STATE OF WISCONSIN DEPARTMENT OF HEALTH SERVICES

Wisconsin SeniorCare

A Pharmaceutical Benefit For Low-Income Seniors

1115 Demonstration Project Renewal
Draft Application

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Contents

I. INTRODUCTION

The Wisconsin Department of Health Services (DHS) requests a 10-year renewal of its section 1115 research and demonstration project for the SeniorCare Prescription Drug Assistance Program. The current waiver is scheduled to expire on December 31, 2018. DHS requests that the waiver be renewed for an additional 10-year period, from January 1, 2019, through December 31, 2028.

Background

On July 1, 2002, DHS received the necessary waiver approvals from the Centers for Medicare and Medicaid Services (CMS) to operate a portion of SeniorCare, a prescription drug benefit for seniors, as a five-year demonstration project. The SeniorCare waiver extends Medicaid eligibility through Title XIX of the Social Security Act of 1965 to cover prescription drugs as a necessary primary health care benefit.

The target population for services under the SeniorCare waiver program is seniors who are age 65 or older with income at or below 200 percent of the federal poverty level (FPL), which is $24,280 for an individual and $32,920 for a two-person family in 2018.

Since its implementation on September 1, 2002, the SeniorCare waiver program has successfully delivered a comprehensive outpatient drug benefit to more than 290,000 seniors in the state.

Advantages of SeniorCare

Simple Application and Enrollment Process

The SeniorCare application consists of a simple application form which must be mailed to the SeniorCare central application processing center with a $30 enrollment fee. SeniorCare requires no asset test. Once approved, seniors are enrolled for a 12-month benefit period. Toward the end of the 12-month period, members are reminded that they must reapply for enrollment in the program.

Open Formulary and Broad Network of Providers

SeniorCare is a comprehensive drug benefit that is easy for seniors to access. SeniorCare has an open formulary nearly identical to that of Wisconsin Medicaid and covers over-the-counter insulin, as well as prescription drugs with a federal rebate agreement. In addition,

SeniorCare provides access to a robust network of pharmacies. More than 1,300 in-state pharmacies and another 100 out-of-state pharmacies are certified as SeniorCare providers.

Affordable and Predictable Cost Sharing for Members

SeniorCare has predictable and affordable cost sharing requirements. All SeniorCare members pay an annual $30 enrollment fee and incur copays of just $5 for generic drugs and $15 for brand name drugs. Individuals or couples with income at or below 160 percent of the FPL have no other out-of-pocket costs. Those whose incomes fall between 160 percent and 200 percent of the FPL pay the first $500 in prescription drug costs at the SeniorCare rate.

Program Cost-Effectiveness

SeniorCare is a financially efficient program for all payers. In calendar year 2017, total drug expenditures of $109 million billed to the SeniorCare program were reduced by manufacturer rebates, member cost sharing, and third-party insurance to a total of just over $23 million, which was paid for by state and federal tax dollars.

By leveraging rebates on this scale, which cover 52 percent of the amount paid to pharmacies, Wisconsin has successfully held drug companies accountable for contributing to reduced drug prices and creating an effective drug benefit.

Medication Therapy Management

SeniorCare offers a comprehensive medication therapy management (MTM) benefit. MTM can improve member health and reduce overall costs to SeniorCare by educating members about their medications and improving adherence to drug regimens. SeniorCare members have received 9,054 intervention-based services and 793 comprehensive medication review and assessment (CMR/A) services from September 2012 to January 2018. Intervention-based services are no longer a separately reimbursed service as of April 1, 2017. A reduction in inappropriate medication use and an increase in medication adherence can ensure seniors stay healthier and reduce inappropriate medical expenditures**.**

Continued Cost-Effectiveness with SeniorCare Waiver Renewal (Budget Neutrality)

DHS projects that the SeniorCare waiver renewal will continue to reduce Medicaid expenditures for seniors who are age 65 or older, from what those expenditures would have been without the waiver, by providing primary care benefits for pharmacy coverage.

As in the original waiver period, budget neutrality will continue to be achieved by reducing

the rate of increase in the use of non-pharmacy-related services provided to this population, including hospital, nursing facilities, and other medical services. These savings will offset the costs of continuing the SeniorCare waiver program. The Medicare program will also realize reductions in expenditures through reduced hospitalizations for this population group.

The SeniorCare waiver achieved budget neutrality throughout the original waiver period, as well as all renewal periods. Initial estimates indicate that the SeniorCare waiver program savings were approximately $40 million for state fiscal year 2017.

Savings are the direct result of reduced Medicaid payments for hospital and nursing home care because seniors with SeniorCare prescription drug coverage are diverted from spending down income and assets to Medicaid eligibility levels. By keeping seniors healthier longer, SeniorCare reduces Medicare expenditures as well.

Excellent Value for Members

SeniorCare also provides exceptional value to its members. In state fiscal year 2017, SeniorCare members had cost sharing of $12.1 million in drug costs of $109 million.

Keeps Seniors Healthier, Longer, and Reduces Medicaid Costs

SeniorCare benefits seniors by keeping them healthy through providing access to medications that are instrumental in the control and prevention of adverse health conditions. Keeping Wisconsin's seniors healthy mitigates costs related to receiving Medicaid benefits.

Overview

A. Prescription Drugs and the Elderly

As health care costs continue to rise for all Americans, access to drugs for the senior population, a basic primary care benefit, is increasingly important. The lack of access to essential medications for the chronically ill and those with acute diseases results in an increase in hospital and nursing home costs. Use of prescription drugs not only improves the quality of primary care services, but is also cost-effective when including the cost of hospitalization or long-term care. Studies have estimated that every dollar spent on pharmaceutical coverage is associated with a significant reduction in hospital expenditures. These savings relate not only to the preventive nature of some pharmaceuticals, but also to the fact that inadequate coverage of this primary care benefit causes millions of low-income elderly to reduce their use of clinically essential medications. The improper use of essential medications due to income constraints increases hospital and nursing home admissions, increasing aggregate health care costs.

B. Current Medicaid Eligibility for Elderly, Blind or Disabled

1. Supplemental Security Income

Wisconsin provides Medicaid coverage to all individuals who receive federally funded cash assistance under the Supplemental Security Income (SSI) program. Wisconsin is not a § Section 209(b) state and, thus, does not impose more restrictive eligibility standards than SSI.

Within the population of SSI-eligible elderly, blind, or disabled individuals, individuals who qualify for and receive the federal SSI payment are the federally mandated coverage group. Wisconsin has also chosen to cover optional groups of people who receive a state-only supplemental payment, as well as people who are eligible for the federal SSI payment but choose not to receive it.

Wisconsin meets federal requirements with regard to a number of groups of individuals formerly eligible for SSI. Wisconsin covers certain disabled individuals who have returned to work and lost SSI eligibility because of employment earnings, but who still have the condition that caused the disability. These individuals meet all non-disability criteria for SSI except income. Wisconsin also covers individuals who were once eligible for both SSI and Social Security payments but who lost their SSI for any reason); however if certain cost-of-living adjustments were excluded from their income, they would be eligible for SSI-related Medicaid. Similar Medicaid continuations are provided for other individuals who become ineligible for SSI due to eligibility for or increases in Social Security or veterans benefits.

Wisconsin also maintains Medicaid coverage for certain SSI-related groups who received benefits in 1973, including those who care for disabled individuals.

2. Medically Needy

Wisconsin offers Medicaid coverage to medically needy elderly, blind, or disabled individuals. By federal law, the associated income limits may not exceed 133.3 percent of the maximum Aid to Families with Dependent Children (AFDC) payment that would have been paid to a family as of July 16, 1996. Wisconsin exercises the federal option to apply the higher two-person standard to single individuals. Further, Wisconsin has opted to provide nursing home care as part of its medically needy program benefit package.

Medical costs are covered under Wisconsin's medically needy Medicaid program when the person (or family) is eligible for Medicaid in all ways except for income level and incurs medical expenses equivalent to the income which is over the medically needy limit.

3. Institutional and Other Long-Term Care

Wisconsin provides Medicaid coverage to residents of a medical institution and individuals participating in community-based long-term care programs under a special optional institutional income rule. This rule permits individuals who are not categorically eligible for SSI and who have income between 100 percent and 300 percent of the monthly federal SSI payment amount to be eligible for Medicaid without spending down to the medically needy income limit. Wisconsin has opted to provide coverage at the maximum of 300 percent of the monthly SSI payment level.

