



Administrator
Washington, DC 20201

MAY 30 2007

Mr. Jason A. Helgerson, Administrator
Division of Health Care Financing
Department of Health and Family Services
1 West Wilson Street
P.O. Box 309
Madison, WI 53701-0309

Dear Mr. Helgerson:

We are pleased to inform you that the extension request of the Wisconsin section 1115 demonstration, BadgerCare, has been approved in accordance with section 1115(a) of the Social Security Act (the Act).

Beginning June 1, 2007, your section 1115(a) demonstration is authorized through March 31, 2010, upon which date, unless reauthorized, all waivers and expenditure authorities granted to operate this demonstration will expire.

Our approval of this demonstration project is subject to the limitations specified in the enclosed Special Terms and Conditions (STCs) and the Waiver and Expenditure Authority list. The State may only deviate from Medicaid State Plan requirements to the extent those requirements have been specifically waived or, with respect to expenditure authorities, listed as inapplicable to expenditures for demonstration expansion populations and other services not covered under the State plan.

During our review of the State's renewal submission, the Centers for Medicare & Medicaid Services (CMS) identified necessary technical changes and therefore, CMS is approving this demonstration contingent upon the State's submission of a Medicaid State plan amendment (SPA). This SPA will provide eligibility through the Medicaid State plan for optional targeted low-income children, specifically children ages 6 through 18 with family incomes above 100 percent up to 200 percent of the Federal poverty level (FPL), and infants and children under age 6 with family income above 185 percent up to 200 percent of the FPL, as well as title XIX expenditure authority, should the State exhaust its title XXI allotment. The SPA will also provide eligibility and expenditure authority in the State plan for parents with family income at or below 130 percent of the FPL. The State should submit the Medicaid SPA with its acceptance of the enclosed STCs, within 30 days of the date of this letter. The current expenditure authority for these populations will expire in this section 1115 demonstration on June 30, 2007, but programmatic waivers of specific provisions of title XIX will remain available through the demonstration renewal period, as specified in the STCs.

The approval is also conditioned upon continued compliance with the enclosed STCs, defining the nature, character, and extent of anticipated Federal involvement in the project.

Several changes to the demonstration have been incorporated into the STCs and expenditure authorities for the extension approval as follows:

- The STCs reference compliance with all Federal laws, regulations, and policies. Language has been added to highlight compliance with the Deficit Reduction Act of 2005, which was signed into law on February 8, 2006;
- Streamlining of document sections related to benefits, eligibility, cost sharing, budget neutrality, allotment neutrality, quarterly and annual Demonstration reporting;
- Specific information and instruction relating to reporting requirements for titles XIX and XXI;
- Removal of references to, as well as the need for, an Operational Protocol through inclusion of pertinent programmatic information in the STCs;
- Revisions to the current Expenditure Authority list as follows:
 1. Technical correction to Demonstration Population 1 to include Children 0-5 years with net family incomes above 133 percent up to and including 200 percent of the FPL, which was previously omitted;
 2. Demonstration Population 2 will consist of two groups: Population 2a - Uninsured custodial parents of children and their spouses with income up to and including 100 percent of the FPL, and Population 2b - Uninsured custodial parents of children and their spouses with income from 100 percent to 130 percent of the FPL; and
 3. Demonstration Population 3 will consist of uninsured custodial parents and their spouses with income above 130 percent up to 200 percent of the FPL; and,
- Trend rates reflecting the President's Federal fiscal year 2008 budget, which include 6.1 percent for adults with incomes below 130 percent of the FPL, are included under the title XIX budget neutrality agreement.

Your project officer is Ms. Wanda Pigatt-Canty. Ms. Pigatt-Canty is available to answer any questions concerning implementation of your section 1115 demonstration. Her contact information is as follows:

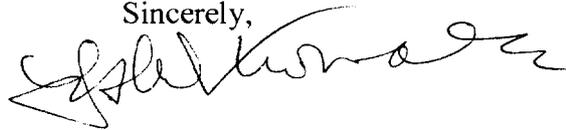
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Center for Medicaid and State Operations
Mail Stop S2-01-16
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Baltimore, MD 21244-1850
Telephone: (410) 786-6177
Facsimile: (410) 786-5882
E-mail: wanda.pigatt-canty@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Pigatt-Canty and to Ms. Phyllis M. Smith, Acting Associate Regional Administrator in our Chicago Regional Office. Ms. Smith's address is:

Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

If you have additional questions, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs, Center for Medicaid and State Operations, at (410) 786-5647. We look forward to continuing to work with you and your staff.

Sincerely,

A handwritten signature in black ink, appearing to read "L. V. Norwalk", written in a cursive style.

