Quality of the medical care received in the last 12 months	N=317	N-119	
Did not receive medical care	0.06	0.05	**
Excellent, Very good	0.65	0.41	
Good	0.22	0.19	
Fair, poor	0.07	0.33	
Missing	0	0.01	
Currently owe money to a health care provider, credit card company, or anyone else for medical expenses	N=317	N-119	
No	0.69	0.30	**
Yes	0.29	0.69	
Missing	0.02	0.02	
Had to borrow money, skip paying other bills, or pay other bills late in order to pay health care bills in last 12 months	N=317	N-119	
No	0.80	0.49	**
Yes	0.20	0.47	
Missing	0	0.04	
Refused treatment by a doctor, clinic, or medical service because of money owed	N=317	N-119	
No	0.97	0.83	**
Yes	0.02	0.13	
Missing	0.02	0.04	
During the past 12 months, had either a flu shot or a flu vaccine that was sprayed in your nose?	N=317	N-119	
No	0.72	0.82	
Yes	0.28	0.17	
Missing	0.01	0.02	
Needed but did not get because of cost: mental health care or counseling	N=317	N-119	
No	0.75	0.66	
Yes	0.09	0.16	
Missing	0.16	0.18	

Last visited a dentist for any reason	N=317	N-119	
Less than 12 months ago	0.51	0.46	
Between 1 and 5 years	0.32	0.39	
More than 5 years ago	0.14	0.10	
Never	0.01	0.02	
Not sure	0.02	0.03	
Problems paying any medical bills in past 12 months	N=317	N-119	
Yes	0.27	0.62	**
No	0.73	0.35	
Missing	0	0.03	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01			
[a]Respondents could select more than one reason for this question. "Cost-related reasons" indicates that the respondent selected options a-d on Q.11, while "non-cost-related reasons" indicates the respondent selected options e-h on the survey. See Attachment for the survey question and response options.			
[b]Respondents could select more than one reason for this question. "Needed ER Only" indicates that the respondent selected only one response. "Other Reasons" indicates the respondent selected more than one response. See Q.18 in Attachment for the survey question and response options.			

Table 6.4 Self-Reported Health Status, TMA v RRP

	TMA	RRP	
Self-reported physical and mental health	N=317	N-119	
Excellent, Very good	0.43	0.43	
Good	0.38	0.33	
Fair, poor	0.19	0.24	
A physical, mental, or emotional problem limits ability to work at a job	N=317	N-119	
No	0.87	0.83	
Yes	0.13	0.17	
Smokes cigarettes	N=317	N-119	
Everyday	0.20	0.22	
Some days	0.09	0.14	
Never	0.71	0.62	
Missing	0	0.02	
Been advised by a doctor or health professional to quit smoking	N=84	N=37	
Yes	0.5	0.71	*
No	0.4	0.28	
No visit in past 12 months	0.05	0.01	
Missing	0.05	0	
Over the past two weeks, bothered by having little interest or pleasure in doing things	N=317	N-119	
Not at all	0.50	0.37	*
A few times	0.28	0.24	
More than half the days	0.08	0.11	
Nearly every day	0.08	0.17	
Don't know	0.06	0.09	
Missing	0	0.01	
Over the past two weeks, bothered by feeling down, depressed, or hopeless?	N=317	N-119	
Not at all	0.55	0.46	
A few times	0.26	0.28	
More than half the days	0.08	0.08	
Nearly every day	0.07	0.15	
Don't know	0.03	0.02	
Missing	0	0.01	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01			

Table 6.5 Knowledge and Attitudes about 2014 Waiver Changes, TMA v RRP

	TMA	RRP	
Enrolled in BadgerCare program before Apr 2014	N=317	N-119	
Yes	0.88	0.71	*
No	0.07	0.17	
Don't know	0.05	0.11	
Missing	0	0.01	
Affected by any new program requirements	N=292	N=101	
Yes	0.53	0.38	
No	0.25	0.38	
Don't know	0.19	0.22	
Missing	0.02	0.02	
Lost eligibility for BadgerCare Plus and were no longer enrolled because of changes made after Apr 2014	N=292	N=101	
Yes	0.52	0.49	
No	0.42	0.41	
Missing	0.05	0.11	
April 2014 Changes: Effect on MONTHLY premium/payment for health care coverage	N=147	N=51	
Increase	0.49	0.36	
Decrease	0.03	0.04	
No change	0.24	0.34	
Not sure	0.14	0.21	
Missing	0.1	0.06	
April 2014 Changes: Effect on PENALTIES for not paying a monthly premium	N=147	N=51	
Increase	0.08	0.17	
Decrease	0	0	
No change	0.45	0.48	
Not sure	0.33	0.28	
Missing	0.14	0.07	
April 2014 Changes: Effect on COPAYMENTS to visit a doctor or clinic	N=147	N=51	
Increase	0.09	0.09	
Decrease	0.03	0	
No change	0.54	0.57	
Not sure	0.22	0.27	
Missing	0.13	0.07	

April 2014 Changes: Effect on MENTAL HEALTH or SUBSTANCE ABUSE TREATMENT BENEFITS	N=147	N=51	
Increase	0.01	0.03	
Decrease	0.01	0	
No change	0.45	0.55	
Not sure	0.37	0.35	
Missing	0.15	0.07	
Satisfaction with the changes that have taken place since Apr 2014	N=146	N=49	
Very satisfied	0.11	0.04	*
Somewhat satisfied	0.16	0.23	
Neither satisfied nor dissatisfied	0.46	0.37	
Somewhat dissatisfied	0.13	0.09	
Very dissatisfied	0.07	0.25	
Missing	0.06	0.01	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01			

Table 6.6 Understanding of Health Insurance Terms, TMA v RRP

	TMA	RRP	
Confident that you understand what the word means: PREMIUM	N=317	N-119	
Very confident	0.55	0.51	
Somewhat confident	0.21	0.17	
Slightly confident	0.17	0.17	
Not at all confident	0.05	0.13	
Missing	0.02	0.02	
Confident that you understand what the word means: DEDUCTIBLES	N=317	N-119	
Very confident	0.51	0.50	*
Somewhat confident	0.24	0.14	
Slightly confident	0.17	0.18	
Not at all confident	0.06	0.16	
Missing	0.01	0.02	
Confident that you understand what the word means: COPAYMENTS	N=317	N-119	
Very confident	0.62	0.63	
Somewhat confident	0.2	0.14	
Slightly confident	0.11	0.11	
Not at all confident	0.06	0.1	
Missing	0.01	0.02	
Confident that you understand what the word means: COINSURANCE	N=317	N-119	
Very confident	0.27	0.39	
Somewhat confident	0.26	0.18	
Slightly confident	0.18	0.16	
Not at all confident	0.28	0.26	
Missing	0.01	0.02	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01			

Question 9: Effect of new or increased premium amounts on access to care

How is access to care affected by the application of new, or increased, premium amounts?

The survey fielded in 2016 included a range of questions intended to help assess how the application of new, or increased, premium amounts affected access to care. This question pertains to BadgerCare parents (BCP) who experience an increase in income above 100% FPL and enter Transitional Medical Assistance (TMA). As part of Wisconsin's 2014 waiver, TMA enrollees with incomes 100-133% FPL were not required to pay premiums for the first six months of their TMA enrollment, and faced a sliding-scale premium set as a percentage of their income in subsequent months. TMA enrollees with incomes greater than 133% FPL faced a premium for each month enrolled in TMA.

Premiums' effect on the TMA population could manifest in two ways: 1) via enrollment: those in the premium paying category disenroll or lapse their payments and fall into a restrictive reenrollment period (RRP), or 2) differences emerge in program and utilization experience between those in TMA category not immediately exposed to premiums (<133% FPL) and those immediately exposed to premiums (>133% FPL). The discussion in the preceding section (Question 6) explores how premiums affect access to care via enrollment, assessing the impact of RRP on utilization, costs, and/or health care outcomes. We now assess how premiums differentially affect those in the TMA categories.

Key Findings

The main finding is that TMA members across the income ranges look substantially similar on almost all dimensions. Because the experience of the TMA group as a whole is of interest, we summarize some key dimensions related to access to care from the survey using the entire TMA population. For the TMA group as a whole, 88% report having been enrolled in BadgerCare before the April 2014 program changes, so have experienced the program both before and after the changes (Table 9.5). Slightly over half (52%) report that they were affected by the program changes, while a fifth (19%) report that they do not know if they were affected; a quarter say they were not affected, and third were not sure if there had been a change in their premiums (Table 9.5). About 80% report getting all medical care and medications they needed over the past year (Table 9.3). Of those who report not getting all care of medications needed, most cite cost-related reasons. In sum, these findings suggest low levels of understanding of program changes and relatively common financial burden in the TMA program, but the exact linkage to program policy change cannot be established with the survey data.

Research Design

Actively enrolled TMA adults were surveyed in 2016 in two groups stratified by income, which determined the premium policy they faced: 100-133% FPL (Group A) and >133% FPL (Group B). We compare access to care for TMA Group B, who would always have been required to pay a premium to that of TMA Group A, who become subject to a premium requirement only after six months of TMA enrollment. Hypothetically, Group B's immediate exposure to premiums, in comparison to Group A's more limited exposure, might demonstrate the degree to which the April 2014 premium changes affected access to care.

Description of Sample (Table 9.1)

The TMA sample for the 2016 survey, described in Table D.1 included a total of 600 individuals comprised of two groups separated by income at the time the sample was drawn: 100-133% FPL (Group A) and >133% FPL (Group B). Of these 600 persons, 36 were ineligible to participate in the survey, and a total of 317 completed the survey for an overall response rate of 56%. These 317 respondents to the survey included 165 individuals in Group A and 152 individuals in Group B.

Table 9.1 summarizes the demographic and socioeconomic characteristics of the TMA respondents. The two groups represented among the respondents appear remarkably similar. The only statistically significant difference is age: on average, Group A is more likely to report age older than 35. The two groups do appear to report different household incomes, contrary to what might be expected, with group B more likely to report income less than $30,000/year. However, to compare poverty status in the two groups it would be necessary to further adjust for household income.

Overall the two groups appear to be similar in terms of observable demographics. Sex is similarly distributed across the two groups, both at close to 75% male. About 70% of both groups report that they are non-Hispanic white, and other race and ethnicity categorizations are also similarly distributed across the two groups. Educational attainment is also very similar across the groups with roughly an even split between those having a high school diploma or less and those having more than a high school education. Both groups are highly likely to have children they financially support (close to 90%) and live in households of more than two members (more than 80%).

Analysis

We calculated means and proportions for each of the study variables, applying survey weights. To calculate statistical significance for differences between two groups, we calculated standard test statistics (i.e., *t*-statistics for proportions and *chi*-squared statistics for categorical and ordinal data). These statistics were adapted for weighted data in the survey routine in Stata. We consider $p<.05$ to indicate statistically significant differences between groups. Unless otherwise noted, all between-group differences reported in this section are statistically significant.

Results

TMA Groups A and B look remarkably similar in their insurance status and other experience over the 12 months prior to the survey (Tables 9.2-9.6). TMA Groups A and B do not demonstrate statistically significant differences on almost any of the survey items. This result is consistent with what we would expect based on the existing literature: that premiums primarily affect health care access and use via enrollment.[5]

Although we do not find any statistically significant differences between TMA groups A and B, we believe there is also value in considering the responses of the TMA group as a whole (i.e., combining the response of the two groups to look at overall TMA patterns). This group in total experienced changes in

[5] Dague L. 2014. "The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach," Journal of Health Economics, 37: 1-12. Available at http://www.sciencedirect.com/science/article/pii/S0167629614000642

premiums and other program rules after April 1, 2014. The responses reflect how those in a premium-paying eligibility group experience the BadgerCare program and health care generally.

Insurance Status (Table 9.2)

About 9% of TMA respondents report being currently without health insurance coverage, and 71% report having had insurance coverage for all 12 months of the previous year. About 45% of respondents report that they are covered by Medicaid/BadgerCare, with 15% reporting ACA coverage and 18% other private coverage. Proportionately more persons in Group B report Medicaid/BadgerCare coverage, while more in Group A report ACA coverage, but the difference is not statistically significant.
For both groups, 70% of the persons who report no longer having BadgerCare report that the reason is that they are no longer eligible. This is perhaps not surprising, as TMA is, by definition, time-limited coverage.

Access and Service Use (Table 9.3)

About 95% of those in the TMA groups report having needed medical care in the past 12 months and, of those, 79% report getting all the treatment they needed. About 20% identify "cost-related reasons" Among the 21% who report not getting all the care they needed, 88% cited cost-related reasons.

Over three-quarters of respondents on these groups reported needing a prescription medication in the past year and, of these, over 80% reported getting all the medications needed. Among those 16% who went without needed medications, 73% cite cost-related reasons. About 86% report having a doctor's office, health center of clinics as a usual source of care, while 5% report using urgent care as their usual source. About 36% report visiting the emergency department times in the last 12 months, with 15% reporting more than one visit in the last year. Of those reporting emergency department visits, over three-quarters cite reasons other than needing emergency care.

About half of respondents reported that they had last visited a dentist within the past 12 months and about 14% reporting that their dental visit had been over 5 years ago. Only 28% of respondents report having received a flu vaccine in the last year.

Nearly 30% of respondents report owing money for medical expenses, and 27% said they had problems paying medical bills. But very few said they were refused care due to owing money to a provider.

Self-Reported Health Status (Table 9.4)

No significant differences are noted between TMA Groups A and B in their self-reported health status. About 71% of respondents report good, very good, or excellent health, while 19% report fair or poor health; 13% report that a physical, mental, or emotional problem limits their ability to work at a job.
A fifth of this group reports smoking cigarettes, and 71% of them have been advised by a health professional within the past year to quit smoking.

A substantial proportion of these groups report signs of depression, with 16% reporting being "bothered by having little interest of please in doing things" more than half of the days to nearly every day in the past two weeks. The same proportion reports being "bothered by feeling down, depressed, or hopeless" in the past two weeks. Beyond this, an additional 26-28% report having these feelings a few times over the past two weeks, leaving about half of the respondents reporting not having these feelings in that time period. This domain is the only area where statistically significant differences emerge between TMA Groups A and B, with Group B about twice as likely as Group A to report feeling various signs of depression on most or all days in the past two weeks.

Knowledge and Attitudes about 2014 Waiver Changes (Table 9.5)

Here again, both TMA groups appear quite similar in their responses. Of these groups, 88% report having been enrolled in BadgerCare before the April 2014 program changes, so have experienced the program both before and after the changes. Slightly over half (52%) report that they were affected by the program changes, while a fifth (19%) report that they do not know if they were affected, and a quarter say they were not affected. Half reported that they lost eligibility due to the April 2014 program changes. Half reported that their monthly premium increased. Less than 10% identified changes in the penalties for not paying a monthly premium, while 45% thought there had been no change, and a third were not sure. About 10% thought that co-payments had increased or decreased, while over half though there had be no change, and 22% were not sure. Virtually no respondents were able to identify changes in mental health or substance abuse treatment benefits, with 45% reporting no change and 37% reporting that they were not sure.

Overall, 27% of respondents report that they are somewhat or very satisfied with program changes, while 20% report that they somewhat or very dissatisfied.

Understanding about Health Insurance Terms (Table 9.6)

TMA members face premiums and, after 12 months, are expected to move to other sources of coverage. Their understanding of their financial responsibilities under TMA and within private insurance affect their ability to maintain coverage.

Three-quarters of TMA members (76%) report feeling very or somewhat confident in their understanding of the word "premium" and 75% in the word "deductibles." Even more (82%) report confidence in understanding "copayments," while substantially fewer (53%) reporting such confidence in the word "coinsurance." These appear strong relative to findings reported by other surveys[6], but at the same time it is important to note that over 20% report that they are only slightly or not at all confident in their understanding of "premium" and deductibles" and a fully 46% reported such lack of confidence in their understanding of the word "coinsurance."

Limitations

It is possible that other factors explain the lack of observed differences between Groups A and B. First, the two groups are in relatively close income range, and may have churn above and below the income dividing line between sample draw and survey response, such that neither group has a continuous experience under a single set of program rules. Second, the number of TMA survey respondents was limited, which means that any differences would need to be fairly large in order for us to reach statistical significance.

