STATE OF WISCONSIN DEPARTMENT
OF HEALTH SERVICES

WISCONSIN SENIORCARE

A PHARMACEUTICAL BENEFIT
FOR LOW-INCOME WISCONSIN SENIORS

1115 DEMONSTRATION PROJECT RENEWAL
REVISED FINAL APPLICATION

Original Application: June 30, 2015
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I. INTRODUCTION

The Wisconsin Department of Health Services requests a three-year renewal of its Section 1115 Demonstration Project for the SeniorCare Prescription Drug Assistance Program. The current waiver is scheduled to expire on December 31, 2015. The Department requests that the waiver be renewed for an additional three-year period, from January 1, 2016, to December 31, 2018.

Background

On July 1, 2002, the Department 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 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 $23,540 for an individual and $31,860 for a two-person family in 2015.

Since its implementation on September 1, 2002, the SeniorCare waiver program has successfully delivered a comprehensive outpatient drug benefit to more than 260,000 seniors in the state.

Advantages of SeniorCare

Simple Application and Enrollment Process

The SeniorCare application consists of a simple, one-page application form, which must be mailed to the SeniorCare central application processing center with a $30 enrollment fee. SeniorCare requires no asset test, seniors may enroll at any time without penalty. 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 re-apply 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 all legend drugs with a federal rebate agreement, as well as over-the-counter insulin. 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 with no significant gaps in coverage. All SeniorCare members pay an annual $30 enrollment fee and incur co-pays 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 (CY) 2014, total drug expenditures billed to SeniorCare were reduced from nearly $191 million to just over $27 million, which was paid for by state and federal tax dollars, manufacturer rebates and member cost sharing.

By leveraging rebates on this scale, Wisconsin has successfully held drug companies accountable for contributing to reduced drug prices and the creation of 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 8,819 intervention-based services and 668 Comprehensive Medication Review and Assessment (CMR/A) services since September 2012. A reduction in inappropriate medication use and an increase in medication adherence can ensure seniors stay healthier and reduce any inappropriate medical expenditure.

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

The Department 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 facility and other medical services. These savings will offset the costs of continuing the SeniorCare waiver program. Reductions in expenditures will also be
realized by the Medicare Program through reduced hospitalizations for this population group.

The SeniorCare waiver has 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 $130 million for State Fiscal Year (SFY) 2014.

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 SFY 2014, SeniorCare reduced drug costs for Wisconsin seniors by approximately $191 million.

**Keeps Seniors Healthier, Longer, and Reduces Medicaid Costs**

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

**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 result 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 health care costs in the aggregate.
B. Current Medicaid Eligibility for Elderly, Blind or Disabled

1. Supplemental Security Income (SSI)

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, the federally mandated coverage group is individuals who qualify for and receive the federal SSI payment. Wisconsin has chosen to cover the additional optional groups of persons who receive a state-only supplemental payment, as well as individuals 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 as a result of employment earnings, but who still have the condition that rendered them disabled (and meet all non-disability criteria for SSI except income). Also covered are individuals who were once eligible for both SSI and Social Security payments but who lost their SSI because of certain cost-of-living adjustments to their Social Security. Similar Medicaid continuations are provided for certain 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 also offers Medicaid coverage to medically needy elderly, blind or disabled individuals. By federal law, the associated income standards 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 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 nursing home residents 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 greater 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 gainful employment 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 Beneficiaries (QMBs):** These are individuals entitled to Medicare hospital insurance benefits (i.e., Medicare Part A) whose income does not exceed 100 percent of the FPL and whose resources do not exceed twice the SSI resource limit. For these individuals, Medicaid reimburses 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 Beneficiaries (SLMBs):** Medicaid pays the full Medicare Part B premium for individuals who otherwise meet the QMB requirements but have income between 100 percent and 120 percent of the FPL.
- **Qualifying Individuals I (QIs I):** Medicaid pays the full Medicare Part B premium for individuals who are not eligible for full-benefit Medicaid, who otherwise meet the QMB/SLMB requirements and who have income between 120 percent and 135 percent of the FPL.
- **Qualified Disabled and Working Individuals (QDWIs):** 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, have income at or below 200 percent of the FPL and have assets up to twice the SSI resource limits (and who are not otherwise Medicaid eligible).

C. Overview of SeniorCare; Demonstration Project Renewal Program

In response to the critical need for prescription drug coverage for the elderly, Wisconsin, as part of 2001 Wisconsin Act 16, established a prescription drug assistance program titled SeniorCare. SeniorCare statutes require the Department to submit to the U.S. Department of Health and Human Services a request that SeniorCare be covered under a Medicaid 1115 Demonstration Project, which was granted in 2002.

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, including application processing, claims processing, federal reporting, and safeguards for fraud and abuse.

The successful and popular SeniorCare program historically has received strong support from the Wisconsin Legislature, which has fully funded SeniorCare since its inception in 2002. These state funds cover for approximately 22 percent of the SeniorCare program. Wisconsin is currently in the middle of the SFY 2016-2018 biennial budget deliberations. Once the budget is finalized, the Department will assess the impact of any required changes to the SeniorCare program as a result of the budget and will work with CMS as appropriate.

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 260,000 seniors in the state. As of April 2015, 87,700 seniors were enrolled in SeniorCare. More than 49,000 of these seniors are enrolled in the waiver portion of the program (for those at or below 200 percent of the FPL).

The Department which administers the state's Medicaid program also administers 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, even with the availability of
Medicare Part D:
- Help to preserve the health of the senior population by providing financial support for costly but essential drugs, thereby providing more affordable and comprehensive primary health care services.
- Improve the quality of life of Wisconsin's seniors, thus allowing them to remain in less costly home and community settings while avoiding expensive acute or long-term care services resulting from a lack of access to necessary drugs.
- Reduce the rate at which seniors spend down to Medicaid eligibility and become entitled to all benefits available under the Medicaid program.
- Save the federal government money by improving the health of seniors, resulting in savings to the Medicare program.
- 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 55 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 legend drugs and over-the-counter insulin as currently provided under the Wisconsin Medicaid State Plan. Those seniors with prescription drug coverage under other plans are also eligible to enroll, with SeniorCare covering eligible costs not covered under 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 and 200 percent of the FPL are also responsible for the first $500 of prescription drug costs each year at the SeniorCare rate.

The simple, one-page application form requests the applicant's name, age, Social Security number, income, residence, spouse's name and other limited information needed to determine his or her eligibility. The form is easy to read and complete. Seniors submit applications by mail to a central processing center administered by the Department.

Applicants receive notices about their eligibility, whether they have an annual payment, and other information regarding their participation in the program. Upon enrollment in SeniorCare, members receive an identification card distinct from the normal ForwardHealth card, which they use when purchasing prescription drugs. Members may to begin participation in the program on the first day of the month following the month in which all eligibility criteria are met. Once determined eligible for the SeniorCare program, an individual may remain eligible
for 12 months from the date of initial enrollment, regardless of changes in income.

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 (STAT-PA), prospective and retrospective Drug Utilization Review (DUR), and other cost containment processes. The system enables Medicaid-enrolled providers to submit real-time 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 members' deductibles and copayments, again with the information 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 or other economic support programs. A SeniorCare customer service hotline, which began operations 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 eligibility and enrollment functions. The Department leverages existing system capacity to meet the program needs in the most efficient way.

II. SENIORCARE OBJECTIVES

The program objectives below are found in the 2013 Special Terms and Conditions. SeniorCare will continue to pursue these objectives for the new waiver renewal period.

1) *Keeping Wisconsin seniors healthy by continuing to provide a necessary primary health care benefit.*

SeniorCare helps seniors afford their medications so they will keep taking them. A senior who is taking his or her medication is likely to be healthier because of it.