Leslie V. Norwalk, Esq.
Acting Administrator

Enclosures

cc: Mr. James Jones
Deputy Administrator
Division of HealthCare Financing
Department of Health and Family Services

Ms. Phyllis M. Smith
Acting Associate Regional Administrator
Chicago Regional Office

Mr. Charles Friedlich
Chicago Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AND EXPENDITURE AUTHORITY**

NUMBER: 11-W-00125/5 and 21-W-00001/5

TITLE: Wisconsin BadgerCare

AWARDEE: Wisconsin Department of Health and Family Services

The following populations are included in the Demonstration:

- Population 1: Children ages 0 to 5 years with net family incomes above 133% up to and including 200% of the Federal poverty level (FPL), and children 6 to 19 years who have net family incomes above 100% up to and including 200% of the FPL and who are optional, targeted, low-income children as defined in section 1905(u)(2)(B) of the Social Security Act (the Act).
- Population 2: 2a- Uninsured custodial parents of children who are eligible under the Medicaid State plan or included in Demonstration Population 1, and the uninsured spouses of these custodial parents, with net family incomes up to and including 100% of the FPL and who are themselves not eligible for Medicaid under the State plan, and 2b - Uninsured custodial parents of children who are eligible under the Medicaid State plan or included in Demonstration Population 1, and the uninsured spouses of these custodial parents, with net family incomes from 100% up to and including 130% of the FPL and who are themselves not eligible for Medicaid under the State plan.
- Population 3: Uninsured custodial parents of children who are eligible under the Medicaid State plan or included in Demonstration Population 1, and the uninsured spouses of these custodial parents, with net family incomes above 130% up to and including 200% of the FPL and who are themselves not eligible for Medicaid under the State plan.

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to Demonstration Populations 1 and 2, as described for the Demonstration project beginning July 1, 2007, through March 31, 2010.

The following waivers shall enable Wisconsin to implement the Medicaid section 1115 Demonstration.

1. Freedom of Choice Section 1902(a)(23)

To enable the State to restrict freedom-of-choice of providers.

2. Comparability of Services

Section 1902(a)(10)(B)

To enable the State to offer additional benefits such as case management and health education that are unavailable to Medicaid beneficiaries unless enrolled in the demonstration program.

3. Eligibility

Section 1902(a)(17)

Section 1902(a)(34)

To permit the State to exclude from eligibility individuals who have health insurance coverage, and to not provide retroactive eligibility.

4. Cost-Sharing Limitations

Section 1902(a)(14)

To enable the State to impose premiums on the demonstration populations in excess of the amounts permitted under title XIX but no more than the amounts that would be allowed under title XXI of the Act.

5. Waiting Period

Section 1902 (a)(8)

To enable the State to impose a 6-month period of uninsurance, to the extent that the State excludes individuals from eligibility who have voluntarily terminated private health insurance coverage within the prior 6 months of applying for the State's Demonstration.

Title XIX - Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act, the following expenditures that would not otherwise be regarded as expenditures under title XIX will be regarded as expenditures under the State's title XIX plan. The following expenditure authorities are approved beginning June 1, 2007, through June 30, 2007:

1. Expenditures to provide healthcare coverage to children ages 0 to 5 years with net family incomes above 133% up to and including 200% of the Federal poverty level (FPL) and children 6 to 19 years who have net family incomes above 100% up to and including 200% of the FPL and who are optional, targeted, low-income children as defined in section 1905(u)(2)(B) (Demonstration Population 1).
2. Expenditures to provide health care coverage to the uninsured custodial parents of children who are eligible under the Medicaid State plan or included in Demonstration Population 1, and the uninsured spouses of these custodial parents, with net family incomes up to and including 130% of the FPL and who are themselves not eligible for Medicaid under the State plan (Demonstration Population 2).

Title XIX Requirements Not Applicable to the Title XIX Expenditure Authority

All title XIX requirements apply to Demonstration Populations 1 and 2, except the following:

1. Freedom of Choice Section 1902(a)(23)

To enable the State to restrict freedom-of-choice of providers.

2. Comparability of Services Section 1902(a)(10)(B)

To enable the State to offer additional benefits such as case management and health education that are unavailable to Medicaid beneficiaries unless enrolled in the demonstration program.

3. Eligibility Section 1902(a)(17)
Section 1902(a)(34)

To permit the State to exclude from eligibility individuals who have health insurance coverage, and to not provide retroactive eligibility.

4. Cost-Sharing Limitations Section 1902(a)(14)

To enable the State to impose premiums on the demonstration populations in excess of the amounts permitted under title XIX but no more than the amounts that would be allowed under title XXI of the Act.

5. Waiting Period Section 1902 (a)(8)

To enable the State to impose a 6-month period of uninsurance, to the extent that the State excludes individuals from eligibility who have voluntarily terminated private health insurance coverage within the prior 6 months of applying for the State's Demonstration.