[6] Kenney GM, Karpman M, Long SK. 2013. Uninsured Adults Eligible for Medicaid and Health Insurance Literacy. Health Reform Monitoring Survey. The Urban Institute. Available at http://hrms.urban.org/briefs/medicaid_experience.pdf

Table Q9.1. Demographic and Socioeconomic Characteristics of TMA Sample

	TMA A 100-133% FPL	TMA B >133 FPL	Total	
AGE	N=165	N=152	N=317	
Younger than 35	0.30	0.50	0.40	*
35 and above	0.70	0.50	0.60	
Missing	0	0	0	
SEX	N=165	N=152	N=317	
Female	0.74	0.78	0.76	
Male	0.26	0.22	0.24	
RACE	N=165	N=152	N=317	
Spanish, Hispanic or Latino	0.04	0.09	0.07	
White , Non-Hispanic	0.74	0.68	0.71	
Black, Non-Hispanic	0.07	0.1	0.08	
Other race (Asian, Indian), not Hispanic	0.07	0.07	0.07	
Mixed Race, not Hispanic	0.07	0.04	0.05	
Missing	0.01	0.02	0.02	
EDUCATION	N=165	N=152	N=317	
High school diploma or Less than high school	0.51	0.48	0.5	
More than high school	0.49	0.51	0.5	
Missing	0.01	0.01	0.01	
INCOME	N=165	N=152	N=317	
< $30000	0.51	0.71	0.61	**
>= $30000	0.49	0.29	0.39	
PARENTAL STATUS	N=165	N=152	N=317	
No	0.88	0.88	0.88	
Yes	0.11	0.11	0.11	
Missing	0.01	0.01	0.01	
HOUSEHOLD COMPOSITION	N=165	N=152	N=317	
Living alone	0.03	0.11	0.07	
Living with partner or spouse	0.31	0.24	0.27	
Living with Others	0.63	0.62	0.63	
Missing	0.02	0.03	0.03	
HOUSEHOLD SIZE	N=165	N=152	N=317	
>2 members	0.82	0.82	0.82	
<=2 members	0.18	0.18	0.18	
HOUSEHOLD AGE	N=165	N=152	N=317	
>=Two HH members below age 19	0.53	0.64	0.58	
0-1 HH member below age 19	0.47	0.36	0.42	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01				

Table 9.2 Health Insurance Status, TMA Sample

	TMA A	TMA B	Total	
Currently Have Health Insurance	N=165	N=152	N=317	
No	0.09	0.08	0.09	
Yes	0.91	0.92	0.91	
Some kind of health care coverage in past 12 months	N=165	N=152	N=317	
Full year uninsured	0.03	0	0.01	
1-11 months	0.26	0.28	0.27	
all 12 months	0.71	0.71	0.71	
Missing	0.01	0.01	0.01	
Current health care coverage	N=165	N=152	N=317	
Medicaid, BC, BC core	0.39	0.51	0.45	
Employer or family member's employer	0.10	0.11	0.11	
Private (I pay for myself), Other	0.08	0.06	0.07	
Medicare	0.04	0.04	0.04	
ACA/Obamacare	0.19	0.12	0.15	
Uninsured	0	0	0	
Missing	0.21	0.16	0.18	
For those who no longer have BadgerCare coverage: Reasons why	N=60	N=44	N=104	
Not eligible	0.74	0.62	0.69	
Premium related	0.01	0.05	0.03	
Other reasons	0.09	0.08	0.09	
Missing	0.15	0.25	0.2	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01				

Table 9.3 Utilization and Access, TMA Sample

	TMA A	TMA B	Total	
Needed medical care in past 12 months	N=165	N=152	N=317	
No	0.04	0.04	0.04	
Yes	0.96	0.94	0.95	
Missing	0.01	0.02	0.01	
Among those who needed care in the past 12 months: Got all the treatment needed	N=155	N=142	N=297	
No	0.21	0.21	0.21	
Yes	0.79	0.79	0.79	
Missing	0	0	0	
Among those who went without needed medical care: Main reasons[a]	N=31	N=29	N=60	
Non-cost related reasons	0.12	0.08	0.1	
Cost related reasons	0.85	0.92	0.88	
Missing	0.04	0	0.02	
Needed prescription medication in past 12 months	N=165	N=152	N=317	
No	0.24	0.19	0.22	
Yes	0.76	0.80	0.78	
Missing	0	0.01	0	
Among those who needed prescription medications in the past 12 months: Got all medications needed?	N=128	N=121	N=249	
No	0.15	0.17	0.16	
Yes	0.82	0.83	0.83	
Missing	0.03	0.01	0.02	
Among those who went without needed prescription medications you needed: Reasons why	N=20	N=22	N=42	
Non-cost related reasons	0.23	0.10	0.16	
Cost related reasons	0.6	0.86	0.73	
Missing	0.17	0.03	0.1	
Usual source of care	N=140	N=123	N=263	
Doctor's office, health center, clinic	0.88	0.85	0.86	
Urgent care	0.06	0.04	0.05	
No usual place, don't know	0	0.01	0.01	
Other	0.05	0.04	0.04	
Missing	0.02	0.06	0.04	

ER visit in the last 12 months	N=165	N=152	N=317	
Zero times	0.67	0.61	0.64	
1 time	0.21	0.2	0.21	
2 or more times	0.12	0.18	0.15	
Among those with an ER visit in last 12 months: Main reason[b]	N=52	N=57	N=109	
Other reasons	0.75	0.72	0.73	
Needed ER only	0.25	0.26	0.26	
Missing	0	0.02	0.01	
Quality of the medical care received in the last 12 months	N=165	N=152	N=317	
Did not receive medical care	0.07	0.05	0.06	
Excellent, Very good	0.63	0.67	0.65	
Good	0.23	0.21	0.22	
Fair, poor	0.06	0.08	0.07	
Currently owe money to a health care provider, credit card company, or anyone else for medical expenses	N=165	N=152	N=317	
No	0.69	0.69	0.69	
Yes	0.29	0.29	0.29	
Missing	0.02	0.02	0.02	
Had to borrow money, skip paying other bills, or pay other bills late in order to pay health care bills in last 12 months	N=165	N=152	N=317	
No	0.76	0.84	0.8	
Yes	0.24	0.16	0.2	
Refused treatment by a doctor, clinic, or medical service because of money owed	N=165	N=152	N=317	
No	0.96	0.98	0.97	
Yes	0.03	0.01	0.02	
Missing	0.01	0.02	0.02	
During the past 12 months, had either a flu shot or a flu vaccine that was sprayed in your nose?	N=165	N=152	N=317	
No	0.74	0.69	0.72	
Yes	0.26	0.3	0.28	
Needed but did not get because of cost: mental health care or counseling	N=165	N=152	N=317	
No	0.76	0.74	0.75	
Yes	0.09	0.09	0.09	
Missing	0.14	0.18	0.16	

Last visited a dentist for any reason	N=165	N=152	N=317	
Less than 12 months ago	0.56	0.46	0.51	
Between 1 and 5 years	0.3	0.33	0.32	
More than 5 years ago	0.12	0.17	0.14	
Never	0.01	0.02	0.01	
Not sure	0.02	0.01	0.02	
Problems paying any medical bills in past 12 months	N=165	N=152	N=317	
Yes	0.27	0.27	0.27	
No	0.73	0.73	0.73	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01				
[a]Respondents could select more than one reason for this question. "Cost-related reasons" indicates that the respondent selected options a-d on Q.11, while "non-cost-related reasons" indicates the respondent selected options e-h on the survey. See Attachment for the survey question and response options.				
[b]Respondents could select more than one reason for ER use. "Needed ER Only" indicates that the respondent selected only one response. "Other Reasons" indicates the respondent selected more than one response. See Q.18 in Attachment for the survey question and response options.				

Table 9.4 Self-Reported Health Status, TMA Sample

	TMA A	TMA B	Total	
Self-reported physical and mental health	N=165	N=152	N=317	
Excellent, Very good	0.44	0.42	0.43	
Good	0.41	0.36	0.38	
Fair, poor	0.15	0.22	0.19	
A physical, mental, or emotional problem limits ability to work at a job	N=165	N=152	N=317	
No	0.85	0.89	0.87	
Yes	0.15	0.11	0.13	
Smokes cigarettes	N=165	N=152	N=317	
Everyday	0.22	0.18	0.2	
Some days	0.06	0.12	0.09	
Never	0.72	0.7	0.71	
Missing	0	0	0	
Been advised by a doctor or health professional to quit smoking	N=40	N=44	N=84	
Yes	0.7	0.73	0.71	
No	0.3	0.25	0.28	
No visit in past 12 months	0	0.02	0.01	
Missing	0	0	0	
Over the past two weeks, bothered by having little interest or pleasure in doing things	N=165	N=152	N=317	
Not at all	0.59	0.41	0.50	**
A few times	0.26	0.29	0.28	
More than half the days	0.03	0.13	0.08	
Nearly every day	0.07	0.08	0.08	
Don't know	0.04	0.09	0.06	
Over the past two weeks, bothered by feeling down, depressed, or hopeless?	N=165	N=152	N=317	
Not at all	0.66	0.45	0.55	**
A few times	0.22	0.31	0.26	
More than half the days	0.05	0.11	0.08	
Nearly every day	0.04	0.09	0.07	
Don't know	0.03	0.04	0.03	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01				

Table 9.5 Knowledge and Attitudes about 2014 Waiver Changes, TMA Sample

	TMA A	TMA B	Total	
Enrolled in BadgerCare program before Apr 2014	N=165	N=152	N=317	
Yes	0.84	0.92	0.88	
No	0.09	0.06	0.07	
Don't know	0.07	0.03	0.05	
Affected by any new program requirements	N=149	N=143	N=292	
Yes	0.52	0.54	0.53	
No	0.24	0.27	0.25	
Don't know	0.21	0.17	0.19	
Missing	0.03	0.02	0.02	
Lost eligibility for BadgerCare Plus and were no longer enrolled because of changes made after Apr 2014	N=149	N=143	N=292	
Yes	0.53	0.51	0.52	
No	0.4	0.45	0.42	
Missing	0.06	0.04	0.05	
April 2014 Changes: Effect on MONTHLY premium/payment for health care coverage	N=75	N=72	N=147	
Increase	0.49	0.49	0.49	
Decrease	0.03	0.03	0.03	
No change	0.22	0.26	0.24	
Not sure	0.14	0.14	0.14	
Missing	0.11	0.09	0.1	
April 2014 Changes: Effect on PENALTIES for not paying a monthly premium	N=75	N=72	N=147	
Increase	0.05	0.10	0.08	
Decrease	0.01	0	0	
No change	0.42	0.47	0.45	
Not sure	0.37	0.3	0.33	
Missing	0.16	0.13	0.14	
April 2014 Changes: Effect on COPAYMENTS to visit a doctor or clinic	N=75	N=72	N=147	
Increase	0.12	0.07	0.09	
Decrease	0.04	0.01	0.03	
No change	0.44	0.62	0.54	
Not sure	0.25	0.19	0.22	
Missing	0.15	0.11	0.13	

April 2014 Changes: Effect on MENTAL HEALTH or SUBSTANCE ABUSE TX BENEFITS	N=75	N=72	N=147	
Increase	0.02	0	0.01	
Decrease	0.01	0.01	0.01	
No change	0.42	0.49	0.45	
Not sure	0.39	0.36	0.37	
Missing	0.16	0.14	0.15	
Satisfaction with the changes that have taken place since Apr 2014	N=74	N=72	N=146	
Very satisfied	0.09	0.13	0.11	
Somewhat satisfied	0.12	0.19	0.16	
Neither satisfied nor dissatisfied	0.5	0.44	0.46	
Somewhat dissatisfied	0.11	0.15	0.13	
Very dissatisfied	0.10	0.05	0.07	
Missing	0.08	0.04	0.06	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01				

Table 9.6 Understanding of Health Insurance Terms, TMA Sample

	TMA A	TMA B	Total	
Confident that you understand what the word means: PREMIUM	N=165	N=152	N=317	
Very confident	0.59	0.50	0.55	
Somewhat confident	0.21	0.22	0.21	
Slightly confident	0.13	0.22	0.17	
Not at all confident	0.05	0.05	0.05	
Missing	0.03	0.01	0.02	
Confident that you understand what the word means: DEDUCTIBLES	N=165	N=152	N=317	
Very confident	0.56	0.47	0.51	
Somewhat confident	0.24	0.25	0.24	
Slightly confident	0.13	0.21	0.17	
Not at all confident	0.06	0.06	0.06	
Missing	0.01	0.01	0.01	
Confident that you understand what the word means: COPAYMENTS	N=165	N=152	N=317	
Very confident	0.66	0.58	0.62	
Somewhat confident	0.14	0.26	0.2	
Slightly confident	0.12	0.1	0.11	
Not at all confident	0.06	0.06	0.06	
Missing	0.01	0	0.01	
Confident that you understand what the word means: COINSURANCE	N=165	N=152	N=317	
Very confident	0.27	0.27	0.27	
Somewhat confident	0.24	0.27	0.26	
Slightly confident	0.21	0.15	0.18	
Not at all confident	0.26	0.3	0.28	
Missing	0.01	0.01	0.01	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01				

Question 17: Childless Adult Beneficiary Enrollment in the Medicaid Standard Plan

Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries demonstrate an increase in the continuity of coverage?

The objective of this question is to understand whether and to what extent the provision of standard Medicaid benefits to childless adult (CLAs) beneficiaries increased continuity of health coverage. In the 2016 Interim Evaluation Report, we focused on enrollment-related outcomes from the CARES administrative data. We compared the continuity of coverage for newly eligible CLA beneficiaries to the continuity of coverage for continuing CLA beneficiaries enrolled in the Standard Plan after April 2014. Continuing CLA beneficiaries refer to childless adults enrolled in the Core plan immediately before April 2014 and enrolled in the Standard Plan after April 2014. This survey report complements those initial findings by characterizing outcomes that are directly related to continuity of health *care* -- health care access and health outcomes-- in addition to the continuity of health insurance coverage.

Key Findings

There are several key findings that provide insight into the continuity of coverage and health care for childless adults under the Core and Standard plans: 1) The likelihood and duration of health insurance coverage increased from 2014 to 2016, the Core- and Standard- plan periods for this analysis (Table 17.4); 2) CLAs' reported need for medical care increased as did their likelihood of obtaining all needed care under the Standard plan compared to the Core plan period (Table 17.5); 3) The likelihood of borrowing money or skipping payment of other bills in order to pay for health care substantially decreased after implementation of the 2014 waiver (Table 17.5); and 4) No significant changes occurred in overall self-reported health status. However, the probability increased from 2014-2016 of having a work-limiting health problem (Table 17.6). In general, the CLAs under the Standard plan period report better outcomes with respect to coverage and access than CLAs reported under the Core plan period. These observational findings, while not causal, provide important indicators of the relative experience of childless adult beneficiaries under two distinct coverage and enrollment policy periods.

Research Design

The Wisconsin Department of Health Services requested an assessment of CLA Standard Plan enrollees' outcomes relative to the two comparators, A and B, described below. The 2014 and 2016 surveys provide a unique data source to implement comparison A using two alternative samples. Table 17.1 describes these sample, followed by a discussion of their strengths and limitations. The survey data do not support a robust comparison of post-waiver outcomes for new and continuing CLA beneficiaries (i.e., Comparison B).

A. Comparison of CLA beneficiaries' outcomes while enrolled in the Standard Plan relative to their outcomes while enrolled in the Core Plan; and
B. Comparison of post-waiver outcomes for two groups of CLA beneficiaries enrolled in the Standard Plan: new CLA beneficiaries who became eligible on or after April 2014; and continuing CLA beneficiaries who transitioned from Core plan coverage to Standard Plan coverage in April 2014.

Table 17.1 Study groups and sample sizes

	Sample Description	2014 Sample Size	2016 Sample Size
Sample A1	The cohort of CLA 2014 survey respondents who responded to both the 2014 and 2016 surveys.	118	118
Sample A2	All CLA beneficiaries who responded to the 2014 survey and all CLA beneficiaries who responded to the 2016 survey.	194	278

Sample A1 supports a comparison of outcomes for each individual at two time points, before and after the implementation of the 2014 waiver. This comparison describes the experience of CLA beneficiaries under two Medicaid coverage policies: Core and Standard plan coverage. To attribute a change in outcomes to Standard plan coverage, it is necessary to assume no plausible alternative explanations. By using a cohort sample, we eliminate changes in sample composition as one important alternative explanation. It remains possible that changes over the same time period in factors related to the outcomes may contribute to changes in the outcomes.