4. MEDICAID PURCHASE PLAN

In March 2000, Wisconsin implemented a new option provided under federal Medicaid law to extend Medicaid coverage to certain working disabled adults. The program is intended to remove financial disincentives to work and generally covers disabled individuals with income less than 250 percent of the FPL. Disability and family income are determined in accordance with SSI rules, and there is a $15,000 asset limit. Program members must engage in work activity or participate in a program certified to provide health and employment services aimed at helping the member achieve employment goals.

5. LOW-INCOME MEDICARE BENEFICIARIES

Wisconsin provides limited Medicaid coverage to the following groups of low-income Medicare beneficiaries:

- Qualified Medicare Beneficiary (QMB): These are individuals whose income does not exceed 100 percent of the FPL and whose resources do not exceed the program limit are entitled to Medicare hospital insurance benefits (i.e., Medicare Part A). The resource limit is adjusted annually in accordance with increases in the consumer price index. In 2018, the resource limit is $7,560 for an individual or $11,340 for a married couple. For these individuals, Medicaid pays any required Medicare premiums, coinsurance, and deductibles for both Medicare Parts A and B. Cost sharing amounts are paid up to the maximum amount Medicaid would reimburse for the service rendered.
- Specified Low-Income Medicare Beneficiary (SLMB): Medicaid pays the full Medicare Part B premium for individuals who otherwise meet the QMB requirements but have income between100 and 120 percent of the FPL.
- Specified Low-Income Medicare Beneficiary Plus (SLMB+): Medicaid pays the full Medicare Part B premium for individuals who are not eligible for full-benefit Medicaid who otherwise meet the QMB or SLMB requirements and who have income between 120 and 135 percent of the FPL.
- Qualified Disabled and Working Individual (QDWI): These are individuals who formerly received Social Security disability benefits and Medicare, have lost eligibility for both programs, but are permitted under Medicare law to continue to receive Medicare in return for payment of the Medicare Part A premium. Wisconsin has chosen to pay the entire

Medicare Part A premium for individuals in this category who are under age 65, not otherwise eligible for Medicaid, have income at or below 200 percent of the FPL, and have assets up to twice the SSI resource limits.

C. Overview of the SeniorCare Demonstration Project Renewal Program

In response to the critical need for prescription drug coverage for the elderly, Wisconsin established a prescription drug assistance program titled SeniorCare through 2001 Wisconsin Act 16. SeniorCare statutes required DHS to submit to the federal Department of Health and Human Services (HHS) a request that SeniorCare be covered under a section 1115 research and demonstration project, which was granted in 2002. This section and Appendix A describe the history of the SeniorCare demonstration project.

Under the terms of the waiver, SeniorCare has complied with federal and state laws and regulations (except those for which a specific waiver is requested) for Medicaid eligibility, benefits, and administration. This includes application processing, claims processing, federal reporting, and safeguards for fraud and abuse.

The successful and popular SeniorCare program has historically received strong support from the Wisconsin Legislature, which has provided funding for SeniorCare since its inception in 2002. These state funds cover approximately 10 percent of the SeniorCare program.

The SeniorCare waiver program serves seniors with incomes at or below 200 percent of the FPL. Since implementation on September 1, 2002, the SeniorCare waiver has successfully delivered a comprehensive outpatient drug benefit to over 290,000 Wisconsin seniors. As of March 2018, more than 46,000 seniors were enrolled in SeniorCare.

Through a section 1115 research and demonstration project renewal, Wisconsin seeks to continue Medicaid federal matching funds for individuals who qualify for SeniorCare. By extending access to prescription drugs for the elderly, Wisconsin will continue to provide a needed health care benefit to low-income seniors. Continuing to provide pharmacy benefits through SeniorCare will provide the following advantages:

- Offer a prescription drug benefit that provides comprehensive coverage comparable to Medicare Part D prescription drug plans, but has a simple application and enrollment process, a broad network of pharmacy providers, and affordable and predictable cost sharing for costly but essential drugs.
- Help to preserve the health and quality of life of the senior population, resulting in lower utilization and expenditures of other health care services and savings to the Medicare and Medicaid programs.
- Protect the finances of low-income seniors, reducing the rate at which seniors spend down to Medicaid eligibility and become entitled to Medicaid benefits.

- Provide an outpatient pharmacy benefit that offers an excellent value to the federal government by offsetting federal expenditures with a substantial state financial commitment and substantial (approximately 53 percent of expenditures) manufacturer rebates.

Under the SeniorCare program, Wisconsin residents who are ages 65 or older, not currently eligible for Medicaid benefits, and whose income does not exceed 200 percent of the FPL are eligible for coverage of prescription drugs and over-the-counter insulin as currently provided under the Wisconsin Medicaid state plan. Seniors with prescription drug coverage under other plans are also eligible to enroll in SeniorCare, and SeniorCare will cover eligible costs that are not covered by the other plans. There is no asset test.

Members pay an annual $30 enrollment fee. Individuals with income at or below 160 percent of the FPL are responsible for a copayment of $15 for each brand name prescription and $5 for each generic prescription. Individuals with an income above 160 percent of the FPL and at or below 200 percent of the FPL are also responsible for the first $500 of prescription drug costs each year at the SeniorCare rate.

The simple SeniorCare application form requests the applicant's name, birth date, Social Security number, income, residence, spouse's name, and other limited information needed to determine their eligibility. Seniors submit signed applications by mail to a central processing center administered by DHS.

Applicants receive notices about their eligibility, whether they have an annual payment, and other information about their participation in the program. Once they are enrolled in SeniorCare, members receive an identification card that is distinct from the ForwardHealth card that they use when purchasing prescription drugs. A member’s enrollment in SeniorCare begins on the first day of the month following the date their completed application is received and they meet all enrollment rules, including paying the enrollment fee. Once someone is enrolled in SeniorCare, they may remain eligible for 12 months from the date of initial enrollment, regardless of changes in income. However, if a person permanently leaves Wisconsin or passes away, they are no longer eligible for the SeniorCare waiver program.

SeniorCare uses the state Medicaid program's point-of-sale (POS) system for claims processing. The POS system has mechanisms in place for drug pricing, calculation of copayments and deductibles, coordination of benefits, Specialized Transmission Approval Technology-Prior Authorization, prospective and retrospective drug utilization review, and other cost containment processes. The POS system allows Medicaid-enrolled providers to submit claims electronically for prescription drugs and to receive an electronic response indicating payment or denial within seconds of submitting the claim. The system also verifies

member eligibility, including other health insurance coverage, and tracks a member's deductibles and copayments. This information is available to pharmacists in real time. As a result, seniors filling their prescriptions may receive real-time information about their prescription costs.

Similar to Medicaid, SeniorCare must coordinate eligibility across programs and coordinate with benefits covered by other insurers. Many seniors who are eligible for SeniorCare are also eligible for programs such as FoodShare and other economic support programs. A SeniorCare customer service hotline, which began operating in July 2002, allows members to receive answers to questions about eligibility, applications, and program benefits. SeniorCare application processing staff are trained to answer questions and provide referrals for seniors seeking information about SeniorCare or other programs.

Existing systems that support the Medicaid program are used for automated support for SeniorCare eligibility and enrollment functions. DHS leverages existing system capacity to meet the program needs in the most efficient way.

II. SENIORCARE OBJECTIVES

1) Keeping Wisconsin seniors healthy by providing a necessary prescription drug benefit with low administrative burden and high level of member satisfaction.

Enrolling in programs like Medicaid and Medicare Part D often requires a significant administrative burden and that may lead to confusion and poor coverage decision-making by many seniors. SeniorCare has a simple application, enrollment, and renewal process that provides a valuable and necessary prescription drug insurance benefit for Wisconsin seniors.

2) Helping protect the finances of low-income Wisconsin seniors by controlling prescription drug costs and reducing financial barriers to obtaining needed medications.

Many seniors, including seniors enrolled in Medicare Part D, face problems affording medically necessary prescription drugs. SeniorCare helps reduce these financial barriers by providing affordable and predictable cost sharing.