Title XXI - Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act, the following expenditures that would not otherwise be regarded as expenditures under title XXI will be regarded as expenditures under the State's title XXI plan. The following expenditure authorities are approved beginning June 1, 2007, through March 31, 2010:

1. Expenditures to provide healthcare coverage to uninsured custodial parents of children who are eligible under the Medicaid State plan or included in Demonstration Population 1, and the uninsured spouses of these custodial parents, with net family incomes above 130% up to and including 200% of the FPL and who are themselves not eligible for Medicaid under the State plan (Demonstration Population 3).

Title XXI Requirements Not Applicable to the Title XXI Expenditure Authority

All title XXI requirements apply to Demonstration Population 3, except the following:

1. General Requirements, Eligibility, and Outreach Section 2102

The demonstration populations do not have to reflect the State child health plan population and eligibility standards do not have to be limited by the general principles in section 2102(b). To the extent other requirements in section 2102 of the Act duplicate Medicaid or other SCHIP requirements for these or other populations, they do not apply, except that the State must perform eligibility screening to ensure that the demonstration populations do not include individuals otherwise eligible for Medicaid.

2. Restrictions on Coverage and Eligibility to Targeted Low-Income Children Section 2103 Section 2110

Coverage and eligibility for Demonstration Population 3 is not restricted to targeted low-income children.

3. Federal Matching Payment and Family Coverage Limits Section 2105

The State will be allowed to receive Federal matching payment for Demonstration Population 3 without the restrictions described in section 2105(c)(2) that would otherwise require the State to remain under the 10% administrative cap for a population other than targeted low-income children that meet the requirements of section 2103. This provision does not waive the 10% administrative cap for title XXI expenditures. It does, however, allow the State to cover a population besides children outside of a health service initiative and the 10% administrative cap, which would be the customary vehicle for covering a population other than children.

4. Annual Reporting Requirements Section 2108

The State does not have to meet the annual reporting requirements (the submission of an annual report into the State Annual Report Template System/SARTS) of the Federal regulations at 42 CFR section 457.750 for the demonstration population. The State will report on issues related to the demonstration population in quarterly and annual reports and enrollment data through the Statistical Enrollment Data System (SEDS).

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00125/5 and 21-W-00001/5

TITLE: Wisconsin Medicaid Section 1115 Health Care Reform Demonstration (BadgerCare)

AWARDEE: Wisconsin Department of Health and Family Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Wisconsin's BadgerCare section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the Wisconsin Department of Health and Family Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, extent of Federal involvement in the Demonstration, and the State's obligations to CMS during the life of the Demonstration. The STCs are effective June 1, 2007, unless otherwise specified. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This Demonstration extension is approved through March 31, 2010.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Conditions; General Program Requirements; Eligibility, Benefits, and Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements ; General Financial Requirements Under Title XIX; Monitoring Budget Neutrality; General Financial Requirements Under Title XXI; Evaluation of the Demonstration; and Schedule of State Deliverables for the Demonstration Extension Period.

II. PROGRAM DESCRIPTION AND OBJECTIVES

BadgerCare was created as a health insurance program for low-income working families with children. BadgerCare is intended to provide health care coverage to families with incomes too high for Medicaid and who do not have access to affordable health insurance. By extending health care coverage to uninsured low-income families, BadgerCare originally sought to provide a safeguard against increasing the number of uninsured families and children as a result of Wisconsin's welfare reform program. BadgerCare is designed to bridge the gap between low-income Medicaid coverage and employer-provided health care coverage.

III. GENERAL PROGRAM CONDITIONS

A. Coordination With Other Waivers Or Programs

The State's title XXI Children's Health Insurance Program, as approved on May 29, 1998, will continue to operate concurrently with the section 1115 demonstration.

IV. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Changes in the Enforcement of Medicaid or SCHIP Laws, Regulations, or Policies.** All requirements of the Medicaid and SCHIP programs expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these STCs are a part, will apply to the demonstration. This requirement shall also apply to all applicable regulation and policy issued by CMS with respect to the Deficit Reduction Act of 2005, signed into law on February 8, 2006, including but not limited to the documentation of citizenship requirements contained in section 1903(x) of the Act and applicable CMS regulations in the Code of Federal Regulations (CFR). For the current extension period of this Demonstration and effective with the terms specified in Section IX, paragraph 39 of this document, this requirement shall also apply to the effective date of the final regulation entitled “Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal State-Financial Partnership,” a proposed regulation published on January 18, 2007.
- 3. Changes in Medicaid or SCHIP Laws.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid or SCHIP program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid or SCHIP spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program elements of the demonstration (e.g., laws affecting sources of Medicaid or SCHIP funding), the State must submit its methodology for complying with the change in law to CMS for approval within 30 days. The methodology must be consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law. Should CMS and the State, working in full corporation to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration States.
- 4. Impact on Demonstration of Changes in Federal Law.** To the extent that a change in Federal law requires either a reduction or an increase in Federal financial participation (FFP) in expenditures under the Demonstration, the State will adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified budget neutrality agreement would be effective upon the implementation of the change in