For example, this cohort was defined based on their CLA eligibility status before implementation of the 2014 waiver as described in Section D5. A change in insurance coverage options (e.g., ACA exchange plans) after 2014 may affect survey outcomes related to health care access independent of the introduction of Standard plan coverage. It is also worth noting that the generalizability of these estimates may be limited to the degree that cohort sample members differ from the current CLA beneficiary population in ways related to the outcomes (e.g., income, health, etc.).

Sample A2 supports a comparison of outcomes for two cross-sectional samples: CLA beneficiaries enrolled in the Core plan before implementation of the 2014 waiver; and CLA beneficiaries enrolled in the Standard plan after implementation of the 2014 waiver. A potential difference in outcomes between these 2 groups is attributable to Standard plan coverage when two assumptions hold: the groups are comparable with respect to the outcomes and factors related to the outcomes; and no unobserved events or trends confound the relationship between CLA enrollment and outcomes. The cross-sectional samples offer an important potential advantage in generalizability over the cohort Sample A1. Membership in the cross-sectional samples required participation in only one survey, 2014 or 2016, in contrast to the cohort Sample A1 that required a response to both surveys. The attrition in participation that occurs from one survey to the next may reduce the representativeness of the remaining sample.

The survey sampling design does not allow Comparison B, a comparison of post-waiver outcomes for CLA beneficiaries newly enrolled in the Standard plan and continuing CLA beneficiaries. To do so requires samples of the newly enrolled and continuing CLA beneficiaries that represent those two Medicaid populations. The 2016 survey includes the former but not the latter. The administrative data are well suited to support the implementation of Comparison B, and we will continue to use those resources to evaluate this second comparison of interest.

Sample Construction

The analytic sample for this report includes CLA respondents from the 2014 and 2016 surveys. The response rate for CLAs to these surveys was 65% and 55% respectively. The 2014 survey aimed to assess beneficiaries' health, health care use, and health insurance status after the July 2012 implementation of new premium and restricted reenrollment policies. The 2014 survey sample included a random selection of CLA beneficiaries who were enrolled in the Core plan between January 2012-March 2014. For programmatic reasons, the survey was fielded just after implementation of the April 2014 waiver. However, because the reference period for most of the survey questions assessed the beneficiary's experience in the past 12 months, the responses provide an estimate of study outcomes during the Core plan period.

The 2016 survey resampled all of the CLA respondents to the 2014 survey in addition to CLA beneficiaries currently enrolled in the Standard plan in 2016. The subset of 2014 CLA respondents who responded to the 2016 survey comprise Sample A1 (N=118). The CLA respondents to the 2014 survey serve as the comparison population for Sample A2 (N=194). The sample construction is depicted in Table 17.2.

Table 17.2 Survey Sample Construction for Childless Adult Beneficiaries

	(I) 2014 Survey	(II) 2016 Survey
Total Sample N	300	600
* Ineligible	n/a	96
All CLA Respondents (Sample A2)	194	278
Respondents to both 2014 & 2016 (Sample A1)	118	118
Dates of Survey Data Collection	4/1/2014-8/30/14	5/10/16 – 9/26/16
*Individuals who died, moved out of state, or reported no history of Medicaid coverage		

Description of Sample (Table 17.3)

Table 17.3 presents the socio-demographic characteristics of the CLA samples. The data included in column I summarizes the responses for the cohort of individuals under two coverage policies, Core and Standard plan coverage. Few differences appear in the socio-demographic characteristics of this cohort over time; this finding is not surprising given that several outcomes are relatively time-invariant within-person. Educational achievement is an exception. In the 2016 survey, 45% of respondents reported more than a high school education compared to 27% in the 2014 survey. More generally, about 63% of the cohort is female, and more than 70% are White and older than 35 years of age.

Table 17.3 presents the same characteristics for the second comparison of interest in column II, all 2014 CLA survey respondents compared to all 2016 CLA survey respondents. The general profile of the 2016 CLA beneficiary sample after implementation of the waiver is similar to the pre-waiver sample with respect to age, educational achievement, and household size. Several differences in sample characteristics are noteworthy. First, a larger proportion of CLA beneficiaries in the post-waiver period report a non-White race; 55% of the CLA population in 2016 is male compared to 41% in the 2014 CLA population; and the percentage of CLA beneficiaries that report annual income less than $30,000 increased from 83% to 96% consistent with the lower income eligibility threshold after 2014.

Analysis

We calculated means and proportions for each of the study variables, applying survey weights. To calculate statistical significance for differences between two groups, we calculated standard test statistics (i.e., *t*-statistics for proportions and *chi*-squared statistics for categorical and ordinal data). These statistics were adapted for weighted data in the survey routine in Stata. We consider $p<.05$ to indicate statistically significant differences between groups. Unless otherwise noted, all between-group differences reported in this section are statistically significant.

The overall outcomes of interest for Q17 are health care continuity and health insurance continuity. The survey includes several domains of questions that map directly to these outcomes. Each of the following tables includes the results for Samples A1 and/or A2 for one of these domains. Because the 2016 survey was designed with the current Section 1115 waiver in mind, some questions appear for the first time in 2016. In those instances, the results are reported for the 2016 CLA sample only. While these outcomes have no comparison group, they provide a richer characterization of the current CLA population.

Results

Coverage, Service, and Access to Care (Table 17.4 and Table 17.5)
Insurance Coverage. Within the cohort of CLA subjects (i.e., Sample A1), the percentage that report having any type of health insurance increased from 68% in 2014 to 84% in 2016 as shown in Table 17.4, column I. Similarly, the duration of insurance coverage within the past 12 months increased: 62% of cohort members reported full-year coverage in 2016 compared to 44% in 2014. The percentage of the cohort that reported Medicaid as the current source of health insurance coverage remained constant over time at 15%. The percentage of the group that reported Medicare or the ACA as the source of current health insurance coverage increased from 2014 to 2016 while the proportion reporting other private coverage or no coverage declined.

The relatively low percentage of the CLA cohort that reported Medicaid as the *current* source of coverage is likely a consequence of the time lag between sample selection and survey implementation for the 2014 survey. The 2014 sample was selected based on their Core plan enrollment status before 2014 while survey implementation was delayed until April 2014 for programmatic reasons. Thus, sample members with income greater than 100% FPL were ineligible for Medicaid when the 2014 survey was fielded. When resurveyed in 2016, the percentage of the CLA cohort that reported Medicaid as their current source of coverage remained low.

The results in column II of Table 17.4 compare health insurance coverage for all CLA respondents in 2014 to all CLA respondents in 2016 (i.e., Sample A2). In 2016, CLAs were more likely to report having health insurance; 95% of the sample reported that they currently had health insurance compared to 68% of the 2014 CLA sample. Just over three-quarters of CLAs in 2016 reported having health insurance coverage for 12 of the past 12 months compared to 47% of CLAs in 2014. Significant change occurred in the sources of health insurance coverage for CLAs from 2014 to 2016. The percentage of CLAs that reported Medicaid as the current source of coverage increased from 15% to 68%. Among those who reported no longer having Medicaid/BadgerCare coverage, CLAs in the 2016 sample were less likely to report ineligibility or premium-related reasons than were individuals in the 2014 sample. These differences are expected given the relatively short time lag between sample selection and survey administration in 2016, and the lack of premium-related programmatic changes for CLAs in 2016.

Service use and access to care. The first column of Table 17.5 shows that self-reported need for medical care and prescription medications increased for the CLA cohort (i.e., Sample A1) from 2014 to 2016 as did the likelihood of obtaining all of the care and prescription medications that were needed. No significant changes occurred in the cohort's reported use of the emergency room, the usual source of care, the quality of care received, or the likelihood of owing money to providers or creditors for medical expenses. The experience of health care use and access for the full 2014 and 2016 CLA sample (i.e., Sample A2) is presented in column II. In 2016, CLAs were more likely than their peers in 2014 to report a need for medical care in the past 12 months and more likely to note that they received all of that care.

For those individuals who went without needed medical care, the probability of reporting a cost-related reason decreased from 87% in 2014 to 72% in 2016 (column II). Similarly, CLAs in 2016 were more likely to report obtaining all of the prescription medications needed in the past 12 months. Among those who did not, 69% reported cost-related reasons in 2016 compared to 95% in 2014. Relatedly, the percentage of CLAs that reported borrowing money or not paying other bills to pay health care bills declined from 32% in 2014 to 8% in 2016. The probability of having one or more emergency room visits in the past 12 months increased from 27% to 43% for CLAs from 2014 to 2016. Overall, 60% of CLAs in 2016 rated their medical care in the prior 12 months as excellent or very good compared to 48% of CLAs in 2014.

Self-reported health (Table 17.6)

Table 17.6 presents the results for self-reported health outcomes. Within the cohort of individuals who participated in both the 2014 and 2016 surveys (i.e., Sample A1), approximately 35% reported excellent or very good health in both years, and the percentage of cohort members who reported a work-limiting physical, mental or emotional problem increased over time from 16% to 24% (column I). As shown in column II, there was no significant difference in self-reported general health between the full 2014 and 2016 samples. However, 46% of individuals in the 2016 sample reported a work-limiting physical, mental, or emotional problem compared to 19% in the full 2014 sample (column II). This finding is likely associated with the reduction in the income eligibility for CLAs from 200% FPL to 100% FPL in April 2014 rather than a consequence of health care continuity or discontinuity. On average, individuals with health problems have lower incomes than similarly situated, healthy individuals because poor health limits employment. As the average income of the CLA enrollee population declines (in response to the income criterion), the prevalence of the correlates or causes of lower personal income increases, including work-limiting health problems.

As previously noted, some survey questions were only available in 2016. Results for these questions are shown in column II. Approximately, 38% of the 2016 CLA sample reports smoking cigarettes at least some days. Among smokers, 61% reported that a physician or health care professional advised them to quit smoking within the past 12 months. Symptoms of poor mental health were relatively prevalent in the CLA population in 2016. Specifically, 28% of CLA individuals in 2016 report mental health problems on more than half of the days in the past two weeks related to being bothered or not being able to experience pleasure in the last two weeks (symptoms of depression or anxiety).

Insurance Knowledge and Attitudes About Program Changes (Table 17.7)

The 2016 survey includes several questions related to the implementation and provisions of the 2014 1115 waiver. Table 17.7 presents the responses to these questions for the full 2016 CLA sample (N=278). Almost half of the sample reported that they were enrolled in BadgerCare before April of 2014. Among this subgroup, 17% were affected by the waiver's new program requirements, and 18% reported that they were no longer enrolled because of the changes made. Overall, within the sample subgroup who had prior BadgerCare enrollment, 46% reported that they were somewhat or very satisfied with the

changes in the program since April 2014. This group reported limited awareness of the differences in coverage for mental health and substance use disorder (MHSUD) treatment under the standard plan relative to the core plan. Specifically, among CLAs who reported enrollment in BadgerCare before 2014, 84% reported either no change in MHSUD coverage or uncertainty about any such change after April 2014.

Limitations

There are several limitations to consider when interpreting these findings. First, the results of the 2014 survey reflect the responses of childless adults who were enrolled in the Core plan at the time the sample was constructed rather than at the time the survey was implemented. Questions that pertain to the respondent's current status rather than his/her status during the past 12 months are unlikely to reflect his/her Core plan experience. Second, to attribute the observed outcome differences between the 2014 and 2016 samples (Sample A2) to Standard plan coverage, it is necessary to assume that the two groups are comparable in factors related to the outcomes. These samples differ across several observable characteristics related to health care access and coverage (e.g., sex, race, income), suggesting that this assumption may not hold. Finally, secular changes between 2014 and 2016 related to health insurance coverage and care access (e.g., employment, ACA, etc.,) may contribute the differences we observe in our study outcomes.

Table 17.3. Demographic Characteristics of Childless Adults

	(I) Sample A1			(II) Sample A2		
	2014	2016		2014	2016	
AGE	118	118		194	278	
Younger than 35	0.19	0.16		0.23	0.26	
35 and above	0.77	0.82		0.75	0.72	
Missing	0.04	0.02		0.02	0.02	
SEX	118	118		194	278	
Female	0.63	0.62		0.59	0.45	
Male	0.37	0.37		0.41	0.55	
RACE	118	118		194	278	
Spanish, Hispanic or Latino	0.05	0.07	*	0.05	0.03	**
White , Non-Hispanic	0.73	0.74		0.69	0.64	
Black, Non-Hispanic	0.11	0.15		0.15	0.19	
Other race (Asian, Indian), not Hispanic	0.01	0.02		0.01	0.07	
Mixed Race, not Hispanic	0.02	0.02		0.02	0.04	
Missing	0.08	0.01		0.09	0.02	
EDUCATION	118	118		194	278	
High school diploma or Less than high school	0.71	0.52	**	0.70	0.69	
More than high school	0.27	0.45		0.28	0.30	
Missing	0.03	0.03		0.02	0.02	
INCOME	118	118		194	278	
< $30000	0.80	0.77		0.83	0.96	**
>= $30000	0.20	0.23		0.17	0.04	
PARENTAL STATUS	118	118		194	278	
No	0.88	0.94	*	0.89	0.93	
Yes	0.09	0.06		0.10	0.06	
Missing	0.03	0		0.02	0.01	
HOUSEHOLD COMPOSITION	118	118		194	278	
Living alone	0.30	0.35		0.35	0.24	**
Living with partner or spouse	0.33	0.37		0.32	0.28	
Living with Others	0.34	0.27		0.31	0.47	
Missing	0.03	0.01		0.02	0.01	
HOUSEHOLD SIZE	118	118		194	278	
>2 members	0.27	0.30		0.28	0.36	
<=2 members	0.73	0.70		0.72	0.64	
HOUSEHOLD AGE	118	118		194	278	
>=Two HH members below 19	0.12	0.11		0.15	0.12	
0-1 HH member below 19	0.88	0.89		0.85	0.88	
*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01						

Table 17.4. Health Insurance Status, Childless Adults

	(I) Sample A1			(II) Sample A2		
	2014	2016		2014	2016	
Currently Have Health Insurance	N=118	N=118		N=194	N=278	
No	0.3	0.09	**	0.3	0.03	**
Yes	0.68	0.84		0.68	0.95	
Missing	0.03	0.06		0.02	0.02	
Some kind of health care coverage in past 12 months	N=118	N=118		N=194	N=278	
Full year uninsured	0.24	0.12	**	0.23	0.04	**
1-11 months	0.32	0.21		0.29	0.17	
all 12 months	0.44	0.62		0.47	0.76	
Missing	0	0.05		0.01	0.03	
Current health care coverage	N=118	N=118		N=194	N=278	
Medicaid, BC, BC core	0.15	0.15	**	0.15	0.68	**
Employer or family member's employer	0.2	0.2		0.17	0.04	
Private (I pay for myself), Other	0.12	0.09		0.12	0.06	
Medicare	0.08	0.16		0.11	0.05	
ACA/Obamacare	0.13	0.19		0.13	0.11	
Uninsured	0.3	0.09		0.3	0.03	
Missing	0.03	0.11		0.02	0.04	
For those who no longer have BadgerCare coverage: Reasons why	N=92	N=87		N=153	N=56	
Not eligible	0.52	0.67	**	0.49	0.25	**
Premium related	0.23	0.05		0.24	0	
Other reasons	0.17	0.2		0.15	0.23	
Missing	0.08	0.08		0.11	0.52	

*Indicates a difference between outcomes that is statistically significant at p< 0.05.
**Indicates a statistically significant different at p <0.01.
Sample A1 refers to the cohort of childless adults who responded to both the 2014 and 2016 surveys. Sample A2 refers to all childless adults who responded to the 2014 survey and all childless adults who responded to the 2016 survey.