3) Reducing the rate of increase in the medical services provided to this population such as hospital, emergency department, and nursing facility services.

A senior who takes his or her medications is more likely to have reduced medical spending, therefore decreasing overall health care costs. SeniorCare helps to preserve the health and quality of life of the senior population, resulting in lower utilization and expenditures for other

health care services and savings to the Medicare and Medicaid programs.

III. DEMONSTRATION PROJECT RENEWAL PROGRAM DESIGN

Wisconsin will continue the current SeniorCare program design through the demonstration project renewal, as described in the following sections.

A. Eligibility Requirements

State Medicaid programs may have two types of eligibility categories: categorically needy and medically needy. Both categories are established under the Social Security Act of 1965. Certain groups, such as pregnant women and the elderly, are considered categorically eligible if they also meet income criteria based on the FPL. Individuals are considered medically needy if they cannot afford to pay their medical bills and would be categorically needy except for their slightly higher income. To be eligible for prescription drug services under the SeniorCare waiver program, individuals must meet all of the following eligibility requirements:

- Be a Wisconsin resident.
- Be a U.S. citizen or have qualifying immigrant status.
- Not be a recipient of full-benefit Medicaid. This does not include low-income Medicare beneficiary programs QMB, SLMB, SLMB+ or QDWI.
- Be age 65 or older.
- Have household income at or below 200 percent of the FPL.
- Pay the applicable annual enrollment fee of $30 per person.

Individuals with a household income above 200 percent of the FPL receive program benefits after they have met program requirements for a deductible and spenddown, if required. Income is calculated as follows:

- A gross income test is used except in cases of self-employment income. The standard Medicaid for the elderly, blind, or disabled deductions and other deductions are not applied.
- In cases of self-employment income, current policy for Medicaid for the elderly, blind, or disabled is followed. Therefore, deductions for allowable business expenses, losses and depreciation are permitted for individuals with self-employment income.
- Income is determined annually on a prospective basis.
- A fiscal test group that is consistent with current policy for Medicaid for the elderly, blind, or disabled is used. Thus, individual income is used for a married person not living with their spouse, and joint income is used for a married person living with their spouse. These income amounts are compared to the FPL for a group size of one if counting only the income of the individual, or for a group size of two if counting the income of the applicant and their spouse.

- There is no asset test related to eligibility for the SeniorCare waiver program.

B. Application Process for SeniorCare Waiver Program Benefits

The application process for eligible seniors in the SeniorCare waiver program is comprised of the following components:

- The senior completes the simple, short application.
- The senior submits the application by mail or online.
- A central unit administered by DHS processes the application.
- Near the end of the individual's year of eligibility, DHS notifies the individual of the need for an annual redetermination of their eligibility. DHS provides the individual with a pre-printed renewal form containing some of the information they provided the previous year. To continue coverage, the individual must complete the renewal form in a timely manner and pay the annual enrollment. The renewal must be processed and approved by DHS.
- Upon initial enrollment, the SeniorCare waiver program member receives an identification card distinct from the current ForwardHealth card. The members must present the identification card to the pharmacy or pharmacist when purchasing prescription drugs.

The SeniorCare enrollment process focuses primarily on eligibility for the SeniorCare waiver program. Seniors are also advised to consider Medicare Part D enrollment to cover their prescription drug needs or to complete a full Medicaid application if they are applying for benefits other than prescription drugs.

C. Enrollment Periods

The enrollment periods for members enrolled in SeniorCare are as follows:

- Once determined eligible for the SeniorCare waiver program, an individual may remain eligible for 12 months from the date of initial enrollment, regardless of changes in income. However, if a person permanently leaves Wisconsin or passes away, they are no longer eligible for the SeniorCare waiver program.
- If a member loses eligibility due to a change of income, they may reapply if their income decreases. For example, if an individual with income at or above 165 percent of the FPL subsequently loses a part-time job resulting in income below 160 percent of the FPL, the individual may reapply. In this situation, the individual would no longer be required to pay the first $500 in prescription drug costs but would need to pay a new $30 enrollment fee to establish a new 12-month benefit period.
- An individual is able to begin participating in the program on the first day of the month following the date their completed application is received and they meet all enrollment rules, including paying the enrollment fee.
- SeniorCare enrollment is only prospective. There is no retroactive enrollment in the program.

D. Coordination of Benefits

The SeniorCare waiver program extends coverage only to prescription drugs and to over-the-counter insulin. These are drugs that are currently covered by the Wisconsin Medicaid state plan. Benefits are coordinated similarly to the Medicaid program. The SeniorCare waiver program uses a combination of automated, pre-payment cost avoidance within the POS system and, where necessary, will bill liable third parties after the payment is made.

If a person is eligible to receive MTM services through commercial insurance or Medicare, the pharmacist is required to submit the MTM claims to other payers.

SeniorCare is the payer of last resort for covered services.

E. Cost Sharing

SeniorCare members are required to comply with cost sharing provisions that vary by income level. The following sections describe the cost sharing features in more detail.

1. Annual Enrollment Fees

All SeniorCare members are required to pay an annual $30 enrollment fee. Once an applicant is determined eligible for SeniorCare, the applicant will receive a letter notifying them of the eligibility and cost sharing requirements. All applicants have the option to decline participation in SeniorCare if they notify DHS within the 30-day processing period or within 10 days of the date on the enrollment letter, whichever is later. If an individual declines to participate in SeniorCare within this time period, DHS will refund the enrollment fee paid for that benefit period. If an individual has paid the annual enrollment fee with their application and is determined ineligible for the program, DHS will refund the paid enrollment fee.

2. Annual Costs for Certain SeniorCare Members

Certain SeniorCare members pay the first $500 in prescription drug costs at the SeniorCare rated during each enrollment period.

- SeniorCare members with income above 160 percent of the FPL and at or below 200 percent of the FPL are responsible for the first $500 of prescription drug costs per year. The first $500 will be paid by the member at the SeniorCare rate.
- If SeniorCare members chooses to receive MTM services and their income is above 160 percent of the FPL and at or below 200 percent of the FPL, they are responsible for paying Medicaid rates for the MTM services while in the $500 deductible period. Member payments toward MTM services will count toward the member's deductible.
- SeniorCare members with income at or below 160 percent of the FPL are not required to

pay a $500 deductible for prescription drug costs or MTM services.

3. COPAYMENTS

For SeniorCare members with income above 160 percent of the FPL and at or below 200 percent of the FPL who have met the $500 annual deductible, and for members with income at or below 160 percent of the FPL, a copayment is required for each prescription drug for the remainder of that 12-month period. The following copayments apply:

- $15 copayment per prescription for brand name drugs.
- $5 copayment per prescription for generic drugs.

There is no copayment for MTM services.

F. Coordination with Other Medicaid Programs

There are certain circumstances when Medicaid and SeniorCare need to coordinate benefits and enrollment policies between the two programs:

- SeniorCare members whose income decreases to allowable Medicaid eligibility levels and who want to receive full Medicaid benefits must apply. They must apply for full-benefit Medicaid through the normal Medicaid application process and be determined eligible for the program.
- Except during the 30-day initial processing period, the enrollment fee is not refundable to SeniorCare members who become eligible for full Medicaid benefits during their 12-month SeniorCare benefit period. SeniorCare will remain open to these individuals. Thus, if they subsequently become ineligible for full Medicaid benefits during the 12 months, they will automatically be able to receive SeniorCare benefits for the remainder of the12-month period without having to pay another $30 fee.
- SeniorCare members who are terminated from the SeniorCare program or who fail to reenroll will not be automatically reviewed for eligibility for other Medicaid programs prior to termination.

G. Benefits

1. PHARMACY BENEFITS

Wisconsin Medicaid covers prescription drugs and over-the-counter insulin prescribed by a licensed physician, dentist, podiatrist, nurse prescriber, or ophthalmologist as currently provided under the Wisconsin Medicaid state plan. In addition, physicians may delegate prescription authority to a nurse practitioner or physician assistant.

Wisconsin Medicaid has an open drug formulary. This means that prescription drugs or over-the-counter insulin are covered if they meet all of the following criteria:

- The drug is approved by the federal Food and Drug Administration.
- The manufacturer signed a rebate agreement with CMS.
- The manufacturer has reported data and prices to First DataBank, a national drug database.