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

5. **State Plan Amendments.** The State shall not be required to submit title XIX or title XXI State plan amendments for changes to Demonstration populations made solely eligible through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan is required except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, allotment neutrality, moving demonstration populations to a different funding source (i.e., from title XXI to title XIX funding and vice versa from title XIX to title XXI funding) and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.
7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:
 - a. An explanation of the public process used by the State to reach a decision regarding the requested amendment as referenced in STC #14;
 - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
 - c. An updated SCHIP allotment neutrality worksheet, if applicable;
 - d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

- e. A description of how the evaluations design shall be modified to incorporate the amendment provisions, if applicable.
8. **Extension of the Demonstration.** If the State intends to extend the Demonstration beyond the period of approval granted under section 1115(a), the requirements in section 1115(e) may apply. During the 6-month period ending 1 year before the date the Demonstration would otherwise expire (March 31, 2010), the chief executive officer of the State may submit to the Secretary of the Department of Health and Human Services a written request to extend the Demonstration for up to 3 years. If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted. Further, the Secretary shall take such steps as may be necessary to ensure that in the extension of the Demonstration budget neutrality is maintained. The timeframes for an extension under 1115(e) will not apply if the State has requested changes to the demonstration. In such case, the waiver authority, if approved, would be subject to Section 1115(e) extensions of existing waivers and will only be approved for a 3- year period. The State must also provide an interim evaluation report for the current extension period with the extension request.
9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.
10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.
12. **Withdrawal of Waiver Authority.** CMS reserves the right to modify these special terms and conditions, withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.
14. **Public Notice and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 FR 49249 (September 27, 1994) when any program changes to the Demonstration, including but not limited to those referenced in paragraph 6 are proposed by the State.
15. **Compliance with Managed Care Regulations.** The State must comply with the managed care Federal regulations at 42 CFR 438 et. seq., except as expressly identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR 438.6.

V. ELIGIBILITY, BENEFITS, AND ENROLLMENT

16. **Eligibility.** The groups made eligible under this demonstration are as follows:

Demonstration Eligible Groups	FPL Level and/or other qualifying criteria	Funding Source
Demonstration Population 1- Children 0-19 years who are optional, targeted low-income children as defined in section 1905(u)(2)(B)	<i>Children 0-5 years</i> Above 133% up to and including 200% of the FPL <i>Children 6 -19 years</i> Above 100% up to and including 200% of the FPL	Title XXI
Demonstration Population 2a Uninsured custodial parents of children who are eligible under the State plan or included in Demonstration Population 1, and the uninsured spouses of these custodial parents, and who are themselves not eligible for Medicaid under the State plan	Up to and including 100% of the FPL	Title XIX
Demonstration Population 2b Uninsured custodial parents of children who are eligible under the State plan or included in Demonstration Population 1, and the uninsured spouses of these custodial parents, and who are themselves not eligible for Medicaid under the State plan	Above 100% up to and including 130% of the FPL (Note: This group was changed to title XIX expenditure authority effective June 1,2007, from title XXI expenditure authority.)	Title XIX

Demonstration Eligible Groups	FPL Level and/or other qualifying criteria	Funding Source
Demonstration Population 3 Uninsured custodial parents of children who are eligible under the State plan or included in Demonstration Population 1, and the uninsured spouses of these custodial parents, and who are themselves not eligible for Medicaid under the State plan.	Above 130% up to and including 200% of the FPL (See note in 2b.)	Title XXI

The following eligibility criteria apply to all Demonstration Populations:

- Applicants with total family income that is no more than 185 percent of the Federal poverty level (FPL) are eligible for BadgerCare. An applicant is an individual who was not receiving Medicaid or BadgerCare in the previous calendar month, or who was not part of a family that was receiving BadgerCare in the previous calendar month. Recipients with total family income that does not exceed 200 percent of the FPL remain BadgerCare eligible. Recipients are individuals who were receiving Medicaid or BadgerCare in the previous calendar month, or who are part of a family that was receiving Medicaid or BadgerCare in the previous calendar month. “Family” means a child under 19 years of age, the custodial parent of a child under age 19 (if any), and the spouse of a custodial parent (if any) that reside together;
- No asset test is required to enroll in BadgerCare; and
- Families that currently, have, or have had, insurance in the past 3 months, or who have had access to a group health insurance plan in the past 18 months in which their employer pays at least 80 percent of the monthly premium, are not eligible for BadgerCare with exceptions for good cause reasons that includes: loss of employment, other than a voluntary termination, loss of employment due to the employee's incapacitation, change to a new employer that does not offer coverage, end of COBRA continuation, coverage ends due to death, divorce or age, coverage ends due to reduced (involuntary) hours of employment, and discontinuation of health benefits to all employees by the client's employer.