Table 17.5 Utilization and Access, Childless Adults

	(I) Sample A1			(II) Sample A2		
	2014	2016		2014	2016	
Needed medical care in past 12 months	N=118	N=118		N=194	N=278	
No	0.33	0.06	**	0.3	0.08	**
Yes	0.67	0.93		0.7	0.9	
Missing	0	0.02		0	0.02	
Among those who needed care in the past 12 months: Got all the treatment needed	N=82	N=108		N=137	N=250	
No	0.37	0.19	*	0.3	0.14	**
Yes	0.61	0.81		0.67	0.86	
Missing	0.02	0		0.02	0	
Among those who went without needed medical care: Main reasons	N=27	N=20		N=41	N=32	
Non-cost related reasons	0	0.04		0.01	0.18	*
Cost related reasons	0.87	0.96		0.87	0.72	
Missing	0.13	0		0.11	0.1	
Needed prescription medication in past 12 months	N=118	N=118		N=194	N=278	
No	0.23	0.2		0.21	0.19	
Yes	0.77	0.8		0.79	0.81	
Missing	0	0		0	0.01	
Among those who needed prescription medications in the past 12 months: Got all medications needed?	N=93	N=93		N=154	N=226	
No	0.26	0.14	*	0.29	0.11	**
Yes	0.73	0.81		0.7	0.88	
Missing	0.01	0.05		0.01	0.01	
Among those who went without needed prescription medications you needed: Reasons why[a]	N=22	N=16		N=40	N=28	
Non-cost related reasons	0.04	0.18	*	0.03	0.2	**
Cost related reasons	0.93	0.55		0.95	0.69	
Missing	0.03	0.27		0.02	0.11	
Usual source of care	N=87	N=93		N=148	N=220	
Doctor's office, health center, clinic	0.85	0.86		0.85	0.79	
Urgent care	0.06	0.02		0.09	0.06	
No usual place, don't know	0.02	0.01		0.01	0.03	
Other	0.05	0.08		0.04	0.07	
Missing	0.02	0.03		0.01	0.05	

ER visit in the last 12 months	N=118	N=118		N=194	N=278	
Zero times	0.76	0.77		0.73	0.56	*
1 time	0.13	0.14		0.13	0.22	
2 or more times	0.11	0.09		0.14	0.21	
Among those with an ER visit in last 12 months: Main reason[b]	N=30	N=29		N=53	N=120	
Other reasons	0.68	0.77		0.69	0.57	
Needed ER only	0.32	0.23		0.31	0.41	
Missing	0	0		0	0.02	
Quality of the medical care received in the last 12 months	N=118	N=118		N=194	N=278	
`Did not receive medical care	0.19	0.1		0.18	0.06	**
Excellent, Very good	0.46	0.51		0.48	0.6	
Good	0.19	0.26		0.18	0.22	
Fair, poor	0.16	0.12		0.16	0.1	
Currently owe money to a health care provider, credit card company, or anyone else for medical expenses	N=118	N=118		N=194	N=278	
No	0.53	0.49		0.52	0.63	
Yes	0.47	0.48		0.47	0.36	
Missing	0	0.02		0.01	0	
Had to borrow money, skip paying other bills, or pay other bills late in order to pay health care bills in last 12 months	N=118	N=118		N=194	N=278	
No	0.72	0.76		0.68	0.91	**
Yes	0.28	0.21		0.32	0.08	
Missing	0	0.03		0	0.01	
Refused treatment by a doctor, clinic, or medical service because of money owed	N=118	N=118		N=194	N=278	
No	0.93	0.92		0.91	0.91	
Yes	0.03	0.07		0.06	0.05	
Missing	0.04	0.02		0.04	0.03	
During the past 12 months, had either a flu shot or a flu vaccine that was sprayed in your nose?[a]					N=278	
No					0.75	
Yes					0.25	
Missing					0	
Needed but did not get because of cost: mental health care or counseling[a]					N=278	
No					0.68	
Yes					0.09	
Missing					0.22	

Last visited a dentist for any reason[a]					N=278	
Less than 12 months ago					0.44	
Between 1 and 5 years					0.32	
More than 5 years ago					0.21	
Never					0.02	
Not sure					0.01	
Problems paying any medical bills in past 12 months[a]					N=278	
Yes					0.22	
No					0.76	
Missing					0.02	

*Indicates a difference between outcomes that is statistically significant at p< 0.05.
**Indicates a statistically significant different at p <0.01.
Sample A1 refers to the cohort of childless adults who responded to both the 2014 and 2016 surveys. Sample A2 refers to all childless adults who responded to the 2014 survey and all childless adults who responded to the 2016 survey.
[a]Indicates a question introduced in the 2016 survey.

[a]Respondents could select more than one reason for this question. “Cost-related reasons” indicates that the respondent selected options a-d on Q.11, while “non-cost-related reasons” indicates the respondent selected options e-h on the survey. See Attachment for the survey question and response options.

[b]Respondents could select more than one reason for ER use. “Needed ER Only” indicates that the respondent selected only one response. “Other Reasons” indicates the respondent selected more than one response. See Q.18 in Attachment for the survey question and response options

Table 17.6 Self-Reported Health, Childless Adults

	(I) Sample A1			(II) Sample A2		
	2014	2016		2014	2016	
Self-reported physical and mental health	N=118	N=118		N=194	N=278	
Excellent, Very good	0.36	0.35		0.31	0.27	
Good	0.38	0.37		0.38	0.34	
Fair, poor	0.26	0.28		0.31	0.39	
A physical, mental, or emotional problem limits ability to work at a job	N=118	N=118		N=194	N=278	
No	0.84	0.76	*	0.81	0.54	**
Yes	0.16	0.24		0.19	0.46	
Smokes cigarettes[a]					N=278	
Everyday					0.26	
Some days					0.12	
Never					0.61	
Missing					0.01	
Been advised by a doctor or health professional to quit smoking[a]					N=278	
Yes					0.61	
No					0.31	
No visit in past 12 months					0.04	
Missing					0.04	
Over the past two weeks, bothered by having little interest or pleasure in doing things[b]					N=278	
Not at all					0.36	
A few times					0.26	
More than half the days					0.14	
Nearly every day					0.14	
Dont know					0.09	
Missing					0.01	
Over the past two weeks, bothered by feeling down, depressed, or hopeless?[b]					N=278	
Not at all					0.43	
A few times					0.28	
More than half the days					0.09	
Nearly every day					0.14	
Don't know					0.05	
Missing					0.01	

*Indicates a difference between outcomes that is statistically significant at p< 0.05. **Indicates a statistically significant different at p <0.01. [a]Responses from 2014 are omitted bcause the skip pattern differs from the 2016 survey. [b] Indicates a question introduced in the 2016 survey. Sample A1 refers to the cohort of childless adults who responded to both the 2014 and 2016 surveys. Sample A2 refers to all childless adults who responded to the 2014 survey and all childless adults who responded to the 2016 survey.

Table 17.7 Knowledge and Attitudes about 2014 Waiver Changes, Childless Adults

	Sample A2
	2016
Enrolled in BadgerCare program before Apr 2014	N=278
Yes	0.43
No	0.39
Don't know	0.17
Missing	0.01
Affected by any new program requirements	N=174
Yes	0.17
No	0.5
Don't know	0.29
Missing	0.04
Lost eligibility for BadgerCare Plus and were no longer enrolled because of changes made after Apr 2014	N=174
Yes	0.18
No	0.74
Missing	0.08
MENTAL HEALTH or SUBSTANCE ABUSE TREATMENT BENEFITS	N=143
Increase	0.01
Decrease	0
No change	0.55
Not sure	0.29
Missing	0.13
Satisfaction with the changes that have taken place since Apr 2014	N=143
Very satisfied	0.28
Somewhat satisfied	0.18
Neither satisfied nor dissatisfied	0.36
Somewhat dissatisfied	0.05
Very dissatisfied	0.01
Missing	0.11

Sample A2 refers to all childless adults who responded to the 2014 survey and all childless adults who responded to the 2016 survey. The questions in this table were introduced in the 2016 survey.

F. NEXT STEPS

The results reported here contribute important interim findings toward our overall analysis of each study hypothesis. This process continues, as we move toward fielding the second survey in 2018, and deepen our analysis of the administrative data.

We continue to use the data from the 2016 survey for further analyses:

1. Replicate these survey analyses with adjustment. We will identify a common set of adjustment variables and apply adjustment for specific cases where such methods will improve the comparability of the groups.

2. We have linked virtually all subjects in the survey to their administrative (claims) records.

Linkage of the survey to the claims data may offer several strengths to the evaluation. First, it provides a means of validating some survey-reported measures (e.g., current enrollment status in BadgerCare or Medicaid). Second, the survey domains may be useful in predicting outcomes in the administrative data. For example, we could analyze risk of disenrollment using survey-reported measures (such as self-reported satisfaction with care) in addition to administrative measures (exposure to premium relative to income and health care use, for example). These analyses are complex, and the decision to pursue them will depend on whether they are likely to yield significant new insights and are feasible within current resource and time constraints.

Finally, the 2016 survey results will help inform the design of the 2018 survey. We intend to preserve many of the same questions for 2018, facilitating multi-year comparisons. Different sampling scenarios are possible. We may continue the longitudinal component of this study, depending on sample size required for making over-time within-subject comparisons. Or we may decide to more intensively sample specific groups in 2018 and forgo re-interviewing some from prior surveys.

We will also consider how new Medicaid program changes might affect or relate to the timing of the 2018 survey. Potential changes in state and federal policy in 2018 will pose challenges to fielding a survey intended to capture respondents experience of the 2014 BadgerCare policy changes. However, the 2018 survey could serve as a baseline for the new 1115 waiver. We will work closely with DHS to assure that the survey meets the state's and CMS' evaluation needs and requirements.

G. ATTACHMENT: SURVEY INSTRUMENTS

University of Wisconsin
Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Current or Former
BadgerCare Plus Member Survey

Thank you for taking the time to answer the questions on the following pages. This survey is about your health care coverage through Wisconsin Medicaid or BadgerCare Plus. Your answers will help the Wisconsin Department of Health Services understand how changes to these programs affect your health and health care.

Taking part in this survey is voluntary. You can skip questions that you do not want to answer. If you choose not to take this survey, it will not affect any health care benefits you are getting right now or might get in the future. All information is private and confidential. You will not be individually identified with your responses.

For each question, please fill in the circle next to the answer you choose, or write your answer in the box provided. When you are finished, please place the completed survey into the postage-paid envelope provided, and put it in the mail.

If you have questions about the survey, you can contact one of the people listed below:

Bob Cradock at the University of Wisconsin Survey Center
608-265-9885
cradock@ssc.wisc.edu

Donna Friedsam at the UW Population Health Institute
608-263-4881
dafriedsam@wisc.edu

Thank you again for your help!

Your Health Care Coverage

1. In the past 12 months, how many months did you have some kind of health care coverage? Select *one* answer only.

- ○ No health care coverage during the last 12 months
- ○ 1 to 2 months of health care coverage
- ○ 3 to 5 months of health care coverage
- ○ 6 to 8 months of health care coverage
- ○ 9 to 11 months of health care coverage
- ○ Covered for all of the last 12 months → **Go to Question 3**

2. If you did not have health care coverage in some or all of the past 12 months, what are the reasons you did not have coverage? Select *all* that apply.

	Yes	No
a. I did not qualify for Medicaid/BadgerCare Plus anymore	○	○
b. I could not afford payments to remain on Medicaid or BadgerCare Plus	○	○
c. I could not afford payments for private health care coverage, an employer's insurance, or from the federal Marketplace/Healthcare.gov/ACA/Obamacare	○	○
d. I was not offered health care coverage from an employer	○	○
e. I was not able to afford the health care coverage an employer offered	○	○
f. I did not have access to any health care coverage	○	○
g. I did not want health care coverage	○	○
h. I did not know how to find information on available health care coverage options	○	○
i. I did not have the time to get health care coverage	○	○

3. What type of health care coverage do you *currently* have? Select *all* that apply.

	Yes	No
a. Wisconsin Medicaid Program	○	○
b. BadgerCare Plus	○	○
c. Medicare	○	○
d. Employer or family member's employer	○	○
e. A private plan I pay for myself	○	○
f. A health plan from Healthcare.gov, the federal Affordable Care Act (ACA/Obamacare) Marketplace	○	○
g. Other coverage. Please specify:	○	○
h. None - no coverage/insurance	○	○

If you *currently* have coverage from Medicaid or BadgerCare Plus, please skip to Question 7.

4. For those who no longer have Medicaid/BadgerCare coverage: What are the reasons you no longer have that coverage? Select *all* that apply.

	Yes	No
a. I am not eligible anymore because I have access to other health care coverage.	○	○
b. I am not eligible anymore because my income has changed.	○	○
c. I am not eligible anymore for other reasons.	○	○
d. The premiums increased and so I dropped my Medicaid/BadgerCare Plus coverage.	○	○
e. I missed a premium payment, so the Medicaid/BadgerCare Plus program temporarily removed me from coverage.	○	○
f. Other reason. Please specify:	○	○

5. Have you ever looked for information on health care coverage available from the federal Health Insurance Marketplace (healthcare.gov)? Select *one* answer only.

- ○ Yes
- ○ No, but I plan on looking for information → **Go to Question 7**
- ○ No, and I do not plan on looking for information → **Go to Question 7**
- ○ I have not heard about this kind of health care coverage → **Go to Question 7**
- ○ I do not know how to look for health care coverage → **Go to Question 7**

6. How did the health care coverage available from the federal Health Insurance Marketplace (healthcare.gov) seem to you? Select *one* answer only.

- ○ There are some good options for me
- ○ I can't afford the required premium payments
- ○ The plans don’t cover/include the doctors and providers that I need to see
- ○ I’m not sure

Your Health Care

7. Is there a place you *usually* go to get health care? Select *one* answer only.

- ◯ Yes
- ◯ No → **Go to Question 9**

8. Where do you usually go to get health care? Select *one* answer only.

- ◯ A private doctor's office or clinic
- ◯ A public health clinic, community health center, or tribal clinic
- ◯ A walk-in clinic in a store, such as Walmart or a pharmacy
- ◯ A hospital-based clinic
- ◯ A hospital emergency room
- ◯ An urgent care clinic
- ◯ Some other place. Please specify: _____
- ◯ I don't have a usual place
- ◯ I don't know

9. Do you have at least one person you think of as your personal doctor or health care provider? Select *one* answer only.

- ◯ Yes, more than one person
- ◯ Yes, only one person
- ◯ No, no one
- ◯ I don't know

10. If you needed health care in the past 12 months, did you get all the care you needed?

- ◯ Yes → **Go to Question 12**
- ◯ No
- ◯ I did not need care in the last 12 months → **Go to Question 12**

11. Think about the *most recent time* you went *without* needed health care in the last 12 months. What were the main reasons you went without care at that time? Select *all* that apply.

	Yes	No
a. It cost too much	◯	◯
b. I didn't have health care coverage	◯	◯
c. The doctor wouldn't take my insurance	◯	◯
d. I owed money to the doctor	◯	◯
e. I couldn't get an appointment quickly enough	◯	◯
f. The office wasn't open when I could get there	◯	◯
g. I didn't have a doctor	◯	◯
h. Other reason. Please specify:	◯	◯

12. Was there a time in the *last 12 months* when you needed *prescription medication*?

- ◯ Yes
- ◯ No → **Go to Question 15**

13. If you needed prescription medications in the past 12 months, did you get all the medications you needed? Select *one* answer only.

- ◯ Yes → **Go to Question 15**
- ◯ No
- ◯ I did not need medications in the last 12 months → **Go to Question 15**

14. Think about the *most recent time* you went *without* prescription medications that you needed in the last 12 months. What were the main reasons you went without prescription medications at that time? Select *all* that apply.

	Yes	No
a. They cost too much	◯	◯
b. I didn't have health care coverage	◯	◯
c. I didn't have a doctor	◯	◯
d. I couldn't get a prescription	◯	◯
e. I couldn't get to the pharmacy	◯	◯
f. Some other reason. Please specify:	◯	◯

15. How long has it been since you last visited a dentist or a dental care provider for any reason? *Include visits to dental specialists, such as orthodontists.*

- ◯ Less than 12 months ago
- ◯ Between 1 and 5 years ago
- ◯ More than 5 years ago
- ◯ I have never visited a dentist or dental care provider
- ◯ Not sure

16. In the *last 12 months*, how many times did you visit a doctor's office, an urgent care or walk-in clinic, or other health care provider to get care for yourself? *Do not include hospital and emergency room visits or dental care. Please give your best guess.*

- ◯ 0 times
- ◯ 1 time
- ◯ 2 times
- ◯ 3 or 4 times
- ◯ 5 or more times

17. In the *last 12 months*, how many times did you go to an emergency room to get care for yourself? *Please give your best guess.*

- ◯ 0 times → **Go to Question 19**
- ◯ 1 time
- ◯ 2 times
- ◯ 3 or 4 times
- ◯ 5 or more times

18. Think about the *most recent time* you went to the emergency room in the last 12 months. What were the main reasons you went to the emergency room instead of somewhere else for health care at that time? Select *all* that apply.