SeniorCare statutes define prescription drugs as prescription drugs covered by Wisconsin Medicaid and for which the drug manufacturers enter into a rebate agreement with the state. Like Wisconsin Medicaid, which covers certain over-the-counter drugs, SeniorCare extends coverage to over-the-counter insulin.

2. MEDICATION THERAPY MANAGEMENT BENEFITS

The MTM benefit consists of private consultations between a pharmacist and a member to review the member's drug regimen, as currently provided under the Wisconsin Medicaid state plan.

CMR/A allows specially trained pharmacists to review a member's drug regimen. Members who are at a high risk of experiencing medical complications due to their drug regimen are eligible for this service. During the CMR/A, the pharmacist may:

- Obtain the necessary assessments of the member's health status.
- Formulate a medication treatment plan for the member.
- Provide information, support services, and resources designed to enhance member adherence with the member's therapy regimens.
- Document the care delivered and communication of essential information to the member's primary care providers.
- Refer the member to an appropriate health care provider, if necessary.
- Coordinate and integrate medication management services within the broader health care system.

There is a limit of one initial and three follow-up CMR/As per year. Pharmacists may request an exemption from these limits.

H. Rates

Drugs covered by SeniorCare are reimbursed according to a separate ingredient cost and professional dispensing fee. Ingredient cost reimbursement is based on actual acquisition cost as defined by 42 CFR §§ 447.502. Professional dispensing fee reimbursement is based on a cost-of-dispensing survey, which collects information on the pharmacy costs associated with filling a prescription.

Any changes to ingredient cost or professional dispensing fee methodologies for Wisconsin Medicaid benefits will automatically apply to SeniorCare.

I. Cost Management Strategies

To further enhance the primary health care benefits and the cost-effectiveness of the SeniorCare waiver program, DHS has implemented a number of management strategies to enhance the quality of care and cost-effectiveness within the waiver program. These benefit management strategies are as follows:

1. Pharmacy POS

Wisconsin Medicaid maintains a pharmacy POS electronic claims management system for Medicaid fee-for-service. The POS system allows providers to electronically submit real-time claims for prescription and over-the-counter drugs for immediate adjudication and eligibility verification. The real-time claims submission verifies member eligibility, including other health insurance coverage, and monitors Medicaid drug policies. Claims are also screened against member medical and prescription history within the Medicaid system. Once these processes are complete, the provider receives an electronic response indicating payment or denial. This occurs within seconds of submitting the real-time claim.

2. Prospective Drug Utilization Review

Prospective DUR is used to enhance clinical quality and cost-effective drug use by members. At the POS, the Medicaid POS system screens certain drug therapy problems before the prescription is dispensed to the member. The system screen provides the pharmacist with information about potential contraindications for the member by activating alerts that identify the following problems, which are presented in hierarchical order:

- Drug-drug interactions: The alert is activated when another drug in the drug claims history interacts with the drug being filled.
- Drug-disease contraindications: The alert is activated when a drug is prescribed for a member who has a disease for which the drug is contraindicated.
- Therapeutic duplication: The alert is activated when another drug is present in the claims history in the same therapeutic class as the drug being dispensed.
- Overuse (early refill): The alert is activated when a member is requesting an early refill of a prescription.
- Underuse (late refill): The alert is activated when a member is late in obtaining a refill of a maintenance drug.
- Insufficient quantity (three-month supply): The alert is activated to give pharmacies the opportunity to dispense a three-month supply of medication.

3. Retrospective Drug Utilization Review

On a monthly basis, DHS performs retrospective DUR. During the DUR cycle, drug claims

are reviewed against DUR Board-approved criteria and member profiles are generated. Pharmacists then individually review the member profiles for clinical significance. Each month, potential adverse drug concerns such as drug-drug interactions, overuse, drug-disease contraindications, and duplicate therapy are examined for all providers. If a potential concern is discovered, intervention letters are sent to all providers who have seen members who may be potentially impacted by the concern.

4. State Maximum Allowed Cost List

Under Wisconsin's Medicaid state plan approved by CMS, Wisconsin Medicaid may assign State Maximum Allowable Costs (SMACs) to establish an upper limit for payment of brand or generic versions of the same drug (federal prescription or over-the-counter drugs), regardless of manufacturer.

If Wisconsin Medicaid establishes a SMAC for covered outpatient drugs, then the SMAC rate will be published on a state and specialty pharmacy drug reimbursement rate list. SeniorCare will use the Wisconsin Medicaid SMAC list.

5. Medication Therapy Management

Wisconsin Medicaid's MTM program provides pharmacists with professional fees for providing CMR/As to Wisconsin Medicaid and SeniorCare members.

CMR/As allow specially trained pharmacists to review the member's entire drug regimen. Members who are identified by the program as being at a high risk of experiencing medical complications due to their drug regimen are eligible for this service.

6. Prior Authorization

Under Wisconsin Medicaid, pharmacists are required to receive prior authorization (PA) for certain drugs in order to receive reimbursement for those drugs. PA requests may be submitted electronically for most drugs requiring PA. DHS requires prior authorization for certain drugs to:

- Prevent potential drug abuse or misuse.
- Monitor use of drugs for cosmetic reasons only (e.g., weight loss drugs not used to treat morbid obesity).
- Encourage use of therapeutically equivalent drugs when generics are available in the same drug classification.

While less than one percent of covered drugs require PA, PA has been shown to slow the rate of increase in drug expenditures without impeding access to necessary and appropriate drugs.

Through the PA process, drugs are reviewed to determine if similar products are available, either generically or under a brand name. For drugs that are available both generically and under a brand name, Wisconsin Medicaid requires PA for the brand name drugs. Before any changes are made to PA requirements, drug manufacturers are notified and a review process is followed. This process ensures high quality for SeniorCare members and cost-effectiveness for the program.

7. DIAGNOSIS RESTRICTION AND EXCLUDED DRUGS

Under Wisconsin Medicaid, a diagnosis restriction may apply for certain drugs if the prescribed use is not for a medically accepted indication. In addition, certain drugs may be excluded from coverage if they are on the Medicaid Negative Formulary drug list, are experimental, or have no medically accepted indications.

8. PREFERRED DRUG LIST

On October 1, 2004, DHS implemented a preferred drug list (PDL) and Supplemental Rebate program for Wisconsin Medicaid, BadgerCare Plus and SeniorCare.

Based on the therapeutic significance and cost effectiveness of a drug, supplemental rebates with manufacturers are negotiated and PDL recommendations are made to the Wisconsin Medicaid Prior Authorization Advisory Committee (PAC). This committee is composed of physicians, pharmacists, advocates, and consumers from the state of Wisconsin.

To determine drugs to be included on the PDL, the PAC reviews evaluations of a drug's relative safety, effectiveness, clinical outcomes, and the relative cost. Research is based on peer-reviewed medical literature along with current studies and trials.

Non-preferred drugs require PA. Preferred drugs on the PDL do not generally require PA. Prescribers are encouraged to write prescriptions for preferred drugs; however, a PA process is available for non-preferred drugs.

9. DRUG AUTHORIZATION AND POLICY OVERRIDE CENTER

Providers may contact the Drug Authorization and Policy Override (DAPO) Center in order to request PA for certain drugs or to request an override of current policy on a case-by-case basis. Examples of policies that may be overridden include three-month supply, early refill, quantity limits, opioid script limit, and limits on MTM services.

IV. DEMONSTRATION PROJECT RENEWAL PROGRAM ADMINISTRATION

A. Administering Agency

Wisconsin administers its SeniorCare waiver program through DHS. Portions of the program, such as claims processing, communications, customer service, application processing, and other related services, may be administered by private entities under contract with DHS,.

B. Financing

Prescription drug services under the SeniorCare waiver program are funded jointly through state general purpose revenue funds and matching federal funds. Additional program revenue for the SeniorCare waiver program comes from annual enrollment fees, copayments, and drug rebates. DHS currently has drug rebate agreements with all pharmaceutical companies participating in the Medicaid rebate program, pursuant to § Section 1927 of the Social Security Act of 1965.

C. Provider Network

The SeniorCare waiver program provides access to a robust network of pharmacies. There are currently1,300 in-state pharmacies and another 100 out-of-state pharmacies that are Medicaid-enrolled providers. SeniorCare Wis. Admin. Code ch. 109.52(2)(a) requires Medicaid-enrolled pharmacies to serve SeniorCare members.