2) *Helping control overall costs for the senior Medicaid population by preventing seniors from becoming eligible for full Medicaid due to deteriorating health and having to “spend down” to Medicaid eligibility levels.*
When seniors stay healthy, there are savings for the Medicaid and Medicare programs which is evidenced in our budget neutrality calculations. Studies have found that spending on pharmaceutical coverage is associated with a significant reduction in hospital, nursing home and emergency room expenditures. A senior who takes his or her medications is less likely to have hospital and nursing home admissions and other long-term care situations, therefore decreasing overall health care costs.

3) Reducing the rate of increase in the use of non-pharmacy-related services provided to this population including hospital, nursing facility and other related medical services.

Extending pharmacy benefits to the senior population will result in a reduction to the use of inappropriate non-pharmacy-related services in population.

III. DEMONSTRATION PROJECT RENEWAL PROGRAM DESIGN

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

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. Certain groups, such as pregnant women or the elderly, are considered categorically eligible if they also meet income criteria based on the FPL. Individuals considered medically needy eligible are those who would be categorically needy except for their slightly higher income, but who cannot afford to pay their medical bills. To be eligible for prescription drug services under the SeniorCare waiver program, individuals must:

1. Be a Wisconsin resident;
2. Be a U.S. citizen or have qualifying immigrant status;
3. Not be a recipient of Medicaid, other than as a low-income Medicare beneficiary (QMB, SLMB, QI-1 or QDWI);
4. Be age 65 or older;
5. Have household income at or below 200 percent of the FPL; and
6. 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 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
Elderly, Blind or Disabled (EBD) Medicaid deductions and other deductions are not applied.

- In cases of self-employment income, current policy for elderly, EBD Medicaid is followed. Therefore, deductions for business expenses, losses and depreciation are permitted for individuals with self-employment income.
- Income is determined on a prospective basis, annually.
- A fiscal test group that is consistent with current EBD Medicaid policy is used. Thus, individual income is used for a married person not living with his or her spouse, and joint income is used for a married person living with his or her 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 his or her 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 regular mail or online.
- The application is processed by a central unit administered by the Department.
- Near the end of the individual's year of eligibility, the Department notifies him or her of the need for an annual re-determination of his or her eligibility. The Department provides the individual with a pre-printed renewal form containing some of the information provided in the previous year. To continue coverage, the form must be filed in a timely manner and receive approval. The individual must also pay the annual enrollment fee.
- Upon 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.

This enrollment process focuses primarily on eligibility for the SeniorCare waiver program. In addition, seniors are advised to complete a full Medicaid application if they are applying for benefits other than prescription drugs.

C. Enrollment Periods

Enrollment periods for eligible members 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 becomes deceased, he or she is no longer eligible for the SeniorCare waiver program.
• Members 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 participation in the program on the first day of the month following the month in which all eligibility criteria are met.

• Eligibility for benefits is prospective only. There is no retroactive eligibility.

D. Coordination of Benefits

The SeniorCare waiver program extends coverage only to legend (prescription) drugs and to over-the-counter insulin; these are drugs that are currently covered by the Wisconsin Medicaid State Plan. Coordination of benefits is applied in a manner similar to the Medicaid program. The SeniorCare waiver program uses a combination of automated, pre-payment cost avoidance with 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 and/or Medicare, the pharmacist is required to submit claims to other payers. SeniorCare is the payer of last resort for these services.

E. Cost Sharing

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

1. Annual Enrollment Fees

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

2. Annual Costs for Certain SeniorCare Members

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

- SeniorCare members with income between 160 percent and 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 choose MTM services when filling their prescriptions and their income is between 160 percent and 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 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**

The following are stipulations regarding coordination between the Medicaid program and the SeniorCare waiver program:

- SeniorCare members whose income decreases to allowable Medicaid eligibility levels and who want to receive full Medicaid benefits must apply for and be determined eligible for full-benefit Medicaid through the normal Medicaid application process.
- Except during the 30-day initial processing period, the enrollment fee is not refundable to SeniorCare members who, during their 12-month benefit period, become eligible for full Medicaid benefits. However, 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 the 12-month period without having to pay another $30 fee.
- SeniorCare members who are terminated from the SeniorCare waiver program or who fail to re-enroll will not be reviewed for eligibility for other Medicaid programs prior to termination.
G. Benefits

1. Pharmacy Benefits

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

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

- The drug is Food and Drug Administration (FDA)-approved;
- The manufacturer signed a rebate agreement with CMS; and
- 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. However, like Wisconsin Medicaid, which covers certain over-the-counter drugs, SeniorCare extends coverage to over-the-counter insulin.

2. Medication Therapy Management Benefits

Effective September 1, 2012, the Department implemented a comprehensive MTM benefit, which is part of a national trend in health care.

This benefit includes intervention-based Services, during which the pharmacist assists the member in managing their prescription medications. Intervention-based services include:

- Consulting with the member regarding a significant lack of adherence;
- Therapeutic interchange;
- Recommending a change to the member’s dose based on clinical guidelines;
- Instructing the member on using a medication device (e.g., inhaler, syringe); and
- Recommending the addition or deletion of a medication.

For each kind of intervention, there is a limit of four interventions per year, except for interventions that result in immediate cost savings to the program; these services do not have an annual service limit.

MTM also includes CMR/As that allow 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 this 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

SeniorCare follows the CMS-approved ingredient rate methodology found here: https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20home/tabid/77/Default.aspx. Any changes to prescription ingredient and/or dispensing fee methodologies for Wisconsin Medicaid benefits will be automatically applied to SeniorCare.

I. Cost Management Strategies

To further enhance the primary health care benefits and the cost-effectiveness of the SeniorCare waiver program, the Department 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 Point-of-Sale

Wisconsin Medicaid maintains a pharmacy POS electronic claims management system for Medicaid fee-for-service. The POS system enables providers to submit real-time claims electronically for legend 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 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 screen provides the pharmacist with information regarding potential contraindications for the member by activating alerts that identify the following problems, 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.
- Pregnancy alert:
  The alert is activated when the prescribed drug is contraindicated in pregnancy.
- 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, the Department performs retrospective DUR. During the DUR, drug claims are reviewed against DUR Board-approved criteria and member profiles are generated; these profiles are individually reviewed by pharmacists for clinical significance. Each month, for 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 with members who may be potentially impacted by the concern.

4. State Maximum Allowed Cost List

Under Wisconsin's State Medicaid Plan approved by the Center for Medicare and Medicaid Services (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 legend or OTC drugs), regardless of manufacturer.
Wisconsin Medicaid issues its SMAC list monthly and has one of the most extensive SMAC lists in the country. SeniorCare will also use the Wisconsin Medicaid SMAC list. If a product is available generically Wisconsin Medicaid generally adds it to the state's SMAC list. Maximum prices allowed are based on prices for which drugs are readily available through wholesalers in Wisconsin.

When a drug is on the SMAC list, Wisconsin will reimburse the generic price unless the prescriber writes brand medically necessary on the prescription and obtains a prior authorization for the brand name drug. This policy encourages utilization of lower cost therapeutically equivalent generic drugs.

5. Medication Therapy Management

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

For intervention-based services, the professional fee reimburses pharmacists for additional actions they take beyond the required dispensing and counseling for a prescription drug.

In order to be reimbursed, pharmacists must meet all basic requirements of federal and state law for dispensing a drug and must complete specified activities that result in a positive outcome both for the member and the Medicaid program. Positive outcomes include increased patient compliance and prevention of potential adverse drug reactions.