17. Enrollment Limits

- a. The State may adjust the BadgerCare applicant income limit when the State enrollment projections exceed budgeted thresholds by submitting a demonstration amendment for approval in accordance with STC numbers 6 and 7. The State will monitor actual monthly enrollment and will project quarterly enrollment. If quarterly projections show that enrollment will exceed budget thresholds, the State must take the necessary steps to change the income eligibility limits for adult BadgerCare applicants including making applications for the necessary Medicaid State plan or demonstration amendments. To assure full enrollment into BadgerCare, the State

shall adjust the income eligibility limit for adult BadgerCare applicants should it be determined by the State that BadgerCare funding is sufficient, so that the applicant income limit does not exceed 185 percent FPL by submitting an amendment for approval. Specifically, the State must take necessary steps to ensure that the enrollment for title XXI covered populations does not exceed the SCHIP allotment, as further defined in the title XXI funding section under STC #52.

- b. During the demonstration, subsequent changes to the eligibility limit must be submitted as a demonstration amendment no later than 120 days prior to the date of implementation of the change(s) and may not be implemented until approved by CMS. The State will include in its amendment the current income eligibility limit, the proposed new income eligibility limit, and the estimated number of eligibles to be enrolled at the new income eligibility limit and updated budget and allotment neutrality documents. In addition, the State must include in its request a description of its efforts to provide outreach and education to BadgerCare applicants and recipients on how this change will/will not impact their participation in the BadgerCare program in accordance with public notice requirements in STC #14.
- c. The State will not use this process to apply income and resource methodologies that are more restrictive than prior to implementation of the BadgerCare demonstration.

VI. BENEFITS

- 18. The demonstration enrollees will receive the Medicaid State plan benefits through the Wisconsin Medicaid managed care delivery system, or BadgerCare can pay premiums to enroll families into their employer-sponsored health insurance. To qualify for the Health Insurance Premium Purchase (HIPP) program, the employer must pay at least 40 percent, but less than 80 percent of a family premium. In addition, the cost of the family premium, plus required wrap-around costs (coinsurance, deductibles, BadgerCare services not covered by the health plan) equal to BadgerCare coverage, must be cost-effective compared to enrollment into the managed care delivery system. In the case of title XXI children, families are to be informed that all age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) are covered.

VII. COST SHARING

- 19. Families with incomes above 150 percent FPL will pay a monthly premium of 5 percent of family income and no co-payments or other cost sharing consistent with Section 1916(a) of the Act. The State will monitor and include in the quarterly report information related to disenrollments from the BadgerCare demonstration due to nonpayment of premiums.

VIII. DELIVERY SYSTEMS

- 20. Most BadgerCare families receive services through the Wisconsin Medicaid, managed care delivery system with the exception of certain services paid for by the State on a fee-for-service basis as defined under the Medicaid State plan. However,

BadgerCare can pay premiums to enroll families into their employer-sponsored health insurance. To qualify for the HIPP program, the employer must pay at least 40 percent, but less than 80 percent of a family premium. In addition, the cost of the family premium, plus required wrap-around costs (coinsurance, deductibles, BadgerCare services not covered by the health plan) equal to BadgerCare coverage, must be cost-effective compared to enrollment into the managed care delivery system.

IX. GENERAL REPORTING REQUIREMENTS

21. **General Financial Requirements.** The State shall comply with all general financial requirements under title XIX and title XXI as outlined in Sections X and XII.
22. **Reporting Requirements Relating to Budget and Allotment Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality as outlined in Section XI and all reporting requirements for allotment neutrality as outlined in Section XII. The State must submit any corrected budget and/or allotment neutrality data upon request.
23. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. seq., unless expressly identified as not applicable in the expenditure authorities incorporated into these STCs.
24. **Quarterly Calls.** CMS will schedule quarterly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, managed care organization (MCO) operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, family planning issues, the benefit package, audits, lawsuits, financial reporting related to budget neutrality, and allotment neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.
25. **Quarterly Progress Reports.** The State must submit progress reports in the format outlined below no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:
 - a) An updated budget neutrality monitoring spreadsheet;
 - b) An updated allotment neutrality monitoring spreadsheet;
 - c) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting

- with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; and other operational issues;
- d) Action plans for addressing any policy, administrative or budget issues identified;
 - e) Quarterly enrollment reports will be provided to CMS for demonstration eligibles that includes the member months for each demonstration population; and
 - f) Evaluation activities and interim findings.
26. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy, and administrative difficulties and solutions in the operation of the Demonstration. The State must submit the draft annual report no later than 120 days after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.
27. **Title XXI Enrollment Reporting.** The State will provide CMS with an enrollment report by Demonstration population showing end of quarter actual and unduplicated ever enrolled figures. The enrollment data for the title XXI population will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. This includes all populations funded with title XXI.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

28. **Quarterly Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI.
29. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality cap:
- a. **Tracking Expenditures.** In order to track expenditures under this Demonstration, the State must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality cap must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS, (11-W-00125/5) including the project number extension, which indicates

the Demonstration Year (DY) in which services were rendered or for which capitation payments were made. For this purpose, Demonstration Year 1 (DY 1) is defined as the year beginning July 1, 1999, and ending June 30, 2000. DY 2 and subsequent DYs are defined accordingly.