	Yes	No
a. I needed emergency care	◯	◯
b. I didn't have health insurance	◯	◯
c. The doctors' office/clinic was closed	◯	◯
d. I couldn't get an appointment to see a regular doctor soon enough	◯	◯
e. I didn't have a personal doctor	◯	◯
f. I couldn't afford the copay to see a doctor	◯	◯
g. I needed a prescription drug	◯	◯
h. I didn't know where else to go	◯	◯
i. Some other reason. Please specify: _____	◯	◯

19. In the *last 12 months*, how many different times were you a patient in a hospital for at least one overnight? *Do not include hospital stays to deliver a baby.*

[ ] times

20. Overall, how would you rate the quality of the medical care you have received in the *last 12 months*?

◯ Excellent
◯ Very good
◯ Good
◯ Fair
◯ Poor

◯ I did not receive medical care in the last 12 months

21. How satisfied or dissatisfied are you with the following aspects of your current health care?

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
a. The range of health care services available	◯	◯	◯	◯
b. The choice of doctors and other providers	◯	◯	◯	◯

Your Health Care Costs

22. In the past 12 months, did you have problems paying any medical bills, including bills for doctors, dentists, hospitals, therapists, medical equipment, nursing home, or home care?

◯ Yes
◯ No

23. In the past 12 months, did you need any of the following at any time but not get it because of how much it cost? Select *all* that apply.

	Yes	No
a. Prescription drugs	◯	◯
b. Medical care	◯	◯
c. To see a general doctor	◯	◯
d. To see a specialist	◯	◯
e. To get medical tests, treatment, or follow-up care	◯	◯
f. Dental care	◯	◯
g. Mental health care or counseling	◯	◯
h. Eyeglasses or vision care	◯	◯

24. Do you *currently* owe money to a health care provider, credit card company, or anyone else for medical expenses?

◯ Yes
◯ No → **Go to Question 26**

25. About how much do you owe?

$ .00 amount owed

26. In the *last 12 months*, have you had to borrow money, skip paying other bills, or pay other bills late in order to pay health insurance bills?

◯ Yes
◯ No

27. In the *last 12 months*, has a doctor, clinic, or medical service refused to treat you because you owed money to them for past treatment?

◯ Yes
◯ No
◯ I don't know

Your Health

28. In general, would you say your health is:

◯ Excellent
◯ Very good
◯ Good
◯ Fair
◯ Poor

29. How has your health changed in the *last 12 months*?

◯ My health has gotten better
◯ My health is about the same
◯ My health has gotten worse

30. Have you ever been told by a doctor or other health care provider that you have any of the health conditions listed below? Select *all* that apply.

	Yes	No
a. Diabetes or sugar diabetes	◯	◯
b. Asthma	◯	◯
c. High blood pressure	◯	◯
d. Emphysema or chronic bronchitis (COPD)	◯	◯
e. Heart disease, angina, or heart attack	◯	◯
f. Congestive heart failure	◯	◯
g. Depression or anxiety	◯	◯
h. High cholesterol	◯	◯
i. Kidney problems, kidney disease, or dialysis	◯	◯
j. A stroke	◯	◯
k. Alcoholism or drug addition	◯	◯
l. Cancer, except for skin cancer	◯	◯

31. In the past 12 months, have you done any of the following things specifically for any of those health conditions you were told that you have? Select *all* that apply.

	Yes	No
a. I have been to a doctor or clinic	◯	◯
b. I have taken medication regularly	◯	◯
c. I have been to the hospital emergency room because of the condition(s)	◯	◯
d. I have been admitted to the hospital because of the condition(s)	◯	◯
e. I have not been treated for the condition(s)	◯	◯

32. Have you had your blood cholesterol checked?

◯ Yes, within the last 12 months
◯ Yes, but it's been more than 12 months
◯ Never

33. During the past 12 months, have you had either a flu shot or a flu vaccine that was sprayed in your nose?

◯ Yes
◯ No

34. Do you currently smoke cigarettes every day, some days, or not at all?

- ◯ Every day
- ◯ Some days
- ◯ Not at all → **Go to Question 36**

35. In the *last 12 months*, have you been advised by a doctor or health professional to quit smoking?

- ◯ Yes
- ◯ No
- ◯ I haven't seen a doctor in the last 12 months

36. Does a physical, mental, or emotional condition now limit your ability to work at a job?

- ◯ Yes
- ◯ No

37. Over the past two weeks, how often have you been bothered by having little interest or pleasure in doing things?

- ◯ Not at all
- ◯ A few times
- ◯ More than half the days
- ◯ Nearly every day
- ◯ Don't know

38. Over the past two weeks, how often have you been bothered by feeling down, depressed, or hopeless?

- ◯ Not at all
- ◯ A few times
- ◯ More than half the days
- ◯ Nearly every day
- ◯ Don't know

Your Health Care Coverage Experiences

39. Some people find health care coverage and insurance difficult to understand. For each of the words below, please indicate how confident you are that you understand what the word means.

	Very Confident	Somewhat Confident	Slightly Confident	Not At All Confident
a. Premiums	◯	◯	◯	◯
b. Deductibles	◯	◯	◯	◯
c. Copayments	◯	◯	◯	◯
d. Coinsurance	◯	◯	◯	◯

40. Were you enrolled in the BadgerCare program before April 2014?

◯ Yes
◯ No → **Go to Question 45**
◯ Don't know

41. In April 2014, the BadgerCare Plus program changed its program requirements, including how people can become eligible for the program, what services are covered, and what kinds of payments might be required to participate in the program.

To the best of your knowledge were you affected by any new program requirements?

◯ Yes
◯ No
◯ Don't know

42. Did you ever lose eligibility for BadgerCare Plus and were no longer enrolled because of changes made after April 2014?

◯ Yes → **Go to Question 45**
◯ No

43. Think about changes since April 2014 in the BadgerCare Plus program. Please indicate how each of the items below affected you.

	Increased	Decreased	No Change	Not Sure
a. Monthly premium/payments for health care coverage	◯	◯	◯	◯
b. Penalties for not paying a monthly premium	◯	◯	◯	◯
c. Copayments to visit a doctor or clinic	◯	◯	◯	◯
d. Mental health or substance abuse treatment benefits	◯	◯	◯	◯

44. Overall, how satisfied or dissatisfied are you with the changes that have taken place since April 2014? Select one answer only.

- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Somewhat dissatisfied
- ◯ Very dissatisfied

About You

45. Are you male or female?

- ◯ Male
- ◯ Female

46. What is your current age?

- ◯ Younger than age 19
- ◯ Age 19 to 25
- ◯ Age 26 to 34
- ◯ Age 35 to 44
- ◯ Age 45 to 64
- ◯ Age 65 or older

47. Are you currently employed or self-employed?

- ◯ Yes, employed by someone else
- ◯ Yes, self-employed
- ◯ Not currently employed
- ◯ Retired

48. About how many hours per week, on average, do you work at your current job(s)?

- ◯ I don’t currently work
- ◯ I work less than 20 hours per week
- ◯ I work 20 to 29 hours per week
- ◯ I work 30 or more hours per week

49. What was your household's gross income (before taxes and deductions are taken out) for 2015? Include any cash assistance or unemployment benefits you may have received, and include the income of all members of your household. Select *one* answer only. If you do not know, give your best guess.

- ◯ Less than $4,999
- ◯ $5,000 to $9,999
- ◯ $10,000 to $14,999
- ◯ $15,000 to $19,999
- ◯ $20,000 to $29,999
- ◯ $30,000 to $39,999
- ◯ $40,000 to $49,999
- ◯ $50,000 to $59,999
- ◯ $60,000 to $69,999
- ◯ $70,000 to $79,999
- ◯ $80,000 to $89,999
- ◯ $90,000 to $99,999
- ◯ $100,000 or more

50. Would you describe yourself as Spanish, Hispanic, or Latino?

- ◯ Yes
- ◯ No

51. How would you describe your race? Select *all* that apply.

- ☐ White
- ☐ Black or African-American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other, please specify: _____

52. What is the *highest* level of education you have completed? Select *one* answer only.

- ◯ Less than high school
- ◯ High school diploma or General Education Development (GED) certificate
- ◯ Vocational training or 2-year degree
- ◯ Some college but no degree
- ◯ A 4-year college degree or more

53. What is your current living arrangement? *Select all that apply.*

☐ I live alone
☐ I live with my partner or spouse
☐ I live with my parents
☐ I live with other relatives (including children)
☐ I live with friends or roommates
☐ Other, please specify: _____

54. How many family members, <u>including yourself</u>, counting adults and children, are living in your home? (*For example, if you live alone, you should write "1".*)

_____ family member(s) in my home

55. Of the family members living in your home, how many are under age 19?

_____ family member(s) in my home are under age 19

56. Do you have any children under age 19 who you financially support but that do not live in your home?

◯ Yes
◯ No

Thank you for your participation. When you have finished your survey, please place it in the included postage-paid envelope, and drop it in the mail.

SURVEY INSTRUMENT: RRP VERSION

University of Wisconsin
Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Current or Former
BadgerCare Plus Member Survey

Thank you for taking the time to answer the questions on the following pages. This survey is about your health care coverage through Wisconsin Medicaid or BadgerCare Plus. Your answers will help the Wisconsin Department of Health Services understand how changes to these programs affect your health and health care.

Taking part in this survey is voluntary. You can skip questions that you do not want to answer. If you choose not to take this survey, it will not affect any health care benefits you are getting right now or might get in the future. All information is private and confidential. You will not be individually identified with your responses.

For each question, please fill in the circle next to the answer you choose, or write your answer in the box provided. When you are finished, please place the completed survey into the postage-paid envelope provided, and put it in the mail.

If you have questions about the survey, you can contact one of the people listed below:

Bob Cradock at the University of Wisconsin Survey Center
608-265-9885
cradock@ssc.wisc.edu

Donna Friedsam at the UW Population Health Institute
608-263-4881
dafriedsam@wisc.edu

Thank you again for your help!

Your Health Care Coverage

1. In the past 12 months, how many months did you have some kind of health care coverage? Select *one* answer only.

- ○ No health care coverage during the last 12 months → **Go to Question 3**
- ○ 1 to 2 months of health care coverage
- ○ 3 to 5 months of health care coverage
- ○ 6 to 8 months of health care coverage
- ○ 9 to 11 months of health care coverage
- ○ Covered for all of the last 12 months

2. What type of health care coverage do you *currently* have? Select *all* that apply.

	Yes	No
a. Wisconsin Medicaid Program	○	○
b. BadgerCare Plus	○	○
c. Medicare	○	○
d. Employer or family member's employer	○	○
e. A private plan I pay for myself	○	○
f. A health plan from Healthcare.gov, the federal Affordable Care Act (ACA/Obamacare) Marketplace	○	○
g. Other coverage. Please specify: _____	○	○
h. None - no coverage/insurance	○	○

If you *currently* have coverage from Medicaid or BadgerCare Plus, please skip to Question 4.

3. For those who no longer have Medicaid/BadgerCare coverage: What are the reasons you no longer have that coverage? Select *all* that apply.

	Yes	No
a. I am not eligible anymore because I have access to other health care coverage.	○	○
b. I am not eligible anymore because my income has changed.	○	○
c. I am not eligible anymore for other reasons.	○	○
d. The premiums increased and so I dropped my Medicaid/BadgerCare Plus coverage.	○	○
e. I missed a premium payment, so the Medicaid/BadgerCare Plus program temporarily removed me from coverage.	○	○
f. Other reason. Please specify: _____	○	○

4. Some individuals in the BadgerCare Plus program who don't pay their monthly premiums are subject to a "restrictive re-enrollment period", meaning that the program does not allow them to re-enroll in the program for a certain number of months.

Have you been placed in a restrictive re-enrollment period at any point in the last 12 months?

- ○ Yes, I am in a restrictive re-enrollment period right now and plan to re-enroll in Medicaid/BadgerCare Plus when I am able
- ○ Yes, previously, but I re-enrolled in Medicaid/BadgerCare Plus and am not in a restrictive reenrollment period right now
- ○ I stopped paying my premiums because I no longer want Medicaid/BadgerCare Plus coverage → **Go to Question 7**
- ○ No, I have not been in a restrictive re-enrollment period → **Go to Question 7**
- ○ Don't know → **Go to Question 7**

5. During the period of time you could not be enrolled because of Restrictive Reenrollment, which of the following statements applied to your health care needs? Select *all* that apply.

	Yes	No
a. I did not need any health care	○	○
b. I needed health care, but I decided to delay until I had health care coverage again	○	○
c. I received health care in the hospital emergency room	○	○
d. I received health care at a community health center or clinic	○	○
e. I received health care from a private doctor or clinic	○	○
f. I received health care where I usually do when I have health care coverage	○	○

6. How did you pay for the health care you got during the period of time you could not be enrolled in BadgerCare Plus? Select *all* that apply.

	Yes	No
a. I, or a friend or family member, paid directly (out-of-pocket)	○	○
b. I was able to get free/charity care	○	○
c. I used a different health insurance plan	○	○
d. I still owe money/have debt for those bills	○	○

Your Health Care

7. Is there a place you *usually* go to get health care? Select *one* answer only.

- ◯ Yes
- ◯ No → **Go to Question 9**

8. Where do you usually go to get health care? Select *one* answer only.

- ◯ A private doctor's office or clinic
- ◯ A public health clinic, community health center, or tribal clinic
- ◯ A walk-in clinic in a store, such as Walmart or a pharmacy
- ◯ A hospital-based clinic
- ◯ A hospital emergency room
- ◯ An urgent care clinic
- ◯ Some other place. Please specify: _____
- ◯ I don't have a usual place
- ◯ I don't know

9. Do you have at least one person you think of as your personal doctor or health care provider? Select *one* answer only.

- ◯ Yes, more than one person
- ◯ Yes, only one person
- ◯ No, no one
- ◯ I don't know

10. If you needed health care in the past 12 months, did you get all the care you needed?

- ◯ Yes → **Go to Question 12**
- ◯ No
- ◯ I did not need care in the last 12 months → **Go to Question 12**

11. Think about the *most recent time* you went *without* needed health care in the last 12 months. What were the main reasons you went without care at that time? Select *all* that apply.

	Yes	No
a. It cost too much	◯	◯
b. I didn't have health care coverage	◯	◯
c. The doctor wouldn't take my insurance	◯	◯
d. I owed money to the doctor	◯	◯
e. I couldn't get an appointment quickly enough	◯	◯
f. The office wasn't open when I could get there	◯	◯
g. I didn't have a doctor	◯	◯
h. Other reason. Please specify:	◯	◯

12. Was there a time in the *last 12 months* when you needed *prescription medication*?

- ◯ Yes
- ◯ No → **Go to Question 15**

13. If you needed prescription medications in the past 12 months, did you get all the medications you needed? Select *one* answer only.

- ◯ Yes → **Go to Question 15**
- ◯ No
- ◯ I did not need medications in the last 12 months → **Go to Question 15**

14. Think about the *most recent time* you went *without* prescription medications that you needed in the last 12 months. What were the main reasons you went without prescription medications at that time? Select *all* that apply.

	Yes	No
a. They cost too much	◯	◯
b. I didn't have health care coverage	◯	◯
c. I didn't have a doctor	◯	◯
d. I couldn't get a prescription	◯	◯
e. I couldn't get to the pharmacy	◯	◯
f. Some other reason. Please specify:	◯	◯

15. How long has it been since you last visited a dentist or a dental care provider for any reason? *Include visits to dental specialists, such as orthodontists.*

- ◯ Less than 12 months ago
- ◯ Between 1 and 5 years ago
- ◯ More than 5 years ago
- ◯ I have never visited a dentist or dental care provider
- ◯ Not sure

16. In the *last 12 months*, how many times did you visit a doctor's office, an urgent care or walk-in clinic, or other health care provider to get care for yourself? *Do not include hospital and emergency room visits or dental care. Please give your best guess.*

- ◯ 0 times
- ◯ 1 time
- ◯ 2 times
- ◯ 3 or 4 times
- ◯ 5 or more times

17. In the *last 12 months*, how many times did you go to an emergency room to get care for yourself? *Please give your best guess.*

- ◯ 0 times → **Go to Question 19**
- ◯ 1 time
- ◯ 2 times
- ◯ 3 or 4 times
- ◯ 5 or more times

18. Think about the *most recent time* you went to the emergency room in the last 12 months. What were the main reasons you went to the emergency room instead of somewhere else for health care at that time? Select *all* that apply.