MTM also includes CMR/As that 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 PA for certain drugs in order to receive reimbursement for those drugs. PA requests may be submitted electronically for most drugs requiring PA. The Department requires PA for certain drug for the following reasons:

- To prevent potential drug abuse or misuse.
- To monitor use of drugs for cosmetic reasons only (for example, weight loss drugs not used to treat morbid obesity).
- To 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 brand name only brand. 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

Effective October 1, 2004, the Department 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 PA Advisory Committee, which is composed of physicians, pharmacists, advocates, and consumers from the state of Wisconsin.

To determine drugs to be included on the PDL, the PA Advisory Committee reviews research and clinical information prepared by clinical pharmacists. 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 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 and limits on MTM services and opioid prescriptions.
IV. DEMONSTRATION PROJECT RENEWAL PROGRAM ADMINISTRATION

A. Administering Agency

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

B. Financing

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

C. Provider Network

The SeniorCare waiver program provides access to a robust network of pharmacies. There are currently 1,300 in-state pharmacies and another 100 out-of-state pharmacies that are Medicaid-enrolled providers. SeniorCare administrative code requires Medicaid-enrolled pharmacies to serve SeniorCare members.

D. Implementation Schedule

The SeniorCare program is a successful waiver program that determines eligibility and provides outpatient drug benefits to an average of 50,000 seniors per month. The current three-year waiver is set to expire December 31, 2015. With this renewal, the SeniorCare waiver would continue beginning January 1, 2016, through December 31, 2018.

E. EarlyTermination 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. Section 1115(a)(1) of the Social Security Act permits the Secretary of the Department of Health and Human Services (the Secretary) to waive compliance with any of the requirements of Section 1902 of the Social Security Act, 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 the Department 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. These provisions allow the Secretary to waive existing program restrictions and provide expanded eligibility and/or services to members not otherwise covered by Medicaid. The Department requests that the Secretary waive all relevant Medicaid laws and regulations, which would allow the Department to receive federal matching funds, including the following Title XIX provisions:

A. Eligibility

The Department requests that the Secretary waive Sections 1902(a)(10)(A) and 1902(a)(17) of the Social Security Act. These sections prohibit federal financial participation for states that implement eligibility standards in excess of the stated maximums and in manners not consistent with the standards prescribed by the Secretary. 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 member and;
- Apply different standards than those prescribed by the Secretary related to eligibility determination. Eligibility will be re-determined and income will be reassessed for waiver program members once every 12 months.

B. Comparability

The Department requests that the Secretary waive Section 1902(a)(10)(B) of the Social Security Act. 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. The Department seeks a waiver of these provisions to offer a comprehensive drug benefit to the expanded population.

C. Cost Sharing
The Department requests that the Secretary waive Section 1902(a)(14) of the Social Security Act, which relates to enrollment fees, copayments and other cost sharing. The Department 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 benefit of obtaining prescription drugs at the copayment levels; and
- Establish copayment amounts higher than those used for the general Medicaid population.

D. Application Processing and Ex Parte Eligibility Redetermination

The Department requests that the Secretary waive section 1902(a)(19) of the Social Security Act and federal regulations under 42 CFR 435.902, 435.907, 435.916 and 435.930. The Department seeks a waiver to:

- Require that an applicant who is no longer eligible for regular 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; and
- Process applications as described in Section III of this waiver application.

E. Program Integrity

The Department requests that the Secretary waive Section 1902(a)(46) of the Social Security Act and federal regulations under 42 CFR 435.920 and 435.940 through 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, the Department 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 the Department at
application and review. Case situations that exceed tolerance levels will be verified and discrepancies will be resolved. In addition, periodic random samples of all cases will be conducted 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.

- In addition, SSA benefits, earnings from wages, earnings from self-employment, other unearned income and unemployment compensation will be verified after application. In particular, 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 waive Section1902(a)(34) of the Social Security Act and 42 CFR 435.915, which require a state to retrospectively provide medical assistance for three months prior to the date of application in certain circumstances. The Department 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**

The Department requests that the Secretary waive Section 1902(a)(10) of the Social Security Act related to entitlement of benefits. Wisconsin statutes require that, during any period in which funding for benefit payments under the program is completely expended, all of the following must apply:

- The Department 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;
- The Department may not collect rebates from manufacturers for prescription drugs purchased by program members;
- The Department may not pay pharmacies and pharmacists for MTM services received by program members; and
- The Department 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

The Department requests that the Secretary waive Section 1902(a)(3) of the Social Security Act and federal regulations under 42 CFR 431.211 and 431.213 relating to required notification by the Department 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 the Department either orally or in writing that he or she no longer wishes to receive services.

In addition, the Department requests that, under the authority of Section 1115(a)(2) of the Social Security Act, 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 include, but are not limited to, collecting program members' fees, enrolling pharmacies, producing and distributing enrollment/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.

The Department 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, the Department 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 facility and other related medical services. 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 the SeniorCare waiver program and the cost of the waiver program under the proposed renewal. Under both tests, the availability and impact of Medicare Part D is factored into the equation. The tables in Attachment A (Budget Neutrality) and the narrative description below present the data and assumptions used to calculate budget neutrality for the proposed three-year waiver renewal period.

**Table 1A** establishes the pre-waiver historical trend (SFYs 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 and for CYs 2010-2012 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” Medicaid expenditures and enrollment for CYs 2013-2015, as well as for the new renewal period of CYs 2016-2018. In order to project CYs 2016-2018 accurately, this table makes adjustments to the "without waiver" data submitted to CMS in the last waiver renewal application for CYs 2013-2015 by using actual experience for the Wisconsin Medicaid Program during this period.

The adjustments to the number of Medicaid member months for CYs 2013-2015 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 14 percent of our SeniorCare members have been enrolled since the beginning of the program, meaning they have not yet diverted to Medicaid.

Total Member Months diverted in CYs 2013-2018 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 the August 2014 Kaiser Family Foundation report titled “Medicare in Its Ninth Year.” Statistics show that 672,797 Wisconsin residents were enrolled in Medicare Part D. Current Population Survey data was used to determine what percent of Medicare Part D eligibles are under 200 percent of the federal poverty level (FPL). This benchmark aligns with the FPL for the SeniorCare waiver population.

Medicaid members with Medicare Part D (dual eligibles) were removed using the average
monthly Medicare clawback payment statistics. This identifies the number of residents in Wisconsin who are under 200 percent of the FPL and not enrolled in Medicaid.

Because SeniorCare only serves the aged population, whereas Medicare Part D serves both the aged and disabled populations, it is necessary to determine what percent of the 34,540 Medicare Part D enrollees under 200 percent of the FPL are aged. CMS Medicare reports were used to determine that approximately 83.2 percent are aged.

Approximately 20,000 individuals chose Medicare Part D, 9,000 individuals chose both SeniorCare and Medicare Part D, and 42,000 individuals chose SeniorCare. Using these statistics, individuals selected Medicare Part D 34.18 percent of the time, whereas SeniorCare was selected 65.82 percent of the time. Diversion rates for SeniorCare and Medicare Part D are equally attributed to both programs at 50 percent each.

Therefore, of the aged individuals below 200 percent of the FPL diverted from Medicaid, 34.18 percent can be attributed to Medicare Part D.

In order to determine the “without waiver” 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/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 10,000 Medicaid members who previously participated in SeniorCare. The difference in monthly PMPM for a member in Medicaid and a nursing home is approximately $800 higher. This amount was used as our baseline to estimate savings from diverting these costs to the Medicaid program.