Expenditures for Demonstration Population 1. Expenditures for optional targeted low-income children claimed under the authority of title XXI of the Act shall be reported each quarter on Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver. On the Forms CMS 64.21U and CMS 64.21UP Waiver enhanced match (title XXI) funding for total computable is reported in column A and enhanced match in column C.

When expenditures are being reported from more than one Demonstration year there will be multiple pairs of Forms CMS-64.9 Waiver and/or 64.9P Waiver, and CMS-64.21U Waiver and/or CMS -64.21UP Waiver included for the demonstration.

- b. For each Demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, CMS -64 .21U Waiver and/or CMS -64.21 UP Waiver should be submitted reporting expenditures subject to the budget neutrality cap or SCHIP allotment for the following demonstration eligibles as follows:

Demonstration Population	Waiver Name/Eligibility Group (EG) Name	CMS 64 Form	Funding Source/Neutrality Test
Demonstration Population 1	BC CHILDREN	CMS 64.21 U Waiver and/or 21 UP Waiver	SCHIP (title XXI) Allotment neutrality
Demonstration Population 2a	BC:Adults<=100%	CMS 64.9 Waiver and/or 64.9P Waiver	Medicaid (title XIX) Budget Neutrality
Demonstration Population 2b	BC:Adults 100-130%	CMS 64.9 Waiver and/or 64.9P Waiver-starting July 1, 2007	Medicaid (title XIX) Budget Neutrality

- c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10.B, in lieu of Lines 9 or 10.C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

30. Expenditures Subject to the Budget Neutrality Cap. For the purposes of this section, the term, “expenditures subject to the budget neutrality cap” includes all Medicaid expenditures on behalf of the BadgerCare Adults with income up to and including 100% of the FPL, and starting June 1, 2007, for BadgerCare Adults with income 100-130% of the FPL under the Demonstration, which includes both expenditures for expansion individuals enrolled in an MCO and expansion individuals

eligible but not yet enrolled into an MCO.

31. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are attributable to the demonstration. All administrative costs must be identified on the Forms CMS 64.10 Waiver and/or 64.10P Waiver and summarized in the quarterly and annual reports.
32. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.
33. **Reporting Member Months.** The following describes the reporting of member months for Demonstration populations :
 - a. For the purpose of calculating the budget neutrality expenditure cap described in Section XI, the State will provide to CMS on a quarterly basis the actual number of eligible member/months (as defined in paragraph 33b). These will include only member/months (MM) for Demonstration Population 2a, and effective June 1, 2007, separately for Demonstration Population 2b. This information should be provided to CMS as part of the regular quarterly progress report. If a quarter overlaps the end of one Demonstration year (DY) and the beginning of another, member/months pertaining to the first DY will be distinguished from those pertaining to the second Demonstration year. The Demonstration year is defined as the actual date of the implementation of the Demonstration, or the anniversary of that day. **The BadgerCare demonstration year is July 1 through June 30.** Reported MM totals may be revised by the State as needed.
 - b. The term, “eligible member/months” will refer to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months, each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.
34. **Standard Medicaid Funding Process.** The standard Medicaid funding process for annual grant award States will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State shall provide updated estimates of expenditures for the waiver population. CMS will make Federal funds available based upon the State’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 annually with

Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the annual grant award to the State.

35. **Extent of Federal Financial Participation for the Demonstration.** CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Section XI.
- a. Administrative costs, including those associated with the administration of the BadgerCare Demonstration, which will not be included in the per eligible per month cost used for the budget neutrality determination;
 - b. Net expenditures of the Medicaid program and prior period adjustments which are paid in accordance with the approved State Plan (including disproportionate share hospital payments); and
 - c. Net medical assistance expenditures made under Section 1115 waiver authority, including those made in conjunction with the BadgerCare Demonstration.
36. **Premiums Paid by the State via the Health Insurance Premium Purchase (HIPP) Program.** When the State makes payments to buy into employer-sponsored insurance for families who are eligible for Badgercare in lieu of direct enrollment into the BadgerCare demonstration, and the parent or spouse for whom employer sponsored insurance (ESI) is being subsidized are members of Demonstration Population 2a (and after July 1, 2007, Demonstration Population 2b), these expenditures must be reported on the CMS 64.9 waiver and 64.9P waiver as a Line 18c adjustment and will be subject to the budget neutrality cap.
37. **Sources of Non-Federal Share.** The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds shall not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
- a. CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
 - b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
38. **State Certification of Funding Conditions.** The State certifies that the following conditions for non-Federal share of Demonstration expenditures are met:
- a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