	Yes	No
a. I needed emergency care	◯	◯
b. I didn't have health insurance	◯	◯
c. The doctors' office/clinic was closed	◯	◯
d. I couldn't get an appointment to see a regular doctor soon enough	◯	◯
e. I didn't have a personal doctor	◯	◯
f. I couldn't afford the copay to see a doctor	◯	◯
g. I needed a prescription drug	◯	◯
h. I didn't know where else to go	◯	◯
i. Some other reason. Please specify: _____	◯	◯

19. In the *last 12 months*, how many different times were you a patient in a hospital for at least one overnight? *Do not include hospital stays to deliver a baby.*

[ ] times

20. Overall, how would you rate the quality of the medical care you have received in the *last 12 months*?

◯ Excellent
◯ Very good
◯ Good
◯ Fair
◯ Poor

◯ I did not receive medical care in the last 12 months

21. How satisfied or dissatisfied are you with the following aspects of your current health care?

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
a. The range of health care services available	◯	◯	◯	◯
b. The choice of doctors and other providers	◯	◯	◯	◯

Your Health Care Costs

22. In the past 12 months, did you have problems paying any medical bills, including bills for doctors, dentists, hospitals, therapists, medical equipment, nursing home, or home care?

◯ Yes
◯ No

23. In the past 12 months, did you need any of the following at any time but not get it because of how much it cost? Select *all* that apply.

	Yes	No
a. Prescription drugs	◯	◯
b. Medical care	◯	◯
c. To see a general doctor	◯	◯
d. To see a specialist	◯	◯
e. To get medical tests, treatment, or follow-up care	◯	◯
f. Dental care	◯	◯
g. Mental health care or counseling	◯	◯
h. Eyeglasses or vision care	◯	◯

24. Do you *currently* owe money to a health care provider, credit card company, or anyone else for medical expenses?

◯ Yes
◯ No → **Go to Question 26**

25. About how much do you owe?

$ .00 amount owed

26. In the *last 12 months*, have you had to borrow money, skip paying other bills, or pay other bills late in order to pay health insurance bills?

◯ Yes
◯ No

27. In the *last 12 months*, has a doctor, clinic, or medical service refused to treat you because you owed money to them for past treatment?

◯ Yes
◯ No
◯ I don't know

Your Health

28. In general, would you say your health is:

◯ Excellent
◯ Very good
◯ Good
◯ Fair
◯ Poor

29. How has your health changed in the *last 12 months*?

◯ My health has gotten better
◯ My health is about the same
◯ My health has gotten worse

30. Have you ever been told by a doctor or other health care provider that you have any of the health conditions listed below? Select *all* that apply.

	Yes	No
a. Diabetes or sugar diabetes	◯	◯
b. Asthma	◯	◯
c. High blood pressure	◯	◯
d. Emphysema or chronic bronchitis (COPD)	◯	◯
e. Heart disease, angina, or heart attack	◯	◯
f. Congestive heart failure	◯	◯
g. Depression or anxiety	◯	◯
h. High cholesterol	◯	◯
i. Kidney problems, kidney disease, or dialysis	◯	◯
j. A stroke	◯	◯
k. Alcoholism or drug addition	◯	◯
l. Cancer, except for skin cancer	◯	◯

31. In the past 12 months, have you done any of the following things specifically for any of those health conditions you were told that you have? Select *all* that apply.

	Yes	No
a. I have been to a doctor or clinic	◯	◯
b. I have taken medication regularly	◯	◯
c. I have been to the hospital emergency room because of the condition(s)	◯	◯
d. I have been admitted to the hospital because of the condition(s)	◯	◯
e. I have not been treated for the condition(s)	◯	◯

32. Have you had your blood cholesterol checked?

◯ Yes, within the last 12 months
◯ Yes, but it's been more than 12 months
◯ Never

33. During the past 12 months, have you had either a flu shot or a flu vaccine that was sprayed in your nose?

◯ Yes
◯ No

34. Do you currently smoke cigarettes every day, some days, or not at all?

- ◯ Every day
- ◯ Some days
- ◯ Not at all → **Go to Question 36**

35. In the *last 12 months*, have you been advised by a doctor or health professional to quit smoking?

- ◯ Yes
- ◯ No
- ◯ I haven't seen a doctor in the last 12 months

36. Does a physical, mental, or emotional condition now limit your ability to work at a job?

- ◯ Yes
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37. Over the past two weeks, how often have you been bothered by having little interest or pleasure in doing things?

- ◯ Not at all
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Your Health Care Coverage Experiences

39. Some people find health care coverage and insurance difficult to understand. For each of the words below, please indicate how confident you are that you understand what the word means.

	Very Confident	Somewhat Confident	Slightly Confident	Not At All Confident
a. Premiums	◯	◯	◯	◯
b. Deductibles	◯	◯	◯	◯
c. Copayments	◯	◯	◯	◯
d. Coinsurance	◯	◯	◯	◯

40. Were you enrolled in the BadgerCare program before April 2014?

◯ Yes
◯ No → **Go to Question 45**
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41. In April 2014, the BadgerCare Plus program changed its program requirements, including how people can become eligible for the program, what services are covered, and what kinds of payments might be required to participate in the program.

To the best of your knowledge were you affected by any new program requirements?

◯ Yes
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42. Did you ever lose eligibility for BadgerCare Plus and were no longer enrolled because of changes made after April 2014?

◯ Yes → **Go to Question 45**
◯ No

43. Think about changes since April 2014 in the BadgerCare Plus program. Please indicate how each of the items below affected you.

	Increased	Decreased	No Change	Not Sure
a. Monthly premium/payments for health care coverage	◯	◯	◯	◯
b. Penalties for not paying a monthly premium	◯	◯	◯	◯
c. Copayments to visit a doctor or clinic	◯	◯	◯	◯
d. Mental health or substance abuse treatment benefits	◯	◯	◯	◯

44. Overall, how satisfied or dissatisfied are you with the changes that have taken place since April 2014? Select one answer only.

- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Somewhat dissatisfied
- ◯ Very dissatisfied

About You

45. Are you male or female?

- ◯ Male
- ◯ Female

46. What is your current age?

- ◯ Younger than age 19
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- ◯ Not currently employed
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48. About how many hours per week, on average, do you work at your current job(s)?

- ◯ I don’t currently work
- ◯ I work less than 20 hours per week
- ◯ I work 20 to 29 hours per week
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49. What was your household's gross income (before taxes and deductions are taken out) for 2015? Include any cash assistance or unemployment benefits you may have received, and include the income of all members of your household. Select *one* answer only. If you do not know, give your best guess.

- ◯ Less than $4,999
- ◯ $5,000 to $9,999
- ◯ $10,000 to $14,999
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- ◯ $40,000 to $49,999
- ◯ $50,000 to $59,999
- ◯ $60,000 to $69,999
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- ◯ $80,000 to $89,999
- ◯ $90,000 to $99,999
- ◯ $100,000 or more

50. Would you describe yourself as Spanish, Hispanic, or Latino?

- ◯ Yes
- ◯ No

51. How would you describe your race? Select *all* that apply.

- ☐ White
- ☐ Black or African-American
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- ◯ Less than high school
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- ◯ Some college but no degree
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53. What is your current living arrangement? *Select all that apply.*

☐ I live alone
☐ I live with my partner or spouse
☐ I live with my parents
☐ I live with other relatives (including children)
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54. How many family members, <u>including yourself</u>, counting adults and children, are living in your home? (*For example, if you live alone, you should write "1".*)

_____ family member(s) in my home

55. Of the family members living in your home, how many are under age 19?

_____ family member(s) in my home are under age 19

56. Do you have any children under age 19 who you financially support but that do not live in your home?

◯ Yes
◯ No

Thank you for your participation. When you have finished your survey, please place it in the included postage-paid envelope, and drop it in the mail.

Wisconsin BadgerCare Reform 1115 Waiver Demonstration
Section 1115 Quarterly Report

Section 1115 Quarterly/Annual Report Summary

Demonstration Year:
1 (4/1/2014 – 12/31/2014)
Federal Fiscal Quarter:
3 (7/1/2014 – 9/30/2014)

Table of Contents

Introduction

The Wisconsin BadgerCare Reform demonstration provides state plan benefits to childless adults who have family incomes up to 95 percent of the Federal Poverty Level (FPL) (effectively 100 percent of the FPL considering a disregard of 5 percent of income), and permits the state to charge premiums to adults who are only eligible for Medicaid through the Transitional Medical Assistance eligibility group (hereinafter referred to as "TMA Adults") with incomes above 133 percent of the FPL starting from the first day of enrollment and to TMA Adults from 100-133 percent of the FPL after the first 6 calendar months of TMA coverage.

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

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

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

Due to the state's 3-month delay in implementing related BadgerCare Plus Program and Affordable Care Act (ACA) Changes, the provisions of the BadgerCare Reform Waiver did not take effect until April 1, 2014.

On July 10, 2014, the DHS held the initial post award public forum in Milwaukee, WI. Details on the post award public forum are found in the Outreach Activities section of this report.

Starting in July 2014 the DHS began enrolling childless adults into managed care. More information regarding the progress of this enrollment are included in this quarter's report.

On November 12, 2014, the Centers for Medicare and Medicaid Services (CMS) approved the Department of Health Services (DHS) evaluation plan. The DHS has incorporated the approved evaluation plan as Attachment C.

DHS is currently drafting the interagency agreement (including scope of work, workplan, and budget) with the UW Population Health Institute for the demonstration evaluation and is targeting September 1, 2015 to begin work.

Enrollment and Benefits Information

Since April 1, 2014 and for the for the first year of the demonstration enrollment for childless adults (population group 2) has been steadily increasing, while enrollment for TMA adults (population group 1) has been also seen modest increases – specifically in the 133% FPL and over population as compared to enrollment prior to the beginning to the current demonstration. Enrollment for childless adults for the fourth quarter and end of the first demonstration year was 157,399, while enrollment for TMA adults for the same period was 20,157.

In the first quarter of the second demonstration year the rate of disenrollment for the TMA Adult population 100% to 133% FPL was 3%, compared to 19% for the TMA Adult population over 133% FPL. This represents a slight increase of 1% and decrease of 2% respectively from the prior quarter.

During the final quarter and end of the first demonstration year the DHS has not identified any issues related to enrollment, access to care, or delivery of benefits.

Enrollment Counts for Quarter and Year to Date

Demonstration Populations	Total Number of Demonstration Participants Quarter Ending – 12/31/2014*	Current Enrollees (year to date)**	Disenrolled in Current Quarter	TMA Adults Disenrolled Due to Non-Payment of Premiums (current quarter)***
BC Reform Adults	160,095	185,414	13,744	N/A
TMA Adults – 100% to 133% FPL	13,508	27,374	2,475	309
TMA Adults – Over 133% FPL	6,778	13,540	2,560	1,414

*Reflects total unduplicated count of members enrolled during the demonstration quarter

** Reflects total unduplicated count of members enrolled during the demonstration year. Please note that for 2014 the demonstration year is April 1, 2014 to December 31, 2014.

***Disenrollment does not reflect those who maintained eligibility after the closure month for any benefit plan

Outreach/Innovative Activities to Assure Access

On July 10, 2014, the DHS held a post award public forum in accordance with 42 CFR § 431.420. The DHS held the post award public forum in Milwaukee at a location close to public transportation.

The DHS promoted the post award public forum as follows:

- On June 10, 2014, the DHS posted official notice of the post award public forum prominently on their website at www.dhs.wisconsin.gov and www.dhs.wisconsin.gov/badgercareplus/waivers.htm ;
- On June 26, 2014, the DHS created a promotional flyer detailing the post award public forum. The flyer was placed on the DHS website at www.dhs.wisconsin.gov/badgercareplus/waivers.htm;
- On June 27, 2014, the DHS sent email notification to partner and advocate organizations in the Milwaukee area informing them of the post award public forum and attached a copy of the flyer noted above;
- Beginning on June 27, 2014, the DHS printed 1,100 copies of the flyer noted above and hand distributed them to Milwaukee area partners, advocacy organizations and businesses; and

- On June 30, 2014, the public notice was published in the Wisconsin Administrative Register, Volume 702b (http://docs.legis.wisconsin.gov/code/register/2014/702b/register.pdf).

The post award public forum, held at the Greater Philadelphia Church of God in Christ, 2947 N. Dr. Martin Luther King Drive, Milwaukee, WI 53212 was attended by approximately 50 attendees. Marlia Mattke, Deputy Medicaid Director, Vanessa Robinson, Chief Operations Officer/Deputy Director, Milwaukee Enrollment Services, and Craig Steele, Project Manager answered questions and received testimony. The audio at the post award public forum was recorded and posted to the DHS website https://dhsmedia.wi.gov/main/Play/1638b5a2faea4ec1aa93d64fcc94157d1d.

Comments were collected through August 10, 2014. The DHS will provide additional information related to the post award public comments received in the next quarterly progress report.

All HMOs serving BadgerCare Plus members, which includes members of this demonstration waiver population, but are not limited to the demonstration population, are required to submit their member communication and outreach plans to the DHS for review. All materials are reviewed and approved by the DHS prior to distribution to members. Such materials include HMO-developed member handbooks, HMO-developed new member enrollment materials, and HMO-developed brochures.

The DHS currently contracts with the City of Milwaukee Health Department to focus on outreach to current and prospective BadgerCare Plus members in Milwaukee County. As part of this agreement, staff is available at multiple locations throughout the county, including Milwaukee Health Department sites, in order to provide assistance with ACCESS applications and renewals, as well as with other enrollment and eligibility troubleshooting.

Collection and Verification of Encounter Data and Enrollment Data

Starting April 1, 2014 childless adults were enrolled in BadgerCare Plus fee-for-service benefits. Beginning July 2014 the state began enrolling childless adults into managed care with an average of 20,000 new managed care enrollments monthly until full managed care enrollment is achieved. Following is a summary of the managed care enrollments through the end of the first demonstration year. The DHS remains on target to enroll the remaining childless adults into managed care by the end of the first quarter of the second demonstration year.

HMO	Jul-14	Aug-14	14-Sep	Oct-14	Nov-14	Dec-14
Anthum Blue Cross Blue Shield	1488	3255	4884	7508	9896	11591
Childrens Community Health Plan	2078	3682	5234	7062	8388	9633
Compcare	721	1138	1577	2149	2560	2832
Dean Health Plan	1304	2450	3562	4681	5078	5066
Group Health Eau Claire	1107	1856	2349	3078	3655	3980
Group Health South Central	266	509	748	1439	1740	2103
Gundersen	557	927	1147	1275	1399	1509
Health Tradition	362	649	767	791	849	875
iCare	1207	2147	3611	5206	5966	6901
Managed Health Services	1737	3323	4810	6483	7644	8845
Mercy	387	661	906	1247	1500	1725
Molina	1759	3233	4618	6392	7871	8651
Network	1698	3197	4570	6465	7623	8745
Physicians Plus	303	592	872	925	1381	1825
Security	949	3109	3646	4438	5044	5368
Trilogy	345	874	902	1456	2186	3065
UnitedHealthcare	6178	10,712	14,297	18,444	21,706	23,736
Unity	696	1299	1204	1841	1954	1847
Total	**23142**	**43613**	**59704**	**80880**	**96440**	**108297**

Operational/Policy/Systems/Fiscal Developments/Issues

The state has not identified any significant program developments/issues/problems that have occurred in the current quarter or through the end of the first demonstration year are anticipated to occur in the near future that affect health care delivery, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

Financial/Budget Neutrality Development/Issues

The state has not identified any significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter and initial demonstration year.

Please see Attachment A for a copy of the budget neutrality workbook.

The chart provides monthly and quarterly enrollment and expenditure data for the BadgerCare Plus Reform Adult Waiver since its inception in April 2014 through December 2014. This data is compared to the childless adult CORE baseline from April 2013 through December 2014 for budget neutrality purposes.

The data shows waiver enrollment increasing each month, with fee-for-service members peaking in July 2014 and steadily declining each subsequent month. Managed care enrollment shows steady growth of around 20,000 members each month since July 2014. This enrollment trend is in line with state expectations, as the state initially enrolled 10,000 members into managed care in July 2014 and enrolled (on average) 20,000 members each subsequent month.

Since the waiver's April 2014 inception, per-member-per-month cost has increased with overall enrollment. This was expected since claims expenditures are based on date of payment and the timing

of claims lag, therefore, under represents claims experience in the early months. Despite this upward trend, the December 2014 per-member-per-month cost ($387.08) remains lower than the childless adult CORE baseline per-member-per-month year-over-year for the duration of the reporting period. Given the current PMPM rates, no specific concerns exist related to budget neutrality.