In accordance with the Patient Protection and Affordable Care Act (ACA) (2010), SeniorCare requires all physicians and other professionals who prescribe, refer, or order services for SeniorCare members to be enrolled in Wisconsin Medicaid. A limited Medicaid enrollment is available for physicians and other professionals who do not wish to routinely render or be reimbursed for services provided to Medicaid members.

D. Implementation Schedule

SeniorCare is a successful waiver program that determines eligibility and provides outpatient drug benefits to an average of 47,000 seniors per month. The current three-year waiver is set to expire December 31, 2018. With this ten-year renewal, the SeniorCare waiver would continue beginning January 1, 2019, through December 31, 2028.

E. Early Termination of the Waiver Program

Wisconsin reserves the right to end this SeniorCare waiver should actual experience show that it is not cost-effective or cost-neutral.

V. WAIVERS REQUESTED

This waiver renewal requires continued waivers from Title XIX of the Social Security Act of 1965. § Section 1115(a)(1) permits the Secretary of HHS to waive compliance with any of the requirements of § Section 1902, which specify state Medicaid plan requirements, to the extent and for the period necessary to carry out the waiver program. § Section 1115(a)(2) permits DHS to regard as expenditures under the state plan costs of the waiver program, which would not otherwise receive a federal match under section 1903 of the Social Security Act of 1965. These provisions allow the Secretary of HHS to waive existing program restrictions and provide expanded eligibility or services to members not otherwise covered by Medicaid. DHS requests that the Secretary of HHS waive all relevant Medicaid laws and regulations, which would allow DHS to receive federal matching funds, including the following Title XIX provisions:

A. Eligibility

DHS requests that the Secretary of HHS waive § Sections 1902(a)(10)(A) and 1902(a)(17) of the Social Security Act of 1965. These sections prohibit federal financial participation for states that implement eligibility standards in excess of the stated maximums and in manners that are not consistent with the standards prescribed by the Secretary of HHS. These sections also specify that methodologies must be applied in the same manner to all individuals in the same eligibility group. Wisconsin seeks a waiver to:

- Expand eligibility for pharmaceuticals to SeniorCare waiver program members with incomes at or below 200 percent of the FPL.
- Apply different methodologies, described above, to SeniorCare waiver program members than would be applied to elderly, blind, or disabled individuals under age 65 or to regular Medicaid members.
- Apply different standards than those prescribed by the Secretary of HHS related to eligibility determination. Eligibility will be re-determined and income will be reassessed for waiver program members once every 12 months.

B. Comparability

DHS requests that the Secretary of HHS waive § Section 1902(a)(10)(B) of the Social Security Act of 1965. This section requires the amount, duration, and scope of services to be equally available to all members within an eligibility category and be equally available to categorically eligible and medically needy members. DHS seeks a waiver of these provisions to offer a comprehensive drug benefit to the expanded population.

C. Cost Sharing

DHS requests that the Secretary of HHS waive § Section 1902(a)(14) of the Social Security Act of

1965, which relates to enrollment fees, copayments, and other cost sharing. DHS seeks a waiver to:

- Collect an annual enrollment fee of $30 per person. This cost sharing revenue will be used as state matching funds to federal financial participation for the administrative costs of the program.
- Establish that certain members in the SeniorCare waiver program would pay the first $500 of prescription drug costs prior to receiving the SeniorCare benefit and obtaining prescription drugs at the copayment levels.
- Establish copayment amounts higher than those used for the general Medicaid population.

D. Application Processing and Ex Parte Eligibility Redetermination

DHS requests that the Secretary of HHS waive § Section 1902(a)(19) of the Social Security Act of 1965 and federal regulations under 42 C.F.R. §§ 435.902, 435.907, 435.916 and 435.930. DHS seeks a waiver to:

- Require that an applicant who is no longer eligible for full-benefit Medicaid file separate SeniorCare waiver program application prior to being determined eligible for the SeniorCare waiver program.
- Require a SeniorCare waiver program member to file a separate Medicaid application if he or she is interested in receiving benefits under any other Medicaid subprogram.
- Process applications as described in Section III of this waiver application.

E. Program Integrity

DHS requests that the Secretary of HHS waive § Section 1902(a)(46) of the Social Security Act of 1965 and federal regulations under 42 C.F.R.§§ 435.920 and 435.940- 435.965 related to verification of applicant and member income and eligibility information. It is anticipated that certain income sources may have limited applicability for the SeniorCare waiver population, which generally is perceived as having fixed income. Further, because income is tested prospectively on an annual basis under the waiver program, and because data from other sources represents a prior time period; some items may not be relevant in determining eligibility for the SeniorCare waiver program. In exploring the most efficient and effective methods for ensuring program integrity, DHS intends to do the following:

- Validate Social Security numbers at the time of application through the Social Security Administration (SSA) numident process. If an individual does not have a Social Security number, the individual will receive assistance to obtain one. If there is a mismatch between the SSA information and the Social Security number provided by the applicant, the mismatch will be resolved as needed.
- Automatically test SSA benefits against tolerance levels established by DHS at application and renewal. Case situations that exceed tolerance levels will be verified and discrepancies will be resolved. In addition, periodic random samples of all cases will be reviewed to ensure that SeniorCare eligibility is based upon the correct Social Security benefit information,

regardless of whether there is a discrepancy that exceeds the threshold.

- Verify SSA benefits, earnings from wages, earnings from self-employment, other unearned income and unemployment compensation after application. A random sample of all members will be taken. If a failure to report information results in an incorrect eligibility determination, program costs will be recovered.

F. Retrospective Benefits

The Department requests that the Secretary of HHS waive § Section1902(a)(34) of the Social Security Act of 1965 and 42 C.F.R. §§ 435.915, which require a state to retrospectively provide medical assistance for three months prior to the date of application in certain circumstances. DHS requests a waiver to establish the effective date for waiver program members as the date of enrollment as determined in accordance with Section III (C) above.

G. Enrollment

DHS requests that the Secretary of HHS waive § Section 1902(a)(10) of the Social Security Act of 1965 related to entitlement of benefits. Wis. Stat. ch. 49.688 (7)(b) require that, during any period in which funding for benefit payments under the program is completely expended, all of the following must apply:

- DHS may not pay pharmacies or pharmacists for prescription drugs or over-the-counter insulin sold to program members.
- Pharmacies and pharmacists will not be required to sell drugs to eligible program members at the program payment rate.
- Eligible program members will not be entitled to obtain prescription drugs or over-the-counter insulin for the copayment amounts or at the program payment rate.
- DHS may not collect rebates from manufacturers for prescription drugs purchased by program members.
- DHS may not pay pharmacies and pharmacists for MTM services received by program members.
- DHS is required to continue to accept applications and determine eligibility for the program, and must indicate to applicants that the eligibility of program members to purchase prescription drugs under the requirements of the program is conditioned on the availability of funding.

H. Hearings and Appeals

DHS requests that the Secretary of HHS waive § Section 1902(a)(3)of the Social Security Act of 1965 and federal regulations under 42 C.F.R. §§ 431.211 and 431.213 relating to required notification by DHS for an adverse action in cases where the member has clearly indicated that he or she no longer wishes to receive services. These sections specify that the 10-day required notification prior to an adverse action does not apply in cases where the member has clearly

indicated in writing that he or she no longer wishes to receive services. Under the SeniorCare waiver program, an exception to the 10-day required notification would apply in cases where the member has clearly notified DHS either orally or in writing that he or she no longer wishes to receive services.

In addition, DHS requests that, under the authority of § Section 1115(a)(2) of the Social Security Act of 1965, expenditures for the items identified below (which are not otherwise included as expenditures under § Section 1903) be regarded as expenditures under Wisconsin's Medicaid State Plan:

- Expenditures to provide comprehensive pharmacy benefits to seniors age 65 or older whose income is at or below 200 percent of the FPL.
- Administrative expenditures for SeniorCare program members that include, but are not limited to, collecting program member fees, enrolling pharmacies, producing and distributing enrollment and identification cards to program members, responding to member inquires, developing and processing applications, determining eligibility, collecting third-party insurance information, and evaluating and monitoring this waiver.