- b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.
- d. The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

XI. MONITORING BUDGET NEUTRALITY

- 39. **Limit on Title XIX Funding.** The State will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. This limit will be determined using a per capita cost method. In this way, the State will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid eligibles, CMS assures that the State demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.
- 40. **Budget Neutrality Expenditure Cap.** The BadgerCare demonstration was determined to have exceeded its budget neutrality expenditure cap for DY 1 through DY 5, and the State has returned to the Federal Government title XIX matching funds that it received in excess of the cap. Consequently, the matter of budget neutrality for DY 1 through DY 5 is regarded as closed and settled. A separate

budget neutrality test will apply to the period beginning with DY 6 through the end of this extension. For the purpose of calculating the overall expenditure limit for this period, separate budget estimates have been calculated for each year on a DY basis. The annual estimates were added together to obtain an expenditure estimate for DY 6 through the end of this extension. The Federal share of this estimate represents the maximum amount of FFP that the State may receive for the types of Medicaid expenditures described in paragraph 30 above.

41. **Projecting Service Expenditures.** Each demonstration year estimate of Medicaid service expenditures will be calculated as the product of the projected per member/per month (PMPM) cost times the actual number of eligible member months as reported to CMS by the State under the guidelines set forth in Section X, paragraph 33.
42. **Calculation of the Budget Neutrality Expenditure Cap.** The PMPM rate for “BC:Adults <=100%” is \$244.93 through June 30, 2007. Starting July 1, 2007, both “BC:Adults <= 100%” and “BC:Adults 100-130%” have a blended PMPM rate of \$229.58, trended forward by 6.1 percent per year for DY 9 through DY 11. The blended PMPM was developed as a weighted average of two elements: (1) the projected PMPM cost for BC:Adults <= 100% from the March 31, 2004, demonstration extension award (\$244.93) and projected PMPM cost for parents with incomes between 100% and 200% of FPL developed using historic cost data from BadgerCare Demonstration annual reports (\$206.90). The weights are based on the projected numbers of member months in BC:Adults <=100% and BC Adults 100-130% for the last quarter of DY 8, using projections supplied by the State.

Eligibility Group (EG)	DY 8 SFY 2007	DY 9 SFY 2008	DY 10 SFY 2009	DY 11 SFY 2010
BC:Adults <= 100% through June 30, 2007	\$244.93			
BC:Adults <= 100% BC:Adults 100-130% starting July 1, 2007	\$229.58	\$243.58	\$258.44	\$274.20

43. **Enforcement of Budget Neutrality.** The limit calculated above will apply to actual expenditures for Medical services, as reported by the State under Section XI. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the approved renewal period, the budget neutrality test will be based on the time period from renewal through the termination date.
44. **Expenditure Review.** CMS will enforce budget neutrality over the life of the demonstration from Demonstration year 6 forward, rather than on an annual basis. However, if the State’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

Year	Cumulative target definition (period specific)	Percentage
Year 6-8	Budget Neutrality expenditure cap plus	1 percent
Year 6 and 9	Combined budget neutrality expenditure cap plus	0.75 percent
Year 6 through 10	Combined budget neutrality expenditure caps plus	0.5 percent
Year 6 through 11	Combined budget neutrality expenditure caps plus	0 percent

In addition, the State may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the Demonstration will exceed the cap during this extension.

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

45. **Quarterly Reports.** The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved SCHIP plan and those provided through the BadgerCare demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP only for allowable BadgerCare demonstration expenditures that do not exceed the State's available title XXI funding.
46. **Reporting Expenditures for Title XXI Under the Demonstration.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the MBES/CBES, as part of the routine quarterly CMS-21 reporting process. Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver/CMS-21P Waiver, identified by the demonstration project number assigned by CMS (**21W00001/5**) (including project number extension, which indicates the DY in which services were rendered, or for which capitation payments were made). All expenditures for Demonstration Population 3 (and, through June 30, 2007, for Demonstration Population 2b), including expenditures for family planning services, will be reported on Forms CMS-21 Waiver/CMS -21P Waiver and the Federal matching rate for these expenditures will be the title XXI Enhanced FMAP rate.
- a. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

- b. The standard SCHIP funding process will be used during the demonstration. The State must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
 - c. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.
 - d. All administrative costs are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.
47. **Expenditures Subject to the Allotment Neutrality Limit.** The State will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the waiver period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including available reallocated funds published in the *Federal Register*. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of demonstration populations 1 and 3 until the next allotment becomes available.