Consumer Issues

BadgerCare enrollees who are enrolled in an HMO have three levels of appeal available to them. Members may initiate an appeal at any level.

1. Appeal to their HMO;
2. Appeal to the Wisconsin Department of Health Services (DHS); or
3. Appeal to the State Division of Hearings and Appeals (DHA).

HMO level grievances: HMOs are required to submit quarterly complaint and grievance reports to the DHS. The types of complaints monitored include: access problems, billing issues, quality of care, and benefit denials. Benefit denials and quality of service account for the highest number of member complaints. Follow-up is conducted with individual HMOs if an unusual increase in appeals occurs.

DHS level grievances: Quarterly trends for several types of grievance denials (e.g., bariatric surgeries, etc.) are tracked for each quarter. Grievances are closely monitored for the number of upheld, overturned, and HMO resolved decisions. HMOs are individually informed of an increase and/or a high number for their DHS overturned grievances.

The Division of Hearings and Appeals and BadgerCare Plus HMOs continue to report a very low number of member issues related to enrollment and access.

Quality Assurance/Monitoring Activity

The DHS consistently monitors activities using a systematic approach that ensures services for all BadgerCare Plus populations are reviewed for quality assurance. Following are the current activities for the fourth quarter of the demonstration completed by the External Quality Review Organization (EQRO) – MetaStar for the HMOs operating the BadgerCare+ program.

- Conducted one Information Systems Capabilities Assessment.
- Reviewed 2015 Performance Improvement Project (PIPs) proposals; Delivered aggregate report from validation of 2012 PIPs.
- Delivered results from validation of 2013 performance measures and 2015 baseline measures.
- Continued Healthy Birth Outcome reviews for OB Medical Home enrollees and delivered the report for deliveries occurring in first quarter of 2014.

- Deployed the OB Medical Home registry for HMOs, clinics, and DHS.

Managed Care Reporting Requirements

Starting April 1, 2014 childless adults were enrolled in BadgerCare Plus fee-for-service benefits. Starting in July 2014 the state began enrolling childless adults into managed care with an average of 20,000 members in each month until all new members have been enrolled in managed care as applicable.

Following are the fourth quarter health needs assessment (HNA) results reported by the BadgerCare Plus managed care organizations:

- Number of new childless adults members enrolled in HMOs in Q4-2014: 56,672
- Number of screenings of childless adults completed in Q4-2014: 11,552
- Screening Rate: 20.38%
- Number of new childless adults members screened within two months of HMO enrollment in Q4-2014: 9,264
- Timely Screening Rate: 16.35%

Demonstration Evaluation

On November 12, 2014, the Centers for Medicare and Medicaid Services (CMS) approved the Department of Health Services (DHS) evaluation plan. The DHS has incorporated the approved evaluation plan as Attachment C.

The DHS is in the process of executing an interagency agreement with the UW Population Health Institute to conduct the evaluation. The target date for the UW to begin work on the evaluation is September 1, 2015.

State Contact(s)

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Attachment A – Budget Neutrality Monitoring Workbook

Preliminary Childless Adults Draft Financial Statistics - Waiver Reporting for Quarter Ending Dec. 2014

Childess Adult Quarterly Comparison	Claim Expenditures ($ in AF)	Prior Year QE Expenditures ($ in AF)	Ave Monthly Enrollment	Prior Year QE Ave Monthly Enrollment	Ave Monthly PMPM	Prior Year QE Ave Monthly PMPM
QE June 2014	100,336,496	22,166,544	111,184	18,660	300.14	395.96
QE Sept. 2014	135,633,411	21,253,102	130,028	17,487	347.33	405.09
QE Dec. 2014	163,336,911	20,300,350	143,097	16,288	380.41	415.51

CORE Baseline (Childless Adults)	Claim Expenditures ($ in AF)	Fee for Service Enrollees	CAP Expenditures	CAP Members	Total Expenditures	Total Enrollees	Overall PMPM
Apr-13	2,626,255	2,383	4,956,173	16,741	7,582,428	19,124	396.49
May-13	2,586,618	2,333	4,832,357	16,330	7,418,975	18,663	397.52
Jun-13	2,411,712	2,203	4,753,429	15,989	7,165,141	18,192	393.86
Jul-13	2,554,748	1,926	4,721,124	15,922	7,275,872	17,848	407.66
Aug-13	2,398,350	2,233	4,671,819	15,272	7,070,169	17,505	403.89
Sep-13	2,361,651	1,836	4,545,410	15,272	6,907,061	17,108	403.73
Oct-13	2,569,854	1,898	4,411,923	14,809	6,981,777	16,707	417.90
Nov-13	2,223,489	1,657	4,372,572	14,633	6,596,061	16,290	404.91
Dec-13	2,445,227	1,638	4,277,285	14,228	6,722,512	15,866	423.71

BC Reform Adult Waiver (Childless Adults)	Claim Expenditures ($ in AF)	Fee for Service Enrollees	CAP Expenditures	CAP Members	Total Expenditures	Total Enrollees	Overall PMPM
Apr-14	26,018,586	96,175	3,145,984	9,536	29,164,570	105,711	275.89
May-14	30,986,116	100,961	2,953,745	8,883	33,939,861	109,844	308.98
Jun-14	33,409,007	105,843	3,823,058	12,153	37,232,065	117,996	315.54
Jul-14	34,394,772	100,939	7,548,859	23,921	41,943,631	124,860	335.93
Aug-14	30,769,376	85,978	13,653,209	44,292	44,422,585	130,270	341.00
Sep-14	31,003,648	73,253	18,263,547	61,702	49,267,195	134,955	365.06
Oct-14	29,157,797	56,743	24,010,130	82,583	53,167,927	139,326	381.61
Nov-14	24,469,552	43,300	28,619,262	99,201	53,088,814	142,501	372.55
Dec-14	24,698,943	34,265	32,381,227	113,200	57,080,170	147,465	387.08

*MC Enrollees have some of their expenditures in FFS Claims as well: Wrap around, Pharmacy, etc.
**PMPM comparisons may be skewed due to claims lag for months of April 2014 through December 2014
*** Expenditures and enrollment may not tie to future quarterly reports as numbers will be adjusted to account for claims lag
**** All preliminary data pulled February 2015 from DSS, not from MBES quarterly report

Attachment B – Summary of Cost-Sharing for TMA Adults Only

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

TMA Adults (Demonstration Population 1)

Monthly Premium Amount Based on FPL Percentage	Monthly Premium Amount as 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 – 339.99%	7.4%
240 – 249.99%	7.7%
250 – 259.99%	8.05%
260 – 269.99%	8.3%
270 – 279.99%	8.6%
280 – 289.99%	8.9%
290 – 299.99%	9.2%
300% and above	9.5%

Attachment C – Demonstration Evaluation Plan


WI BadgerCare Reform Final Approve


BadgerCare Reform Demonstration Evalua

Attachment D – BadgerCare Plus Reform Waiver Project Work Plan

BadgerCare Plus
Reform Waiver Projec

Wisconsin BadgerCare Reform 1115 Waiver Demonstration
Section 1115 Quarterly Report

Section 1115 Annual Report Summary

Demonstration Year:
2 (1/1/2015 – 12/31/2015)

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Introduction

The Wisconsin BadgerCare Reform demonstration provides state plan benefits to childless adults who have family incomes up to 95 percent of the Federal Poverty Level (FPL) (effectively 100 percent of the FPL considering a disregard of 5 percent of income), and permits the state to charge premiums to adults who are only eligible for Medicaid through the Transitional Medical Assistance eligibility group (hereinafter referred to as "TMA Adults") with incomes above 133 percent of the FPL starting from the first day of enrollment and to TMA Adults from 100-133 percent of the FPL after the first 6 calendar months of TMA coverage.

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

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

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

Enrollment and Benefits Information

Childless Adults (Population Group 2) - In demonstration year 2 the number of unique program participants decreased as did the total number of childless adults enrolled in the program for the year. From the beginning to the end of demonstration year 2 the total number of unique program participants decreased from 174,320to 168,756, a total decrease of 5,564. Total monthly enrollment also decreased from the start to the end of the demonstration year with 155,330 childless adults in January 2015 and 151,417 childless adults in December 2015, for a total drop of 5,357.

Transitional Medical Assistance (TMA) Adults - In demonstration year 2 the number of unique program participants increased significantly while the total number of TMA adults enrolled in the program also increased. From the beginning to the end of the demonstration year the total number of unique program participants increased from 19,218 to 55,973, for a total increase of 36,755 unique program participants. Total monthly enrollment also increased from during the demonstration year with 14,059 TMA adults in January 2015 and 20,459 TMA adults in December 2015.

For demonstration year 2 the rate of disenrollment for non-payment of premiums for the TMA Adult population 100% to 133% FPL was 5%, compared to 21% for the TMA Adult population over 133% FPL.

We will attempt to learn more about the reasons behind the variances between the two populations through the formal evaluation that will be conducted during demonstration year 3.

The DHS has not identified any issues related to access to care or delivery of benefits given the current enrollment trends and will continue to monitor.

Enrollment Counts for Demonstration Year 2

Demonstration Populations	Total Number of Demonstration Participants Quarter Ending – 03/31/2015*	Current Enrollees (year to date)**	Disenrolled in Current Quarter	TMA Adults Disenrolled Due to Non-Payment of Premiums (current quarter)***
BC Reform Adults	174,320	174,320	17,565	N/A
TMA Adults – 100% to 133% FPL	12,741	12,741	1,724	436
TMA Adults – Over 133% FPL	6,477	6,477	1,954	1,216

Demonstration Populations	Total Number of Demonstration Participants Quarter Ending – 06/30/2015*	Current Enrollees (year to date)**	Disenrolled in Current Quarter	TMA Adults Disenrolled Due to Non-Payment of Premiums (current quarter)***
BC Reform Adults	176,378	194,217	33,147	N/A
TMA Adults – 100% to 133% FPL	15,214	20,091	2,473	791
TMA Adults – Over 133% FPL	7,778	11,030	2,641	1,623

Demonstration Populations	Total Number of Demonstration Participants Quarter Ending – 09/30/2015*	Current Enrollees (year to date)**	Disenrolled in Current Quarter	TMA Adults Disenrolled Due to Non-Payment of Premiums (current quarter)***
BC Reform Adults	166,401	213,664	23,109	N/A
TMA Adults – 100% to 133% FPL	17,173	27,410	2,713	833
TMA Adults – Over 133% FPL	9,118	15,975	3,286	1,938

Demonstration Populations	Total Number of Demonstration Participants Quarter Ending – 12/31/2015*	Current Enrollees (year to date)**	Disenrolled in Current Quarter	TMA Adults Disenrolled Due to Non-Payment of Premiums (current quarter)***
BC Reform Adults	168,756	234,578	24,579	N/A
TMA Adults – 100% to 133% FPL	19,082	34,910	2,955	1,071
TMA Adults – Over 133% FPL	9,998	21,063	3,546	2,158

*Reflects total unduplicated count of members enrolled during the demonstration year
** Reflects total unduplicated count of members enrolled during the demonstration year.
***Disenrollment does not reflect those who maintained eligibility after the closure month for any benefit plan

Member Month Reporting

Eligibility Group	Month 1 (January 2015)	Month 2 (February 2015)	Month 3 (March 2015)	Total for Quarter Ending 03/2015
BC Reform Adults	155,330	161,907	163,781	481,018
TMA Adults – 100% to 133% FPL	8,791	8,764	9,020	24,575
TMA Adults – Over 133% FPL	5,268	4,011	4,046	13,325

Eligibility Group	Month 4 (April 2015)	Month 5 (May 2015)	Month 6 (June 2015)	Total for Quarter Ending 06/2015
BC Reform Adults	161,681	154,786	148,945	465,412
TMA Adults – 100% to 133% FPL	9,879	10,435	11,072	31,386
TMA Adults – Over 133% FPL	5,927	4,698	5,311	15,936

Eligibility Group	Month 7 (July 2015)	Month 28(August 2015)	Month 9 (September 2015)	Total for Quarter Ending 09/2015
BC Reform Adults	150,727	150,244	149,291	450,262
TMA Adults – 100% to 133% FPL	11,504	11,947	12,447	35,898
TMA Adults – Over 133% FPL	7,363	5,707	5,908	18,978

Eligibility Group	Month 10 (October 2015)	Month 11 (November 2015)	Month 12 (December 2015)	Total for Quarter Ending 12/2015
BC Reform Adults	149,973	150,612	151,417	452,002
TMA Adults – 100% to 133% FPL	13,206	13,515	14,028	40,749
TMA Adults – Over 133% FPL	8,188	6,330	6,431	20,949

Childless Adult and TMA Re-Enrollment Statistics

In September 2015 CMS requested that Wisconsin analyze the demonstration groups to identify how many members had been disenrolled and subsequently regained program eligibility.

In providing these statistics we included those members that regained full-benefit eligibility within 12 months of the current reporting quarter. The initial statistics provided below include those childless adult and TMA members who were disenrolled since April 2014 (the start of the demonstration) and were enrolled in the final quarter of demonstration year 2.

The table below shows that the percentage of childless adults who were disenrolled in demonstration year 1 and (population group 2) regained eligibility in demonstration year 2 rose to 45%, and for TMA adults (population group 1) nearly 62% had regained eligibility by the end of demonstration year 2.

		Number re-enrolled within one year by benefit plan										
Quarter of Disenrollment	Waiver Group	BCSP	FSTMA	MAP	MAPW	MCD	MCDW	SSIMA	WWMA	All Benefit Plans	Total Disenrolled	% Re-enrolled within one year
04/14 - 06/14	CLA (Group 2)	4,962	1	260	16	399	97	155	8	5,898	16,291	36.20%
04/14 - 06/14	TMA (Group 1)	6,289	0	7	1	25	4	15	2	6,343	10,551	60.12%
07/14 - 09/14	CLA (Group 2)	5,686	1	229	14	386	95	142	3	6,556	14,478	45.28%
07/14 - 09/14	TMA (Group 1)	5,691	0	6	0	15	4	13	3	5,732	9,531	60.14%
10/14 - 12/14	CLA (Group 2)	6,890	1	277	13	412	101	121	2	7,817	17,310	45.16%
10/14 - 12/14	TMA (Group 1)	5,733	0	3	0	14	3	9	1	5,763	9,334	61.74%

CLA = Childless Adults
TMA = Transitional Medical Assistance

Outreach/Innovative Activities to Assure Access

All HMOs serving BadgerCare Plus members, which includes members of this demonstration waiver population, but are not limited to the demonstration population, are required to submit their member communication and outreach plans to the DHS for review. All materials are reviewed and approved by the DHS prior to distribution to members. Such materials include HMO-developed member handbooks, HMO-developed new member enrollment materials, and HMO-developed brochures.

The DHS also contracts with the City of Milwaukee Health Department to focus on outreach to current and prospective BadgerCare Plus members in Milwaukee County. As part of this agreement, staff is available at multiple locations throughout the county, including Milwaukee Health Department sites, in order to provide assistance with ACCESS applications and renewals, as well as with other enrollment and eligibility troubleshooting.

The seven county public health departments are:

- Dunn County Health Department
- Chippewa County Public Health
- Juneau County Health Department
- La Crosse County Health Department
- Polk County Health Department
- Sauk County Health Department
- Washburn County Health Department

Collection and Verification of Encounter Data and Enrollment Data

Following is a summary of the annual managed care enrollment. Managed care enrollment for demonstration year 2 shows X with approximately 85% of all childless adults enrolled in managed care which is comparable with managed care enrollment for other BadgerCare Plus populations.

Managed care enrollment for demonstration year 2 is . . . .