Table 2A shows Medicaid expenditure trends with the SeniorCare waiver in place for SFYs 2002-2007 and CYs 2008-2011. This table tracks trends in 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 2013-2014, the estimated CY 2015 member enrollment and costs, and projected member enrollment and costs for the waiver renewal period of CYs 2016-2018. The member month historical trend has been modified to show a higher member growth rate for CYs 2016-2018 when compared to CYs 2011-2014. The Wisconsin Department of Administration’s projected growth rate for the over-65 population is 23 percent higher for CYs 2015-2020 when compared to CYs 2010-2015.

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. The PMPM trend, which includes Long-Term Care and Family Care, was modified significantly from the base period of CYs 2013-2015 in order to revise an unusually low average annual rate from CYs 2012 -2015.

**Table 3A** shows SeniorCare expenditure data for SFYs 2003-2008 and CYs 2009-2011. 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 2012-2014, and estimated CY 2015 member enrollment and costs, by using trends in this base period; it projects member months and expenditures for the renewal period of CYs 2016-2018. The trend for member months has been changing over recent years with a decline in SeniorCare enrollment from 7.8 percent in CY 2013 to an estimated 1 percent in CY 2015. As a result of recent growth in the “non-waiver” SeniorCare population (200 percent to 240 percent of the FPL) and higher projected growth of the aged population in Wisconsin, it has been assumed that SeniorCare enrollment will grow in CY 2017 and CY 2018.

There has also been a significant change in utilization trends. Although the cost per member declined in years prior to CY 2014, it increased by 11.8 percent in CY 2014 and continues to increase in CY 2015 by a similar rate. As a result, it is assumed that the cost per member will increase by 10 percent annually in CYs 2016-2018. A 10 percent increase seems to be a reasonable assumption based on current industry experience. Finally, Medicare increased its clawback payments from 3 percent to 11 percent to reflect drug expense increases, which also support this assumption.

**Table 4** summarizes the SeniorCare budget neutrality calculation for CYs 2013-2015 and the projected CYs 2016-2018 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, and
- 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 long-term care costs through home and community-based waiver versus nursing home care.

In addition, the federal government will 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.

Ongoing, budget neutrality and cost effectiveness will be reported using the Wisconsin’s Decision Support System (DSS) 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. The Department will continue to use this method of reporting for the new waiver period.

VII. PUBLIC INVOLVEMENT

Wisconsin has a tradition of open government and extensive public involvement in the design, implementation and administration of major programs. In this tradition, the Department provides a general website for the public to access different kinds of information about the SeniorCare program: [www.dhs.wisconsin.gov/seniorcare](http://www.dhs.wisconsin.gov/seniorcare).

A section was added to the general SeniorCare website for specific information about the waiver renewal. The draft waiver renewal application was added to the renewal website in order to allow opportunities for public comment. The waiver renewal page is located at: [www.dhs.wisconsin.gov/seniorcare/input/.htm](http://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; and
- Addresses and phone numbers published for public to comment.

A. SeniorCare Advisory Committee

To ensure ongoing communication and coordination with stakeholders, the Department has
established the SAC. The SAC meets in open forums to advise the Department on important SeniorCare matters. The SAC met on May 11, 2015. Attachment B contains a copy of the announcement for the meeting.

In addition, the SAC will meet in August 2015 to review and/or discuss comments related to the waiver.

In 2015, 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]); and
- Representatives from the Department and CMS.

B. Communication/Coordination with Native Americans

Wisconsin 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, of BadgerCare Plus, and issues 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.

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

A letter to tribal leaders and tribal members was sent on April 30, 2015, offering different options for submitting comments regarding the initial draft waiver application. In addition, the SeniorCare waiver renewal request was discussed at the May 6, 2015, tribal consultation meeting. The two letters are included in Attachment C. Following are details of the tribal meeting:

Tribal Health Directors Meeting
Wednesday, May 6, 2015
C. Public Notices

1. Notices of Public Hearings

As part of the waiver renewal request process, the Department held two public meetings. Notices of each meeting can be found in Attachment B. These notices were published in advance of the dates.

The hearing notices were published in the state’s official administrative record, the Wisconsin Administrative Register, No. 711A2 edition (see Attachment B). These notices included 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. This information was also posted on the Department’s website.

The public was able to call in with their comments at the meeting on May 11, 2015. There were approximately 25 people in attendance at the meeting. The Medicaid director led the SAC Meeting and the SeniorCare public meeting. Following are the details of the two public meetings:

SeniorCare Advisory Committee Meeting
Monday, May 11, 2015
10:00 am to 12:00 pm
Department of Health Services
1 West Wilson Street
Room 751
Madison, WI 53703

SeniorCare Public Meeting
Tuesday, May 12, 2015
10:00 am to 12:00 pm
Wilson Park Auditorium
Wilson Park Senior Center
2601 West Howard Avenue
Milwaukee, WI 53221
D. SeniorCare Waiver Renewal Website

Various written materials were created to inform the public of the Department’s progress and goals in applying for a SeniorCare waiver renewal. These materials include a draft of the application, hearing notices, presentations and media announcements. They are available on the Department’s SeniorCare waiver renewal website at: www.dhs.wisconsin.gov/seniorcare.

On this website, there was a form that could be used to submit comments through an online survey tool. The website also gave an address to which comments could be mailed (this address was also included on meeting notices). The comment period closed on Monday, June 22, 2015.

Attachment D shows screen shots of the website 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. We will continue to update this site throughout the renewal process.

E. Email List

On the SeniorCare waiver renewal website, 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 in July 2015 announcing that the waiver application has been submitted and providing a copy of a press release announcing the submission. Future emails are planned announcing the beginning of the federal comment period and the approval of the waiver application.

F. Post-Award Meetings

As outlined in the original SeniorCare waiver application, the SAC will meet annually in a public forum to solicit comments on the progress of the SeniorCare program. We will continue to hold this public forum at a time that will allow us to include a summary of the forum in our annual report to CMS. SAC meeting notices will continue to be published with the date, time, and location of the public forum in a prominent location on our public website, at least 30 days prior to the date of the planned public forum.

In addition, the Department’s SeniorCare website at www.dhs.wisconsin.gov/seniorcare will continue to be updated to reflect SAC meetings.

VIII. PUBLIC COMMENTS

The Department received approximately 394 comments via telephone, email, Web form,
The following sample comments reflect the main themes of the overall comments received:

- “We love SeniorCare. This program works. Please leave it alone.”
- “I am a Wisconsin resident, formerly from Illinois. Illinois has nothing like this for seniors, turns out it’s the only in Wisconsin. [This] is something [the] officials can be proud of and brag about.”
- “If SeniorCare goes away or is changed, it could place a financial hardship on many seniors that depend on this program. Please leave it alone!”

B. Web Form Comments

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

- “Please support keeping SeniorCare as is. This is a fantastic RX program that is as good as if not better than Part D. Creditable coverage at an affordable cost for those 65 and older. Support this program that works.”
- “The need to preserve SeniorCare in its present state is critical for the elderly that are currently in their 70’s, 80’s and 90’s. Once the baby boomers turn 65, the majority will have higher Social Security income and will probably not be eligible for level 1 or even level 2 of SeniorCare. But for the current elderly population it is critical for them to continue to be able to enroll in SeniorCare for future years. Thank you for your time.”
- “WI SeniorCare program is an important program for seniors and is cost effective for both the senior and the state. Please reapply for another three year federal waiver extension.”

IX. CMS OVERSIGHT OF WAIVER PROGRAM QUALITY

CMS oversight of the SeniorCare waiver program is an ongoing activity that consists of different kinds of interaction with the Departments. Ongoing dialogue is not new. CMS Regional Office staff have always communicated with the Department in many different ways. These interactions throughout the life of a waiver are an important aspect of CMS over-sight activity.