DHS requests the right to request other waivers to implement the proposed SeniorCare waiver program, if necessary.

VI. BUDGET AND COST-EFFECTIVENESS ANALYSIS

As reported to CMS, the SeniorCare waiver achieved budget neutrality throughout the original waiver period and in all waiver extension periods.

Under this proposed SeniorCare waiver renewal, DHS projects that it will continue to reduce overall Medicaid expenditures for the senior population by providing primary care benefits for pharmacy with accompanying MTM services. As in the original waiver period, budget neutrality will be achieved by reducing the rate of increase in the use of non-pharmacy-related Medicaid services provided to this population, including hospital, nursing nursing and other related medical services. Budget neutrality will be supported by having healthier Medicaid members due to the provision of pharmacy services under SeniorCare prior to receiving full-benefit Medicaid. The savings realized by reducing the rate of increase in non-pharmacy-related Medicaid services for this population will offset the costs of continuing the SeniorCare waiver program.

This cost-effectiveness analysis is conducted by projecting Medicaid expenditures for the senior population that would have occurred without the SeniorCare waiver and comparing that to projected Medicaid expenditures for the same population with the continued

operation of SeniorCare and the cost of the waiver program under the proposed renewal. Under each analysis, the availability and impact of Medicare Part D are factored into the equation. The tables in Appendix B (Budget Neutrality) and the narrative description below present the data and assumptions used to calculate budget neutrality for the proposed 10-year waiver renewal period.

Table 1A establishes the pre-waiver historical trend (state fiscal years (SFY) 1998-2002) of Medicaid expenditures and enrollment. The data in this table is the same data used in the original waiver submission. This table also includes previous projected "without waiver" Medicaid expenditures for SFYs 2003-2009, for calendar years (CY) 2010-2012, and CYs 2013-2015 that were previously accepted by CMS. The waiver trends for these time periods were developed by applying rates approved by CMS in the original 2002 waiver submission and subsequent submissions.

Table 1B projects "without waiver" (hypothetical) Medicaid expenditures and enrollment that DHS would have experienced without the waiver for CYs 2016-2018, as well as for the new renewal period of CYs 2019-2028. In order to project CYs 2019-2028 accurately, this table makes adjustments to the "without waiver" (hypothetical) data submitted to CMS in the last waiver renewal application for CYs 2016-2018 by using actual experience for the Wisconsin Medicaid program during this period.

The adjustments to the number of Medicaid member months for CYs 2016-2018 used the actual Aged Medicaid member growth rates that occurred in that period under the waiver with an addition of 0.3 percent to reflect the assumed increase in diversions resulting from SeniorCare and Medicare Part D. It's reasonable to assume that diversion percentages will grow because both programs are relatively young. In addition, statistics show that approximately 15,000 of the 190,600 aged persons who were enrolled in SeniorCare from CY 2002 to CY 2017, are now currently full –benefit Medicaid members. Total member months diverted in CYs 2016-2028 are calculated by subtracting actual Medicaid member months (Table 2B) from the Medicaid "without waiver" member month (Table 1B).

The share of diversions due to Medicare Part D was determined using requested data from the CMS Chronic Condition Data Warehouse (CCW) which supplied data on total Aged Medicare Part D enrollees for CYs 2013-2015 and CY 2017 with a breakout for the aged that were low income subsidy enrollees. The CCW data showed that there were 635,363 aged Part D enrollees in CY 2016. Current Population Survey data was used to determine what percent of aged Medicare Part D eligibles are under 200 percent of the FPL (25.2 percent in CY 2016). This benchmark aligns with the FPL for the SeniorCare waiver population. These statistics indicated that in CY 2016 there were approximately 160,000 aged Medicare Part D enrollees below 200 percent of the FPL.

Full-benefit Medicaid members ages 65 or older with Medicare Part D (dual eligibles) were

removed using enrollment data from the Wisconsin Medicaid data warehouse which showed average monthly duals of approximately 62,000 for CY 2016. Subtracting the 62,000 aged dual enrollees from the 160,000 provides the number of Wisconsin residents ages 65 or older who are under 200 percent of the FPL, enrolled in Medicare Part D, and not enrolled in full-benefit Medicaid (97,900 in CY 2016).

Approximately 89,100 individuals chose Medicare Part D, 8,800individuals chose both SeniorCare and Medicare Part D, and 39,400 individuals chose SeniorCare. If the joint enrollees in both Medicare Part D and SeniorCare are split equally between both programs, individuals selected Medicare Part D 68.1 percent of the time, whereas SeniorCare was selected 31.9 percent of the time. Therefore, of the aged individuals below 200 percent of the FPL diverted from Medicaid, 68.1 percent can be attributed to Medicare Part D.

In order to determine the "without waiver" (hypothetical) projection, it is assumed that the per-member, per-month (PMPM) amounts for the aged population in a world without SeniorCare would be higher.

Both the waiver period of CYs 2013-2015 and the renewal period of CYs 2016-2018 used the projected PMPM from the actual and projected Medicaid member expenditures (Table 2B). This PMPM assumes savings from having healthier recipients in Medicaid due to SeniorCare participation in earlier years.

To estimate the magnitude of these savings, a comparison of current Medicaid members to SeniorCare members in previous years was made. There are approximately 15,000 Medicaid members who previously participated in SeniorCare. For these 15,000 previous SeniorCare enrollees, it was assumed the average PMPM was 10 percent lower than other aged Medicaid enrollees ages 65 and older. This amount was used as our baseline to estimate savings from diverting these costs to the Medicaid program.

Table 2A shows Medicaid expenditure trends from previous waiver submission with the SeniorCare waiver in place for the period prior to the waiver requested period. In addition to the original waiver request, which had the trend period of SFYs 1998-2002, this table shows the prior trend period for the three subsequent waiver requests that include trend data through CY 2015. This table tracks trends actual expenditures, eligible member months, and cost per eligible member for Medicaid members age 65 or older.

Table 2B shows the "with waiver" Medicaid actual member months, expenditures, and cost per member for CYs 2014-2017, the estimated CY 2018 member enrollment and costs, and projected member enrollment and costs for the waiver renewal period of CYs 2019-2028. The Medicaid costs included in this waiver request are more comprehensive than prior waiver requests because they incorporate Medicaid payments for Medicare Part A and Part B premiums. Since the PMPM for the waiver case builds off of actual or projected PMPM for the with waiver case, this has minimal impact on the budget neutrality amounts. The member month trend for the waiver

projection period of CYs 2016-2028 is slightly higher than the member growth rate for CYs 2014-2018 since the aging baby boom generation is expected to increase the population over 65 years of age. The PMPM calculation for Medicaid members includes all Medicaid expenditures tied to individual fee-for-service claims, capitation payments for an individual, and services under home and community based waivers.

Table 3A shows SeniorCare expenditure data for the previous three waiver submissions which encompasses the periods SFYs 2003-2008 and CYs 2009-2015. This table tracks trends in actual expenditures, manufacturer rebates, eligible member months, and cost per eligible member.

Table 3B shows actual SeniorCare expenditure data for the base period of CYs 2014-2017 and estimated CY 2018 member enrollment and costs, by using trends in this base period. It also projects member months and expenditures for the renewal period of CYs 2019-2028. Although the trend for member months has been declining slightly during the base period, it is assumed that enrollment will begin to grow starting in CY 2020 due to baby boomers reaching age 65. During the base period (CY's 2014-2017), PMPM spending for SeniorCare increased from 5 percent to 11 percent annually. For the waiver request period of CYs 2019-2028, it is assumed that the PMPM will increase 6 percent annually, which is only slightly higher than the assumption from Medicare 2-17 Trustee Report for Part D PMPM spending in CYs 2019 and later.

Table 4 summarizes the SeniorCare budget neutrality calculation for CYs 2014-2018 and the projected CYs 2019-2028 waiver renewal period. It compares the total projected Medicaid expenditures with waiver plus SeniorCare waiver expenditures to projected Medicaid expenditures without the waiver. The "without waiver Medicaid expenditures" projected in this table are based on the new expenditures estimated from Table 1B.