BadgerCare Plus Childless Adult HMO Enrollment	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Anthum Blue Cross Blue Shield	12489	13704	14325	14,994	14,503	13,733	14,062	14,072	14,067	14,043	14,029	13,820
Childrens Community Health Plan	10154	10710	11030	11,347	10,913	10,305	10,624	10,304	10,749	10,726	10,794	10,705
Compcare	3306	3647	3750	4049	3896	3644	3803	3806	3796	3798	3784	3800
Dean Health Plan	5112	5059	5027	4836	4478	4214	4521	4573	4626	4663	4724	4717
Group Health Eau Claire	4889	5229	5602	6070	5898	5884	6241	6378	6409	6443	6388	6393
Group Health South Central	2216	2473	2485	2664	2571	2348	2406	2394	2322	2279	2223	2179
Gundersen	2116	2292	2378	2398	2372	2278	2425	2465	2414	2407	2413	2402
Health Tradition	1083	1197	1258	1335	1247	1152	1220	1220	1191	1210	1227	1226
iCare	7255	7597	7753	7873	7446	6918	7043	7073	7058	6988	6905	6826
Managed Health Services	9500	9738	9959	10,230	9669	8991	9123	9174	9094	8952	8862	8724
Mercy	1879	2064	2156	2250	2278	2161	2234	2287	2287	2303	2311	2307
Molina	9227	9643	10132	10,525	10,023	9423	9282	9772	9771	9580	9562	9381
Network	9312	9587	9774	10,200	9547	9120	8986	9049	8939	8937	8905	8746
Physicians Plus	2208	2475	2777	3,089	3,004	2881	2969	2961	2936	2931	2885	2801
Security	6860	7710	8259	8672	8541	8220	8520	8666	8612	8624	8590	8532
Trilogy	3237	3513	3667	3,686	3,514	3398	3502	3493	3499	3,481	3493	3430
UnitedHealthcare	25,552	27,559	28,585	29,962	29,220	28,161	28,833	28,969	28,802	28,560	28,532	28,420
Unity	1785	1757	1723	1621	1499	1351	1389	1369	1361	1324	1340	1348
Total	**118,180**	**125,954**	**130,640**	**135,801**	**130,619**	**124,182**	**127,183**	**128,025**	**127,933**	**127,249**	**126,967**	**125,757**

Operational/Policy/Systems/Fiscal Developments/Issues

The state has not identified program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

Financial/Budget Neutrality Development/Issues

Consumer Issues

Consumers have not reported any significant issues related to coverage and/or access to the program and benefits in the current quarter.

Quality Assurance/Monitoring Activity

The DHS consistently monitors activities using a systematic approach that ensures services for all BadgerCare Plus populations are reviewed for quality assurance.

Health Needs Assessment Requirement for Childless Adults

The 2014-2015 BadgerCare Plus HMO contract required health plans to conduct a Health Needs Assessment (HNA) screening of newly enrolled BadgerCare Plus childless adult members within two months of HMO enrollment. The contract requires HMOs to include the following elements in the HNA screening:

a. Urgent medical and behavioral symptoms (e.g., shortness of breath, rapid weight gain/loss, syncope, suicidal ideations, psychotic break);

b. Members' perception of their general well-being;
c. Identify usual sources of care (e.g., primary care provider, clinic, specialist, dental provider);
d. Frequency in use of emergency and inpatient services;
e. History of chronic physical and mental health illnesses (e.g., respiratory disease, heart disease, stroke, diabetes/pre-diabetes, back pain and musculoskeletal disorders, cancer, overweight/obesity, severe mental illness(es), substance abuse);
f. Number of prescription medications used monthly;
g. Socioeconomic barriers to care (e.g., stability of housing, reliable transportation, nutrition/food resources, availability of family/caregivers to provide support);
h. Behavioral and medical risk factors including member's willingness to change their behavior such as:
   i. Symptoms of depression
   ii. Alcohol consumption and substance abuse
   iii. Tobacco use
i. Weight (e.g., using BMI or waist circumference) and blood pressure indicators.

HMOs can conduct the screening in-person, over the phone, via mail or online. Most HMOs conduct the HNA with members either via mail or over the phone. HMOs must use different modes of contact for reaching out to members, even those that are considered hard-to-reach.

Calendar year 2015 was the first year in which HMOs started to report data on their HNA performance. All 19 BadgerCare Plus HMOs participated. HMOs voiced their concerns about the challenges they face conducting outreach to engage the childless adult population. According to HMOs, there is a significant number of members with poor contact information (incorrect phone numbers and addresses). DHS will continue working with HMOs and members to address the issue of bad contact member information in 2016.

In 2015, DHS also worked with HMOs to modify the HNA contract requirements for 2016 including setting up benchmarks for each HMO on HNA performance and financial penalties for HMOs that do not meet the benchmark.

- For 2016, BadgerCare Plus HMOs are required to meet the lesser of the following targets of timely HNA Screeings:
  a. Performance Level Target: 35% rate of timely HNA Screenings in calendar year 2016-2017; OR
  b. Reduction in Error Target: 10% improvement from baseline.

- HMOs who do not meet the HNA target in 2016 will be subject to liquidated damages. The amount will be the lesser of either $250,000 or $40 per BadgerCare Plus Childless Adult member for whom the HMO failed to meet the target in the calendar year.

In 2015 and early 2016, DHS worked with HMOs on reconciling their HNA quarterly results for the period of 7/1/2014 to 6/30/2015 which was used to set the baselines for the 2016 HNA benchmarks.

External Quality Review Activities

Following are a summary of the annual activities for demonstration year 2 by the External Quality Review Organization (EQRO) – MetaStar for the HMOs operating the BadgerCare+ program.

DY2 – Quarter 1

- Collaborated with the DHS to plan and schedule comprehensive reviews for FY 2014.
- Validated and reported preliminary results of Performance Improvement Projects (PIPs); final reports in progress.
- Collaborated with DHS and HP staff on the review of performance measure charters. Validated performance measures for measurement year 2013; validation will continue in the fourth quarter of 2014 for 2015 baseline measures.
- Performed data abstraction and delivered CY 2013 report for Healthy Birth Outcomes initiative (medical home enrollees). Deployed the OBMH registry (transition from Center for Urban and Population Health).

DY2 – Quarter 2

- Supported DHS in its review of accreditation and certification processes for HMOs.
- Reviewed 2015 Performance Improvement Project (PIPs) proposals for two SMCPs.
- Conducted and/or reported on Compliance with Standards reviews for three HMOs.
- Performed data abstraction and delivered quarterly report for HBO initiative (medical home enrollees). Participated in conference calls with new HMOs regarding medical record submission process.
- Initiated tracking of Performance Improvement Project submissions from HMOs for validation beginning July 1, 2015.
- Delivered the draft FY 15 Annual Technical Report.

DY2 – Quarter 3

- Supported DHS in its review of accreditation and certification processes for HMOs.
- Validated 2014 Performance Improvement Project (PIPs) proposals for all HMOs but one (who received an extension).
- Conducted Certification reviews for assigned sections for all HMOs; held teleconference with contract monitor to deliver findings for one HMO.
- Performed data abstraction and delivered annual report for HBO initiative (medical home enrollees).
- Developed/reviewed SSI CMR materials and delivered to DHS for review and approval.

DY2 – Quarter 4

- In collaboration with DHS, developed and distributed accreditation deeming strategy document request lists for accredited HMOs. Conducted review of documents for accreditation gaps.
- Completed 2016 PIP Proposal Reviews for three HMOs who received extensions.

- Performed data abstraction for HBO initiative (medical home enrollees). Delivered records request lists to HMOs (July-December 2015 postpartum visits). Maintained OBMH registry, triaged questions as needed.
- Met with DHS and began developing HIV/AIDs health home review criteria.
- Developed and delivered to BBM, a Timeline of Activities for External Quality Reviews.

Managed Care Reporting Requirements

Starting April 1, 2014 childless adults were enrolled in BadgerCare Plus fee-for-service benefits. Starting in July 2014 the state began enrolling childless adults into managed care with an average of 20,000 members in each month until all new members have been enrolled in managed care as applicable. HMOs are required to report to the DHS on the status of quality infinitives, PIPs, and other programmatic requirements.

Demonstration Evaluation

On November 12, 2014, the Centers for Medicare and Medicaid Services (CMS) approved the Department of Health Services (DHS) evaluation plan. The DHS has incorporated the approved evaluation plan as Attachment C.

The DHS has signed an interagency agreement and contracted with the UW Population Health Institute to conduct the evaluation. DHS and the UW began work on the evaluation September 1, 2015. The UW's Scope of Work and Workplan are included as Attachment D.

The UW is on schedule to begin the first evaluation survey and report starting in April 2016.

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Attachment A – Budget Neutrality Monitoring Workbook

Childless Adults Draft Financial Statistics - Waiver Reporting for Year Ending Dec. 2015

Childess Adult Quarterly Comparison	Claim Expenditures ($ in AF)	Prior Year QE Expenditures ($ in AF)	Ave Monthly Enrollment	Prior Year QE Ave Monthly Enrollment	Ave Monthly PMPM	Prior Year QE Ave Monthly PMPM
QE June 2014	101,210,605	22,157,735	111,187	18,660	302.75	395.80
QE Sept. 2014	137,243,424	21,246,908	130,036	17,487	351.42	404.97
QE Dec. 2014	167,024,246	20,296,922	143,883	16,288	386.86	415.43

Adult Waiver Quarterly Trends	Claim Expenditures ($ in AF)	Quarter-over-Quarter Percent Change	Ave Monthly Enrollment	Quarter-over-Quarter Percent Change	Ave Monthly PMPM	Quarter-over-Quarter Percent Change
QE June 2015	194,345,577	-	155,819	-	415.89	-
QE Sept. 2015	195,141,175	0.41%	150,702	-3.28%	431.63	3.78%
QE Dec. 2015	194,565,204	-0.30%	150,993	0.19%	429.53	-0.48%

CORE Baseline (Childless Adults)	Claim Expenditures ($ in AF)	Fee for Service Enrollees	CAP Expenditures	CAP Members	Total Expenditures	Total Enrollees	Overall PMPM
Apr-13	2,624,273	2,383	4,956,173	16,741	7,580,446	19,124	396.38
May-13	2,582,125	2,333	4,832,357	16,330	7,414,482	18,663	397.28
Jun-13	2,409,378	2,203	4,753,430	15,989	7,162,808	18,192	393.73
Jul-13	2,553,051	1,926	4,721,124	15,922	7,274,175	17,848	407.56
Aug-13	2,395,752	1,832	4,671,819	15,674	7,067,571	17,506	403.72
Sep-13	2,359,752	1,836	4,545,410	15,272	6,905,162	17,108	403.62
Oct-13	2,568,860	1,898	4,411,923	14,809	6,980,783	16,707	417.84
Nov-13	2,222,150	1,657	4,372,572	14,633	6,594,722	16,290	404.83
Dec-13	2,444,132	1,579	4,277,285	14,288	6,721,417	15,867	423.61
Jan-14	2,372,043	1,519	4,069,353	13,844	6,441,396	15,363	419.28
Feb-14	2,153,802	1,403	3,929,873	13,330	6,083,675	14,733	412.93
Mar-14	2,373,347	1,360	3,793,829	12,830	6,167,176	14,190	434.61

BC Reform Adult Waiver (Childless Adults)	Claim Expenditures ($ in AF)	Fee for Service Enrollees	CAP Expenditures	CAP Members	Total Expenditures	Total Enrollees	Overall PMPM
Apr-14	26,293,463	96,182	3,144,558	9,532	29,438,021	105,714	278.47
May-14	31,276,064	100,972	2,951,909	8,878	34,227,973	109,850	311.59
Jun-14	33,724,699	105,854	3,819,912	12,144	37,544,611	117,998	318.18
Jul-14	34,866,576	100,968	7,541,232	23,898	42,407,808	124,866	339.63
Aug-14	31,278,043	86,034	13,633,326	44,239	44,911,369	130,273	344.75
Sep-14	31,688,502	73,344	18,235,745	61,625	49,924,247	134,969	369.89
Oct-14	30,266,965	56,976	23,979,739	82,485	54,246,704	139,461	388.97
Nov-14	25,478,921	44,182	28,569,601	99,066	54,048,522	143,248	377.31
Dec-14	26,403,009	35,918	32,326,011	113,022	58,729,020	148,940	394.31
Jan-15	26,394,875	33,569	34,803,062	121,838	61,197,937	155,407	393.79
Feb-15	25,007,418	33,697	36,623,234	128,387	61,630,652	162,084	380.24
Mar-15	29,129,303	30,584	38,064,738	133,765	67,194,041	164,349	408.85
Apr-15	29,438,428	29,713	37,521,165	132,325	66,959,593	162,038	413.23
May-15	27,308,302	28,206	36,308,926	127,152	63,617,228	155,358	409.49
Jun-15	28,788,801	28,508	34,979,955	121,553	63,768,756	150,061	424.95
Jul-15	29,565,936	26,454	35,854,746	124,366	65,420,682	150,820	433.77
Aug-15	28,755,176	25,718	36,162,073	125,054	64,917,249	150,772	430.57
Sep-15	28,643,707	25,500	36,159,537	125,014	64,803,244	150,514	430.55
Oct-15	29,000,002	25,920	36,178,029	124,141	65,178,031	150,061	434.34
Nov-15	28,052,991	26,931	36,063,150	123,987	64,116,141	150,918	424.84
Dec-15	29,387,582	28,766	35,883,450	123,233	65,271,032	151,999	429.42

*MC Enrollees have some of their expenditures in FFS Claims as well: Wrap around, Pharmacy, etc.
**FFS Claims are pulled on a date of service basis. PMPM comparisons may be skewed due to claims lag for months of October 2015 through December 2015
*** Expenditures and enrollment may not tie to future quarterly reports as numbers will be adjusted to account for claims lag
**** All data pulled on March 30, 2016 from DSS, not from MBES quarterly report

Attachment B – Summary of Cost-Sharing for TMA Adults Only

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

TMA Adults (Demonstration Population 1)

Monthly Premium Amount Based on FPL Percentage	Monthly Premium Amount as 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 – 339.99%	7.4%
240 – 249.99%	7.7%
250 – 259.99%	8.05%
260 – 269.99%	8.3%
270 – 279.99%	8.6%
280 – 289.99%	8.9%
290 – 299.99%	9.2%
300% and above	9.5%

Attachment C – Demonstration Evaluation Plan


WI BadgerCare Reform Final Approve


BadgerCare Reform Demonstration Evalua

Attachment D – BadgerCare Plus Reform Waiver Project Work Plan

BadgerCare Plus Reform Waiver Projec

Attachment E – University of Wisconsin Scope Work & Project Work Plan

BadgerCare Reform
Waiver Evaluation - S

Historic Demo Population Enrollment

Average Monthly Enrollment by Qtr	DY1 - CY14				DY2 - CY15				DY3 - CY16				DY4 - CY17			
	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1	DY2 Q2	DY2 Q3	DY2 Q4	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
CLA Pop (Group 2)	N/A	111,187	130,036	143,883	160,613	155,823	150,708	151,100	154,108	149,978	148,133	148,008	150,880	148,421	147,900	TBD
TMA Pop (Group 1)	N/A	22,502	20,626	20,286	19,218	22,992	26,291	29,080	28,806	29,615	30,002	30,801	29,138	29,076	28,403	TBD
Q/Q Pop % Change																
CLA Pop (Group 2)	N/A	N/A	17.0%	10.6%	11.6%	-3.0%	-3.3%	0.3%	2.0%	-2.7%	-1.2%	-0.1%	1.9%	-1.6%	-0.4%	TBD
TMA Pop (Group 1)	N/A	N/A	-8.3%	-1.6%	-5.3%	19.6%	14.3%	10.6%	-0.9%	2.8%	1.3%	2.7%	-5.4%	-0.2%	-2.3%	TBD

Historic Demo Population Cost

Qtrly Population Expenditures	DY1 - CY14				DY2 - CY15				DY3 - CY16				DY4 - CY17			
	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1	DY2 Q2	DY2 Q3	DY2 Q4	DY3 Q1	DY3 Q2	DY3 Q3	DY3 Q4	DY4 Q1	DY4 Q2	DY4 Q3	DY4 Q4
CLA Pop (Group 2)	N/A	##########	##########	##########	$ 200,668,520	##########	$219,500,633	##########	##########	##########	##########	##########	##########	##########	##########	TBD
TMA Pop (Group 1)	N/A	$ 2,855,683	$ 9,369,330	$ 12,153,344	$ 11,760,683	$ 8,850,930	$ 17,948,122	$ 17,298,235	$ 17,147,431	$ 11,842,996	$ 18,572,705	$ 16,718,109	$ 17,568,763	$ 10,707,824	$ 19,673,931	
Q/Q Pop % Change																
CLA Pop (Group 2)	N/A	N/A	66.6%	15.5%	3.0%	-22.2%	40.6%	-10.6%	-5.9%	-14.8%	34.8%	-9.4%	0.3%	-20.1%	54.0%	
TMA Pop (Group 1)	N/A	N/A	228.1%	29.7%	-3.2%	-24.7%	102.8%	-3.6%	-0.9%	-30.9%	56.8%	-10.0%	5.1%	-39.1%	83.7%	

*Source of Expenditure Reporting from CMS 64 Report Structure based on date of payment. Note high quarterly variability is based on payment timing and not reflective of date of service trends