Information accumulated though ongoing dialogue with the Department adds to the body of information formally obtained through the quarterly and annual reports, Department responses to CMS requests for information, complaints to CMS and
Department follow-up, CMS technical assistance and training, etc.

When gathered continuously over the three-to-five year cycle, the observations and body of information will serve as the basis for providing the Department with a CMS report on the Department’s management of the SeniorCare waiver program. CMS ongoing dialogue takes many forms, including:

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

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

- Participating in Department oversight activities (e.g., monitoring visits the Department conducts of its service providers); talking with Department staff who carry out this activity;
- Observing delegated program administration functions, (e.g., talking with Department managers about service delivery and their understanding of requirements and the Department’s oversight of their functions; and
- 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 in the system, to learn about the program, to affirm CMS's oversight role 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; and/or
- CMS staff may request of states the opportunity to participate in any standing meetings or events that provide an opportunity to meet with groups of members, families and advocates.

Through the provision of technical assistance, relationships between CMS and Department staff develop that facilitate information sharing. Technical assistance to the Department provides valuable assistance in understanding and meeting CMS expectations and in improving quality. Examples include:

- Phone contact;
• State agency staff visit CMS offices; and
• CMS staff visit the Department.

Review of written documents, including:
• Reports filed by the Department as required follow-up to an inquiry, a review or an investigation;
• Evaluation reports required by a renewal application approval; and
• Standard quality management reports submitted by the Department on a voluntary basis to inform the CMS Regional Office.

Other/General Dialogue
• Attending and presenting at Department-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/phone calls with state Medicaid directors to discuss developments in the federal program and state issues; and

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

X. EVALUATION ACTIVITIES AND FINDINGS

A. Quality Measures

The following are the indicators of the quality and accessibility of the SeniorCare waiver program that the Department has observed through program monitoring activities.

1. Overall Support for SeniorCare

The overwhelming outpouring of support for the SeniorCare Program is evidence that it is perceived by the public as being a high-quality program that provides essential benefits to Wisconsin seniors.

2. High Renewal Rates

Another measure of program quality is the rate at which people whose benefit year expires renew for another 12-month benefit period.
SeniorCare waiver and non-waiver program renewal rates are high and member problems and appeals are low. On average 81 percent of individuals who received a renewal notice returned their renewal in order to extend their benefit period for another 12 months.

**CY 2014 SeniorCare Waiver Applications and Renewals**

<table>
<thead>
<tr>
<th></th>
<th>New Applications</th>
<th>Renewals Due</th>
<th>Renewals Received</th>
<th>Renewal Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>1,108</td>
<td>4,907</td>
<td>3,252</td>
<td>66%</td>
</tr>
<tr>
<td>February</td>
<td>978</td>
<td>5,064</td>
<td>3,572</td>
<td>71%</td>
</tr>
<tr>
<td>March</td>
<td>1,066</td>
<td>4,586</td>
<td>3,921</td>
<td>85%</td>
</tr>
<tr>
<td>April</td>
<td>895</td>
<td>4,588</td>
<td>3,852</td>
<td>83%</td>
</tr>
<tr>
<td>May</td>
<td>981</td>
<td>5,015</td>
<td>4,363</td>
<td>86%</td>
</tr>
<tr>
<td>June</td>
<td>798</td>
<td>3,528</td>
<td>2,980</td>
<td>84%</td>
</tr>
<tr>
<td>July</td>
<td>924</td>
<td>3,827</td>
<td>2,684</td>
<td>82%</td>
</tr>
<tr>
<td>August</td>
<td>974</td>
<td>10,079</td>
<td>8,911</td>
<td>88%</td>
</tr>
<tr>
<td>September</td>
<td>855</td>
<td>5,046</td>
<td>3,762</td>
<td>74%</td>
</tr>
<tr>
<td>October</td>
<td>1,506</td>
<td>5,809</td>
<td>4,896</td>
<td>84%</td>
</tr>
<tr>
<td>November</td>
<td>2,553</td>
<td>8,429</td>
<td>7,041</td>
<td>83%</td>
</tr>
<tr>
<td>December</td>
<td>3,160</td>
<td>11,620</td>
<td>10,053</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15,798</strong></td>
<td><strong>72,498</strong></td>
<td><strong>59,287</strong></td>
<td><strong>81%</strong></td>
</tr>
</tbody>
</table>

In other words, of the 72,498 members eligible for the SeniorCare waiver program during CY 2014, 59,287 (81 percent) applied for renewal and were found to be eligible in 2014. The rest either didn’t apply or applied and were found ineligible for the program.

**2014 Member Renewal Rates**
3. Low Call Volume from Members with Questions

Not only are renewal rates high, but calls from members with questions are low. The SeniorCare Member Service Hotline is staffed with six full-time equivalent (FTE) staff. The majority of calls received by the hotline can be classified into three categories:

- Non-members who have general inquiries about the program;
- Members who want to report a change or have specific questions about benefits; and
- Non-members’ requesting applications.

The following chart shows that for all months, general inquiries are most frequent. Calls from members who have questions about their benefits are of medium frequency in relation to other calls, which is likely, a reflection of the fact that the program is deliberately kept simple.

4. Drug Utilization Review Improves Quality

Earlier in this waiver application is a discussion of the use of the DUR as a cost-saving strategy. Not only does this activity help control costs, but it also contributes to the quality of care delivered under the SeniorCare program.

Prospective DUR occurs at the POS. The Medicaid POS system screens certain drug therapy problems before the prescription is dispensed to the member. The screen provides the pharmacist with information regarding potential contra-indications by activating alerts that identify problems.

On a monthly basis, the Department performs retrospective DUR review. The review of drug
claims against DUR Board-approved criteria generates patient profiles that are individually reviewed for clinical significance. If a potential drug problem is discovered, intervention letters are sent to all providers with members who may be potentially impacted by the concern.

5. **Advisory Committees Help Ensure Quality**

As was already mentioned, the SeniorCare program has its own advisory committee. In addition to that committee, the Department has other committees that advise on topics such as mental health and drugs to include on the PDL. The participation of these groups is essential to improving and maintaining the high quality of care the SeniorCare program has always provided.

6. **Qualitative Review Reveals High Satisfaction**

The Department contracted with Dr. Donald Shepard and Dr. Cindy Thomas of Brandeis University to complete an evaluation of the most recent SeniorCare waiver period of CYs 2010-2012. The researchers completed interviews with approximately 15 individuals. Preliminary reports from the researchers show that the SeniorCare program is an overwhelmingly effective and well-administered program.

In addition to the evaluation, Department staff met with individuals around the state who reported being very satisfied with the program.

**B. Quantitative Measures**

1. **Previous External Evaluation**

Dr. Donald Shepard and Dr. Cindy Thomas also completed a quantitative evaluation of the most recent SeniorCare waiver period of CYs 2010-2012. The Department provided the data for the evaluation. Their analysis of the data showed the following:

- SeniorCare remains a very popular program in Wisconsin.
- The waiver program had a relatively stable enrollment of between 75,000 and 77,000 from 2008 to 2011 (slightly declining in 2011), with a consistent distribution by income and gender over these years.
- SeniorCare is increasingly being used as a wrap-around for Medicare Part D.
- While a considerable number of new members enroll each year, most members have been in the program for three or more years, and about 75 percent re-enroll from one year to the next. This is a favorable retention rate, considering the opt-in design of the plan.
- Between 2002 and 2005, the proportion of Wisconsin seniors without drug coverage (prior to Medicare Part D) decreased by 37 percent for individuals with income less than 100 percent of the FPL and 25 percent for those between 100 percent and 200 percent of the FPL.
- Program spending in total and per member has decreased in the years 2008 through 2012,
including lower member out-of-pocket costs. This is in part due to increased use as a wrap-around to Medicare Part D and other programs; increased use of generic drugs; new generic pricing strategies; and increased use of supplemental rebates.