As shown in Table 4, it is projected that total Medicaid and SeniorCare costs for the aged population with the continued renewal of the SeniorCare waiver will be less than total Medicaid aged costs for this population without the waiver renewal. This expenditure offset is accomplished by:

- Reducing the rate of growth in the number of individuals who otherwise would have become Medicaid eligible during the waiver period as a result of the improved health of this population.
- Reducing the number of individuals in this population who spend down to Medicaid eligibility.
- Reducing the cost per eligible member for a subgroup of Medicaid members who entered Medicaid healthier as a result of participating in SeniorCare, which allowed lower care costs.

The federal government will also benefit from the renewal of the SeniorCare waiver because it will reduce Medicare expenditures by lowering utilization of acute care services for this population group.

Our analysis shows that not only will continuing the SeniorCare waiver be budget neutral; it will produce savings over what would have been spent without the waiver.

Budget neutrality and cost effectiveness will be reported using the Wisconsin's Decision Support System instead of the CMS 64 report. On March 1, 2013, CMS approved this method of reporting for budget neutrality for the CYs 2013-2015 waiver period. DHS will continue to use this method of reporting for the new waiver period.

VII. PUBLIC INVOLVEMENT

Wisconsin has a tradition of open and transparent government and extensive public involvement in the design, implementation, and administration of major programs. In this tradition, DHS provides information on its website for the public to access different kinds of information about the SeniorCare program: www.dhs.wisconsin.gov/seniorcare.

A page was added to the SeniorCare section of the DHS website for specific information about the waiver renewal. The draft waiver renewal application was added to the SeniorCare website on May 7, 2018, in order to allow opportunities for public comment. The waiver renewal page is located at: www.dhs.wisconsin.gov/seniorcare/input.htm.

The draft application includes historical and expected enrollment and expenditures, evaluation parameters, specific waivers requested, a minimum 30-day advance notice of public meeting dates and times, and information on providing comments.

Forums for public information and comment included the following:

- SeniorCare Advisory Committee (SAC)
- Communications with Native American tribal leaders and members
- Public hearings
- SeniorCare waiver renewal website, including online comment form
- Emails, addresses and phone numbers published for public to comment

A. SeniorCare Advisory Committee

To ensure ongoing communication and coordination with stakeholders, DHS has established the SAC. The SAC meets in open forums to advise DHS on important SeniorCare matters. The SAC met on May 14, 2018. Appendix E contains a copy of the announcement for the meeting.

In addition, the SAC will meet later this year to discuss SeniorCare.

In 2018, the SAC included representatives from:

- Senior advocacy groups (e.g., AARP)
- Benefit specialists (e.g., Wisconsin Area Agencies on Aging, and the Wisconsin Board on Aging and Long-Term Care)
- Providers (pharmacists and physicians practicing in Wisconsin)
- Community partners (e.g., county and tribal community care representatives, Pharmacy Society of Wisconsin [PSW] and the Pharmaceutical Research and Manufacturers of America, [PhRMA])
- Representatives from DHS and CMS

B. Communication and Coordination with Native Americans

The Wisconsin Medicaid program has a long-standing working relationship with tribal health directors in the state. The state has worked closely with tribal health directors on Medicaid HMO implementation, BadgerCare Plus implementation, and other initiatives to meet specific tribal health care needs. For instance, a special disenrollment procedure was developed for tribal members that involved close coordination with Indian Health Service clinics, tribal members, and the Medicaid HMO enrollment broker. A special payment system was developed so that non-HMO affiliated Indian Health Service clinics could still be reimbursed by Medicaid fee-for-service funds for services provided to tribal members enrolled in HMOs. This meant that Indian Health Service clinic funds would not be jeopardized by the expansion of the HMO program.

DHS continues to hold regular meetings with tribal members to discuss health care-related issues, including SeniorCare.

A letter to tribal health directors and tribal members was sent on April 13, 2018, offering different options for submitting comments regarding the initial draft waiver application. In addition, the SeniorCare waiver renewal request will be discussed at the May 9, 2018, tribal health director meeting to serve as tribal consultation for this waiver. The two letters are included in Appendix E. Below are details of the tribal meeting:

Tribal Health Directors Meeting
Wednesday, May 9, 2018
10 a.m. to 3:30 p.m.
Quality Inn
2901 Hummingbird Road
Wausau, WI 54401

C. Public Notices

1. NOTICES OF PUBLIC HEARINGS

As part of the waiver renewal request process, DHS will hold two public meetings. Notices (abbreviated and full) of each meeting can be found in Appendix E. The abbreviated notice was published in advance of the public meeting dates in the state's official administrative record, the Wisconsin Administrative Register, No. XX edition (see Appendix B). The full notice was posted on the DHS website prior to the start of the public comment period.

The full notice includes a comprehensive description of the SeniorCare program, including program goals and objectives, eligibility and benefits, historical and expected enrollment and expenditures, evaluation parameters, and specific waivers requested.

The public has an opportunity to call in with their comments at the public meeting on May 14, 2018. There were approximately XX people in attendance at the meetingand XX people provided comment by calling in. The Medicaid director will lead both the SeniorCare public meeting and the SAC Meeting. Following are the details of the two public meetings:

SeniorCare Public Meeting
Thursday, May 10, 2018
2-4 p.m.
Wilson Park Auditorium
Wilson Park Senior Center
2601 West Howard Avenue
Milwaukee, WI 53221

SeniorCare Advisory Committee Meeting*
Monday, May 14, 2018
9:00 am to 12:00 pm
Department of Health Services
1 West Wilson Street
Room 751
Madison, WI 53703
*Join remotely by viewing the webcast at https://livestream.com/accounts/14059632/events/8188702 or by dialing 877-820-7831 (passcode 846590)

D. SeniorCare Waiver Renewal Website

Various written materials were created to inform the public of the goals and progress of DHS in applying for a SeniorCare waiver renewal. These materials include a draft of the application,

hearing notices, copies of the presentation, and meeting agendas. They are available on the DHS SeniorCare waiver renewal webpage at: www.dhs.wisconsin.gov/seniorcare/input.htm.

There is a form on the webpage that can be used to submit comments through an online survey tool. The webpage also lists the address that the public can mail written comments to. This address was also included on meeting notices. The public comment period will close on June 7, 2018.

Appendix E will show screen shots of the webpage during the public comment period, after the comment period but before submission of the waiver renewal application, and after submission of the waiver renewal application. DHS will continue to update this site throughout the renewal process.

E. Email List

On the SeniorCare waiver renewal webpage, there is also a tool that members of the public can use to sign up for email updates on the SeniorCare waiver renewal. An email will be sent on May 7, 2018 announcing that the waiver application has been submitted. Future emails are planned announcing the beginning of the federal comment period and the approval of the waiver application.

F. Post-Award Meetings

The SAC will meet as needed in a public forum to solicit comments on the progress of the SeniorCare program. SAC meeting notices will continue to be published with the date, time, and location of the public meeting in a prominent location on the SeniorCare webpage, at least 30 days prior to the date of the planned public meeting.

In addition, the DHS SeniorCare webpage at www.dhs.wisconsin.gov/seniorcare will be updated to reflect SAC meetings.

VIII. PUBLIC COMMENTS

The Department received approximately <XX> comments via telephone, email, online survey, public hearings, and mail (see Appendix E). Comments were received from a variety of stakeholders including, pharmacists, advocates and SeniorCare program members.

A. Overall Comments

The following sample comments reflect the main themes of the overall comments received:

- **PLACEHOLDER**

B. Web Form Comments

The following sample comments reflect the main themes of the overall comments received:

- **PLACEHOLDER**

IX. CMS OVERSIGHT OF WAIVER PROGRAM QUALITY

CMS oversight of the SeniorCare waiver program is ongoing and consists of different kinds of interaction with DHS. CMS Regional Office staff have always communicated with DHS in many different ways. These interactions throughout the life of a waiver are an important aspect of CMS oversight activity.

When gathered continuously over the 10-year cycle, the observations and body of information will serve as the basis for providing CMS with relevant highlights regarding DHS management of the SeniorCare waiver program. Ongoing dialogue with CMS takes many forms, including:

- On-site, direct observation of DHS activities
- Direct communication with members, families, and advocates
- Provision of technical assistance
- Review of written documents
- Other forms of dialogue

On-site, direct observation of DHS activities provides concrete evidence that DHS is carrying out the SeniorCare waiver program, including quality management activities, as described in its approved waiver. Examples include:

- Participating in DHS oversight activities (e.g., monitoring visits DHS conducts of its service providers) and talking with DHS staff who carry out these activities.
- Observing delegated program administration functions, (e.g., talking with DHS managers about service delivery and their understanding of requirements and DHS oversight of their functions).
- Observing services being delivered and talking with providers about service delivery and their understanding of requirements.