- Remarkably, over half of the program spending is paid for by rebates, and the state portion is less than 20 percent.
- In the cases examined, SeniorCare lowered out-of-pocket costs up to 69 percent over Medicare Part D for those individuals with high drug needs.
- Finally, SeniorCare is an efficient program. Administrative costs are less than three percent of program costs, a favorable comparison to either Medicare or private health insurance.

2. Current Evaluation

The evaluation for the current 2012-2015 waiver period will build on information about program enrollment, utilization, and costs as reported in earlier evaluations. In addition, the evaluation will assess the extent to which SeniorCare waiver members spend down to full Medicaid eligibility, examine the extent to which SeniorCare alleviates members’ prescription-related financial hardship, and also assess the Medication Therapy Management (MTM) benefit which became available to SeniorCare members in September 2012.

This waiver renewal application presents some preliminary descriptive data related to program enrollment, member characteristics, and program utilization and costs. Data for these measures have been drawn from SeniorCare program enrollment and claims data. Other components of the evaluation are in progress and will be reported in the final evaluation report next year.

a. Program Description

The evaluation of the CY 2010-2012 waiver period found relatively stable enrollment levels with the waiver population having a fairly consistent makeup. More recent data present a similar picture. The figure below shows enrollment from September 2002 through December 2014. Enrollment reached a peak of nearly 80,000 in mid-2006, after which enrollment began declining. However, enrollment has been relatively stable in recent years, with members who have income less than 160 percent of the federal poverty level (FPL) representing two-thirds of the waiver population.
The table and chart below show the gender and income composition of the waiver population during three recent years, CY 2012-2014. Consistent with the time series data shown on the previous page, members with income less than 160 percent of the FPL represent not quite two-thirds (63-64 percent) of the waiver population. Approximately three-quarters of the waiver population are female. In fact, almost half of SeniorCare members are women with income less than 160 percent of the FPL.

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Members</td>
<td>Percent of Total</td>
<td>Members</td>
</tr>
<tr>
<td>Female, ≤ 160% FPL</td>
<td>27,047</td>
<td>48.9%</td>
<td>26,423</td>
</tr>
<tr>
<td>Female, &gt; 160% - 200% FPL</td>
<td>14,588</td>
<td>26.4%</td>
<td>13,537</td>
</tr>
<tr>
<td>Male, ≤ 160% FPL</td>
<td>8,035</td>
<td>14.5%</td>
<td>7,985</td>
</tr>
<tr>
<td>Male, &gt; 160% - 200% FPL</td>
<td>5,653</td>
<td>10.2%</td>
<td>5,434</td>
</tr>
<tr>
<td>Totals</td>
<td>55,323</td>
<td>100%</td>
<td>53,379</td>
</tr>
</tbody>
</table>
Individuals who are 65-74 years old comprise just over one-quarter of the SeniorCare waiver population. Approximately 40 percent of the waiver population is 75-84 years old, and those who are 85 years of age or older represent one-third of the waiver population.

One-quarter of the individuals in the waiver program on December 31, 2014, had been enrolled for two years or less. Close to one-half of the members at that time had been enrolled for up to five years, and three-quarters had been enrolled for up to 10 years. Nearly 6,400 members, or 14 percent of those enrolled at the end of CY 2014, had been enrolled for 12-13 years—since the implementation of the waiver program. Thus, while there is a steady influx of new members into the waiver program, some individuals have maintained their SeniorCare membership for an extended period of time.
<table>
<thead>
<tr>
<th>Length of Enrollment (Years)</th>
<th>Members</th>
<th>Percent of Total</th>
<th>Members (Cumulative)</th>
<th>Percent of Total (Cumulative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>6,142</td>
<td>13%</td>
<td>6,142</td>
<td>13%</td>
</tr>
<tr>
<td>1-2</td>
<td>5,619</td>
<td>12%</td>
<td>11,761</td>
<td>25%</td>
</tr>
<tr>
<td>2-3</td>
<td>3,811</td>
<td>8%</td>
<td>15,572</td>
<td>33%</td>
</tr>
<tr>
<td>3-4</td>
<td>3,259</td>
<td>7%</td>
<td>18,831</td>
<td>40%</td>
</tr>
<tr>
<td>4-5</td>
<td>3,679</td>
<td>8%</td>
<td>22,510</td>
<td>48%</td>
</tr>
<tr>
<td>5-6</td>
<td>3,366</td>
<td>7%</td>
<td>25,876</td>
<td>55%</td>
</tr>
<tr>
<td>6-7</td>
<td>2,060</td>
<td>4%</td>
<td>27,936</td>
<td>60%</td>
</tr>
<tr>
<td>7-8</td>
<td>1,627</td>
<td>3%</td>
<td>29,563</td>
<td>63%</td>
</tr>
<tr>
<td>8-9</td>
<td>3,460</td>
<td>7%</td>
<td>33,023</td>
<td>70%</td>
</tr>
<tr>
<td>9-10</td>
<td>2,643</td>
<td>6%</td>
<td>35,666</td>
<td>76%</td>
</tr>
<tr>
<td>10-11</td>
<td>2,121</td>
<td>5%</td>
<td>37,787</td>
<td>80%</td>
</tr>
<tr>
<td>11-12</td>
<td>2,786</td>
<td>6%</td>
<td>40,573</td>
<td>86%</td>
</tr>
<tr>
<td>12-13</td>
<td>6,367</td>
<td>14%</td>
<td>46,940</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>46,940</td>
<td>100%</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

SeniorCare remains very important to the waiver population as a source of insurance coverage for prescription drugs. During CY 2012-2014, nearly 80 percent of waiver members had SeniorCare only, with no other prescription drug coverage. Fifteen percent or less had Medicare Part D in addition to SeniorCare, and less than 10 percent had other insurance coverage for prescription drugs (e.g., employer-based insurance or privately-purchased commercial insurance).
## Enrollment by Benefit Combination

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Enrollment</th>
<th>Enrollment Combinations</th>
<th>Members</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>55,323</td>
<td>SC Only</td>
<td>43,684</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SC + Part D</td>
<td>7,052</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SC + Commercial</td>
<td>3,413</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Three</td>
<td>1,174</td>
<td>2%</td>
</tr>
<tr>
<td>2013</td>
<td>53,379</td>
<td>SC Only</td>
<td>41,879</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SC + Part D</td>
<td>7,877</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SC + Commercial</td>
<td>3,020</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Three</td>
<td>603</td>
<td>1%</td>
</tr>
<tr>
<td>2014</td>
<td>51,830</td>
<td>SC Only</td>
<td>40,820</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SC + Part D</td>
<td>7,858</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SC + Commercial</td>
<td>2,654</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All Three</td>
<td>498</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Prescription Coverage for SeniorCare Members, 2012-2014

- **2012**
  - SC Only: 79%
  - SC + Part D: 13%
  - SC + Commercial: 6%
  - All Three: 2%

- **2013**
  - SC Only: 78%
  - SC + Part D: 15%
  - SC + Commercial: 6%
  - All Three: 1%

- **2014**
  - SC Only: 79%
  - SC + Part D: 15%
  - SC + Commercial: 5%
  - All Three: 1%
b. Program Utilization and Costs

In CY 2014, there were more than 1.5 million drug claims paid on behalf of SeniorCare waiver members, at a cost of nearly $74 million.

<table>
<thead>
<tr>
<th>Total Claims</th>
<th>Total Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>15,10,217</td>
<td>$73,913,268.69</td>
</tr>
</tbody>
</table>

SeniorCare members who had prescription claims in CY 2014 had an average of 33.6 paid claims each. Fifty-five percent of the members had no more than 30 paid claims in the year; only a few members had more than 200 claims during the year.
The program encourages the use of generic drugs when available in a given drug classification and also applies a higher copayment for brand-name drugs in an effort to control program costs. In keeping with this, 81 percent of all paid claims in CY 2014 were for generic drugs, yet generics accounted for only 18 percent of the total amount paid.

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Claims (Unique ICN)</th>
<th>Percent of Total</th>
<th>Total Paid Amount</th>
<th>Percent of Total</th>
<th>Average Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand</td>
<td>270,637</td>
<td>18%</td>
<td>$47,477,356.90</td>
<td>64%</td>
<td>$175.43</td>
</tr>
<tr>
<td>Generic</td>
<td>1,229,273</td>
<td>81%</td>
<td>$13,502,020.66</td>
<td>18%</td>
<td>$10.98</td>
</tr>
<tr>
<td>Specialty</td>
<td>9,163</td>
<td>1%</td>
<td>$12,876,236.74</td>
<td>17%</td>
<td>$1,405.24</td>
</tr>
<tr>
<td>Other</td>
<td>1,144</td>
<td>&lt; 1%</td>
<td>$57,654.39</td>
<td>&lt; 1%</td>
<td>$50.40</td>
</tr>
<tr>
<td>Total</td>
<td>1,510,217</td>
<td>100%</td>
<td>$73,913,268.69</td>
<td>100%</td>
<td>$48.94</td>
</tr>
</tbody>
</table>

A breakdown of claims by cost, using $50 cost increments, shows that the great majority of claims paid on behalf of SeniorCare members are for relatively modest amounts. Eighty-three percent of all paid claims in CY 2014, representing 11 percent of the total amount paid that year,
cost the program less than $50 each; the average amount paid for these claims was $6.68 per claim. Nearly 100 percent of all paid claims were for less than $550; these claims represented 73.3 percent of the total amount paid. (Note that some rows have been omitted from the table below to save space.) At the other end of the distribution, a handful of claims in 2014 cost more than $18,000.

<table>
<thead>
<tr>
<th>Payment Range</th>
<th>Claims (Unique ICN)</th>
<th>Percent of Total</th>
<th>Total Paid Amount</th>
<th>Percent of Total</th>
<th>Average Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-50</td>
<td>1,253,190</td>
<td>83.0%</td>
<td>$8,373,774.61</td>
<td>11.3%</td>
<td>$6.68</td>
</tr>
<tr>
<td>50-100</td>
<td>67,474</td>
<td>4.5%</td>
<td>$4,981,363.16</td>
<td>6.7%</td>
<td>$73.83</td>
</tr>
<tr>
<td>100-150</td>
<td>38,529</td>
<td>2.6%</td>
<td>$4,638,554.17</td>
<td>6.3%</td>
<td>$120.39</td>
</tr>
<tr>
<td>150-200</td>
<td>37,511</td>
<td>2.5%</td>
<td>$6,585,185.28</td>
<td>8.9%</td>
<td>$175.55</td>
</tr>
<tr>
<td>200-250</td>
<td>28,338</td>
<td>1.9%</td>
<td>$6,279,098.32</td>
<td>8.5%</td>
<td>$221.58</td>
</tr>
<tr>
<td>250-300</td>
<td>43,863</td>
<td>2.9%</td>
<td>$12,173,547.87</td>
<td>16.5%</td>
<td>$277.54</td>
</tr>
<tr>
<td>300-350</td>
<td>14,663</td>
<td>1.0%</td>
<td>$4,785,785.95</td>
<td>6.5%</td>
<td>$326.39</td>
</tr>
<tr>
<td>350-400</td>
<td>9,861</td>
<td>0.7%</td>
<td>$3,642,743.24</td>
<td>4.9%</td>
<td>$369.41</td>
</tr>
<tr>
<td>400-450</td>
<td>3,288</td>
<td>0.2%</td>
<td>$1,393,689.28</td>
<td>1.9%</td>
<td>$423.87</td>
</tr>
<tr>
<td>450-500</td>
<td>1,452</td>
<td>0.1%</td>
<td>$693,344.73</td>
<td>0.9%</td>
<td>$477.51</td>
</tr>
<tr>
<td>500-550</td>
<td>1,125</td>
<td>0.1%</td>
<td>$585,038.99</td>
<td>0.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>&gt; 18000</td>
<td>6</td>
<td>0.0%</td>
<td>$320,626.09</td>
<td>0.5%</td>
<td>$53,437.68</td>
</tr>
<tr>
<td>Total:</td>
<td>1,510,217</td>
<td>100.0%</td>
<td>$73,913,268.69</td>
<td>100.0%</td>
<td>---</td>
</tr>
</tbody>
</table>

Therapeutic classes are a way of classifying medical drugs according to their functions. Each therapeutic class is a group of similar medications classified together because they are intended to treat the same medical conditions.

There are many different therapeutic classes. These commonly have names that describe their intended effects, (e.g., antipsychotics, tranquilizers, and decongestants); they are also sometimes named for their chemical method of action (e.g., beta-adrenergic antagonists, more popularly known as beta blockers, which diminish the effects of adrenaline and other stress-related hormones and neurotransmitters).
Medications can also be categorized in more than one drug class, according to context. For example, a drug that can be used to treat both pain and fever, such as aspirin, may be categorized as either an analgesic or an antipyretic, depending on what it is being used for.