Direct communication with members, families, and advocates provides an opportunity to hear directly about the experiences of individuals enrolled in SeniorCare, to learn about the program, to affirm the oversight role of CMS, and to provide information and respond to questions about the federal program. These interactions may occur:

- On a one-to-one basis during program visits.
- In response to complaints from members, families, providers, and other stakeholders.
- When CMS staff request the opportunity to participate in any standing meetings or events that provide an opportunity to meet with groups of members, families and advocates.

Through providing technical assistance, relationships between CMS and DHS staff develop that facilitate information sharing. CMS providing technical assistance to DHS provides valuable assistance in understanding and meeting CMS expectations and in improving quality, including:

- Phone contact.
- State agency staff visit CMS offices.
- CMS staff visit DHS.

Review of written documents**,** including:

- Reports filed by DHS as required follow-up to an inquiry, a review, or an investigation.
- Evaluation reports required by a renewal application approval.
- Standard quality management reports submitted by DHS on a voluntary basis to inform the CMS Regional Office.

Other examples of collaboration include:

- Attending and presenting at DHS-sponsored conferences or meetings including the SAC.
- Hosting education days (meetings or calls) for sharing information among states and the CMS Regional Office.
- Monthly meetings and phone calls with state Medicaid directors to discuss developments in the federal program and state issues.

It is essential that CMS and DHS staff document the ongoing dialogue to record and preserve the interactions between CMS and DHS and the outcome and decisions made as a result of the dialogue.

X. EVALUATION OBJECTIVES AND HYPOTHESES

1. Effects of SeniorCare on the market for prescription drug insurance coverage in Wisconsin.

Hypothesis 1: SeniorCare positively impacts the market for prescription drug insurance coverage for low-income seniors and promotes optimal coverage selections by seniors.

Programs that provide prescription drugs insurance coverage to low-income seniors, such as

Medicaid and Medicare Part D, often require significant administrative burden for enrollment, and lead to confusion and poor coverage decision-making by many seniors. SeniorCare provides low-income seniors with a prescription drug insurance benefit with a simple application, enrollment, and renewal process that increases the likelihood they will choose an appropriate plan that has the drug coverage that meets their needs. There are a number of potential outcomes for this hypothesis.

Market impacts:

- The number, price, and quality of Medicare Part D prescription drug plan options available to low- income seniors.
- The number or fraction of low-income seniors who choose Medicare Part D plans.
- Member satisfaction with the extent of drug coverage (i.e., coverage on the preferred drug list or drug formulary) and ease of access to participating pharmacies (i.e., access to and convenience of provider network).
- Rural members' experience in SeniorCare relative to urban members, where dipartite experience is currently reported by rural Medicare Part D members relative to urban Medicare Part D members.

Plan choice impacts:

- Member understanding of their prescription drug benefit.
- The efficiency and effectiveness of the member's plan choice by comparing coverage and use under SeniorCare compared to what it would have been under Medicare Part D for the same member.
- Member satisfaction with the application, enrollment, and renewal processes.

2. EFFECTS OF SENIORCARE ON COST-RELATED NON-ADHERENCE AND FINANCIAL BURDEN

Hypothesis 2: SeniorCare will have a positive effect on financial hardship and cost-related non-adherence.

Previous studies have shown that Medicare Part D beneficiaries experience significant levels of financial burden due to the high levels of variability in cost sharing for medications. SeniorCare offers a prescription drug insurance benefit with affordable and predictable cost sharing, reducing the out-of-pocket costs and financial hardship seniors experience affording their medications. By increasing affordability and reducing financial burden, seniors will be more likely to take their medications as prescribed and have lower rates of cost-related non-adherence.

Potential outcomes to address in this area include:

- Self-reported financial hardship (e.g., financial burden, having someone else pay, or going

without other necessities in order to fill prescriptions).
- Cost-related non-adherence (e.g., skipping or delaying prescriptions, reducing dosages).
- Adequacy of SeniorCare for meting member medication-related needs.
- Member satisfaction with SeniorCare cost sharing (e.g., annual enrollment fees, deductibles, copayments) and perceived value.

3. Effects of SeniorCare on health outcomes

Hypothesis 3: SeniorCare will have a positive effect on the health outcomes of Wisconsin seniors.

SeniorCare provides affordable drug coverage that reduces the out-of-pocket costs for prescription drugs, which can lead to improved health outcomes for Wisconsin seniors. A senior who takes his or her medications is likely to have reduced medical spending, therefore decreasing the overall health care costs. SeniorCare helps to preserve the health and quality of life of the senior population, resulting in lower utilization and expenditures for other health care services and savings to the Medicare and Medicaid programs.

Potential outcomes to address in this area include:
- Self-reported health status (e.g., overall health, physical health status, mental or emotional health status, health-related quality of life).
- Impact of MTM services on member health (e.g., impact on self-reported status, convenience and feasibility of medication regimen).
- Rates of inappropriate medication use (e.g., Beers list of drugs) compared to comparable seniors with Medicare Part D.

4. Effects of SeniorCare on Medicaid and Medicare

Hypothesis 4: SeniorCare will reduce the likelihood of Medicaid entry and provide cost savings to the Wisconsin Medicaid program.

Hypothesis 5: SeniorCare will provide cost savings to the Medicare program.

SeniorCare helps protect the finances of low-income seniors, reducing the rate at which seniors spend down to Medicaid eligibility and become entitled to Wisconsin Medicaid benefits. It also provides seniors with access to medications that help to prevent and control chronic health conditions, helping to keep seniors healthy and to avoid the use of other more costly medical services that are paid for by other public payers such as Medicaid and Medicare.

Potential outcomes to address in this area include:

- The rate at which seniors spend down to Medicaid eligibility and become entitled to Wisconsin Medicaid benefits.
- Rates and costs of Medicaid-funded nursing home admissions over time compared to comparable seniors with Medicare Part D.
- Rates and costs of Medicare-funded hospital and emergency department visits over time compared to comparable seniors with Medicare Part D.
- Rates and costs of other Medicare-funded medical services (e.g., office visits) over time compared to comparable seniors with Medicare Part D.

Appendix C provides the historical program evaluations for the SeniorCare demonstration project, which clearly show success in achieving expected outcomes for Wisconsin seniors.

DHS will continue to monitor program effectiveness and outcomes by evaluating the following demonstration questions for the renewal period:

- Does SeniorCare positively influence the market for prescription drug insurance coverage for low-income seniors and promote optimal coverage selection by seniors?
- Will SeniorCare have a positive effect on financial hardship and cost-related non-adherence?
- Will SeniorCare have a positive effect on the health outcomes of Wisconsin seniors?
- Will SeniorCare reduce the likelihood of Medicaid entry and provide cost savings to the Wisconsin Medicaid program?
- Will SeniorCare provide cost savings to the Medicare program?

These questions have been modified since they were originally approved by CMS in December 2017.

XI. External Quality Review Organization reports

Federal regulations at 42 §§ CFR Part 438, subpart E External Quality Review (EQR) equality review) set forth the parameters that states must follow when conducting an EQR of its contracted managed care organizations (MCOs). An EQR is the analysis and evaluation by an external quality review organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that an MCO furnishes to Medicaid recipients. SeniorCare is a comprehensive drug benefit that is not contracted to MCOs. The EQRO summary can be found on Appendix D.

The DHS Medicaid Quality Control section leads two federally mandated Medicaid quality control programs, the Medicaid Eligibility Quality Control program (MEQC) and the Payment Error Rate Measurement (PERM) programs. As part of the audits performed by the Quality Control section, random samples of members are selected, including SeniorCare members, for a

comprehensive eligibility review. The ACA has suspended formal MEQC and PERM requirements. Instead, states have been directed to conduct targeted pilot reviews of ACA-affected populations. SeniorCare members are not part of the ACA expansion or otherwise affected population.