Calendar Year 2014 SeniorCare drug claims were classified by therapeutic class. The table below shows claims and amounts paid for the 25 types of drugs most commonly dispensed to SeniorCare members in CY 2014, ranked by the number of paid claims. The number of claims in each class is shown as a percentage of the total of all drugs purchased in CY 2014; likewise, the amount paid for drugs in each class is shown as a percentage of the total amount paid for all claims in CY 2014. The 25 types of drugs most often purchased through SeniorCare by members represented 66 percent of all claims paid in CY 2014 and accounted for 44 percent of the total amount paid that year.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Claims</th>
<th>Percent of Total</th>
<th>Amount Paid</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proton-pump inhibitors</td>
<td>88,502</td>
<td>6%</td>
<td>$2,439,315.98</td>
<td>3%</td>
</tr>
<tr>
<td>Antihyperlipidemic - HMG COA reductase inhibitors</td>
<td>88,222</td>
<td>6%</td>
<td>$1,694,406.78</td>
<td>2%</td>
</tr>
<tr>
<td>Beta-adrenergic blocking agents</td>
<td>87,499</td>
<td>6%</td>
<td>$2,478,232.04</td>
<td>3%</td>
</tr>
<tr>
<td>Analgesics, narcotics</td>
<td>61,493</td>
<td>4%</td>
<td>$1,379,893.79</td>
<td>2%</td>
</tr>
<tr>
<td>Calcium channel blocking agents</td>
<td>50,365</td>
<td>3%</td>
<td>$768,821.59</td>
<td>1%</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>47,734</td>
<td>3%</td>
<td>$1,466,438.77</td>
<td>2%</td>
</tr>
<tr>
<td>Antihypertensives, ace inhibitors</td>
<td>47,368</td>
<td>3%</td>
<td>$169,114.99</td>
<td>0%</td>
</tr>
<tr>
<td>Potassium replacement</td>
<td>46,459</td>
<td>3%</td>
<td>$897,067.05</td>
<td>1%</td>
</tr>
<tr>
<td>Thyroid hormones</td>
<td>42,507</td>
<td>3%</td>
<td>$784,956.01</td>
<td>1%</td>
</tr>
<tr>
<td>Selective serotonin reuptake inhibitor (SSRIs)</td>
<td>41,711</td>
<td>3%</td>
<td>$100,140.30</td>
<td>0%</td>
</tr>
<tr>
<td>Loop diuretics</td>
<td>41,349</td>
<td>3%</td>
<td>$108,288.85</td>
<td>0%</td>
</tr>
<tr>
<td>Miotics/other intraocular pressure reducers</td>
<td>36,331</td>
<td>2%</td>
<td>$2,117,164.79</td>
<td>3%</td>
</tr>
<tr>
<td>Anti-anxiety drugs</td>
<td>35,449</td>
<td>2%</td>
<td>$49,391.87</td>
<td>0%</td>
</tr>
<tr>
<td>Anticoagulants, Coumarin type</td>
<td>35,111</td>
<td>2%</td>
<td>$107,430.75</td>
<td>0%</td>
</tr>
<tr>
<td>Insulins</td>
<td>29,623</td>
<td>2%</td>
<td>$7,901,109.39</td>
<td>11%</td>
</tr>
<tr>
<td>Antihypertensives, angiotensin receptor antagonist</td>
<td>29,298</td>
<td>2%</td>
<td>$996,882.31</td>
<td>1%</td>
</tr>
<tr>
<td>Medication Class</td>
<td>Claims</td>
<td>Percent</td>
<td>Amount Paid</td>
<td>Percent</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>--------</td>
<td>---------</td>
<td>-------------</td>
<td>---------</td>
</tr>
<tr>
<td>Thiazide and related diuretics</td>
<td>24,474</td>
<td>2%</td>
<td>$101,034.50</td>
<td>0%</td>
</tr>
<tr>
<td>Platelet aggregation inhibitors</td>
<td>24,077</td>
<td>2%</td>
<td>$649,176.31</td>
<td>1%</td>
</tr>
<tr>
<td>Bone resorption inhibitors</td>
<td>23,532</td>
<td>2%</td>
<td>$322,575.83</td>
<td>0%</td>
</tr>
<tr>
<td>Glucocorticoids</td>
<td>22,066</td>
<td>1%</td>
<td>$597,779.01</td>
<td>1%</td>
</tr>
<tr>
<td>Beta-adrenergic and glucocorticoid combinations</td>
<td>21,489</td>
<td>1%</td>
<td>$4,881,426.16</td>
<td>7%</td>
</tr>
<tr>
<td>Benign prostatic hypertrophy/micturition agents</td>
<td>21,137</td>
<td>1%</td>
<td>$116,254.39</td>
<td>0%</td>
</tr>
<tr>
<td>Antihyperglycemic, biguanide type</td>
<td>17,209</td>
<td>1%</td>
<td>$96,576.34</td>
<td>0%</td>
</tr>
<tr>
<td>Lipotropics</td>
<td>16,665</td>
<td>1%</td>
<td>$2,002,748.11</td>
<td>3%</td>
</tr>
<tr>
<td>Beta-adrenergic agents</td>
<td>15,018</td>
<td>1%</td>
<td>$630,196.65</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total Claims and Amount Paid, Top 25 Drugs (HIC3)</strong></td>
<td>994,688</td>
<td>66%</td>
<td>$32,856,422.56</td>
<td>44%</td>
</tr>
<tr>
<td><strong>Total Claims and Amount Paid, All Drugs in 2014</strong></td>
<td>1,510,217</td>
<td>100%</td>
<td>$73,913,268.69</td>
<td>100%</td>
</tr>
</tbody>
</table>

c. Medication Therapy Management

The MTM benefit was implemented for SeniorCare members in September 2012. The benefit includes two levels of service, intervention-based services and Comprehensive Medication Review and Assessment (CMR/A), and is intended to help members manage their medications and improve adherence. The MTM benefit expands upon the Pharmaceutical Care services model used previously; most services previously billed under Pharmaceutical Care are now classified as intervention-based services. These include generic substitutions, transitioning from one-month to three-month supplies, dosage changes, consultations about a lack of adherence, adding or eliminating medications based on clinical concerns, education about medication administration devices, and in-home medication management for those who are not able to pick up their medication.

Intervention-based services generally involve a pharmacist providing a brief consultation to a member on an unscheduled, as-needed basis. The CMR/A provides an opportunity for the pharmacist to provide in-depth analysis of the member’s drug regimen and offer education and support. The CMR/A involves a scheduled, 60-minute consultation and up to three 30-minute follow-up consultations per year; it is intended for members considered at high risk of medical complications due to the nature of their drug regimen. The table below summarizes the SeniorCare members receiving MTM services, and the services received, since the benefit was implemented.
<table>
<thead>
<tr>
<th></th>
<th>Members Receiving MTM Services (Cumulative thru March 2015)</th>
<th>MTM Services Provided to Members (Cumulative thru March 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial assessment</td>
<td>403</td>
<td>426</td>
</tr>
<tr>
<td>Follow-up assessment</td>
<td>60</td>
<td>81</td>
</tr>
<tr>
<td>Cost effectiveness</td>
<td>518</td>
<td>656</td>
</tr>
<tr>
<td>Three-month supply</td>
<td>2,143</td>
<td>4,689</td>
</tr>
<tr>
<td>Dose/form/duration change</td>
<td>320</td>
<td>378</td>
</tr>
<tr>
<td>Focused adherence</td>
<td>1,633</td>
<td>2,732</td>
</tr>
<tr>
<td>Medication additions</td>
<td>117</td>
<td>152</td>
</tr>
<tr>
<td>Medication deletions</td>
<td>140</td>
<td>170</td>
</tr>
<tr>
<td>Medication device instruction</td>
<td>209</td>
<td>252</td>
</tr>
<tr>
<td>In-home medication management</td>
<td>13</td>
<td>39</td>
</tr>
</tbody>
</table>

From the inception of the MTM benefit in September 2012 through March 2015, 403 SeniorCare waiver members have had an initial assessment (CMR/A), and 60 members have received a follow-up assessment. The most common services resulting from these assessments are the Three-Month Supply and Focused Adherence.

Other data show that females outnumber males by three-to-one among members getting MTM services, consistent with the gender ratio in the waiver population overall.

d. Other Evaluation Activities

In addition to the descriptive data reported here, activities related to other components of the evaluation are in progress; results are not yet available and are not reported here. In July 2015, a survey will be mailed to approximately 1,000 recent SeniorCare enrollees. In addition, examinations of the effect of SeniorCare on Medicaid receipt, nursing home admissions, and hospitalizations for selected health conditions are also being conducted. Additional MTM-related analyses will also be included in the final evaluation report.

3. Future Evaluation

The Department will continue to monitor SeniorCare program data in order to ensure that
program goals and objectives are met.

The objectives for the waiver period are to keep Wisconsin seniors healthy by continuing to provide a necessary primary health care benefit and helping control overall costs for the senior Medicaid populations by preventing seniors from becoming eligible for full Medicaid due to deteriorating health and having to “spend down” to Medicaid eligibility levels.

Using program metrics such as SeniorCare duration of enrollment, program expenditures and utilization trends; Medicaid enrollment trends and expenditures; and member feedback, the Department will continue to monitor SeniorCare enrollment; how members are being served by the program; and how the program is a cost- effective option for drug coverage for the state.

Data may be collected from the Medicaid Management Information Systems (MMIS) claims and financial reporting systems, eligibility processing center, SeniorCare call center, member communications response systems, and public meeting forums.