Demonstration Population	Waiver Name and Eligibility Group Name	CMS 21 Form
Demonstration Population 1	BC Children (ADM)	CMS 21 Waiver/CMS 21P Waiver
Demonstration Population 2b	Parents: 100-130% FPL	CMS 21 Waiver/CMS 21P Waiver through June 30, 2007
Demonstration Population 3	Parents:130-200% FPL	CMS 21 Waiver/CMS 21P Waiver

48. **Premium Collections (Non-HIPP Program).** Premiums and other applicable cost sharing contributions from enrollees that are collected by the State under this demonstration and which will offset program expenditures must be reported to CMS each quarter on the CMS-21 waiver or 21P waiver as a line 1D.-Premium –over 150% -Cost Sharing offset. This applies only to premiums and cost sharing collections from families in which the parent and/or spouse are members of Demonstration Population 3, or through June 30, 2007, Demonstration Population 2b.
49. **Premiums Paid by the State via the HIPP Program.** When the State makes payments to buy into ESI for families who are eligible for Badgercare in lieu of

enrollment into the BadgerCare demonstration and the parents or spouse whose ESI is being subsidized is a member of Demonstration Population 3 (or through June 30, 2007, Demonstration Population 2b) the premiums paid for this program will be reported on the Forms CMS-21 Waiver and CMS-21P Waiver as a Line 1A Premiums - Up to 150 percent Gross, Premium Paid or 1C - Premiums Over 150 percent Gross Premiums Paid, and will be subject to the allotment neutrality cap.

50. Priority Order for the Use of Title XXI Funds. The State will use title XXI funds in the following priority order:

- a. Any title XXI State plan population, BC Children (Demonstration Population 1) and BC Children (ADM); and
- b. Parents: 130-200 percent FPL (Demonstration Population 3): Custodial parents and spouses of title XXI eligible children with net family incomes above 130 percent up to and including 200 percent FPL, and who are themselves not eligible for Medicaid under the State plan.

If during the course of regular CMS monitoring of the State's SCHIP expenditures, the quarterly title XXI reports indicates that the State will not be allotment neutral for the year, the State will take actions with respect to Demonstration Population 3 including enrollment limits or waiting lists consistent with STC #53, lowering the FPL used to determine eligibility, or discontinuing coverage. The State will be required to submit an amendment request to CMS in order to impose enrollment limits or waiting lists, lowering the FPL or discontinuing coverage of Demonstration Population 3.

51. Confirmation of SCHIP Allotment with the Submission of SCHIP State Plan Amendments. Should the State seek an amendment under the SCHIP State plan that has a budgetary impact on allotment neutrality, the State shall submit an updated allotment neutrality budget with the SCHIP State plan amendment for CMS review and approval.

52. Ensuring Title XXI Expenditures Do Not Exceed Available Title XXI Funds.

Changes Impacting Demonstration Population 3 Require An Amendment

The State is required to take necessary steps to ensure that expenditures funded through title XXI do not exceed the State's available title XXI allotment. The State is not precluded from changing eligibility levels, closing enrollment or instituting a waiting list for Demonstration Population 3 in order to ensure that expenditures do not exceed the State's available title XXI allotment. In order to make any of these changes (or changes to benefits or cost sharing), the State will submit an amendment request to the assigned CMS Project Officer and Regional Office and provide timely public notice as described in STC #14. The amendment should be submitted no later than 120 days prior to the date of implementation of the change(s) and may not be implemented until approved by CMS. All Federal rules shall continue to apply during the period of the demonstration that title XXI Federal funds are not available.

No Changes Are Allowable for Children While Demonstration Population 3 Is Funded with Title XXI

In addition, the State may not decrease benefits, increase cost sharing, or decrease eligibility standards with respect to the children covered under its title XXI State plan or Demonstration population 1 while the demonstration is in effect or title XXI funding will be terminated for Demonstration Population 3.

Available Funds Considered Under Allotment Neutrality

When taking necessary steps to ensure that expenditures funded through title XXI do not exceed the State's available title XXI allotment, the amount of reallocated funds for the State must be based on Federal funding that has already been made available to the State and published in the *Federal Register*. The State may only include in its budget projections those reallocated funds that have already been allocated to the State as published in the *Federal Register*. The State may not project any redistribution or retained funds for current or future fiscal years.

- 53. Outreach and Administrative Costs.** Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of the total title XXI net expenditures.

XIII. EVALUATION OF THE DEMONSTRATION

- 54. State Must Evaluate Components of the Demonstration.** As outlined below, the evaluation describes whether the State met the Demonstration goal and objectives with recommendations for future efforts. The State must submit to CMS for approval a draft evaluation design no later than October 1, 2007. The evaluation must outline and address evaluation questions for the following:

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

- 55. Renewal and Final Evaluation Plans and Evaluation Reports.** CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 54, within 60 days of receipt of CMS comments. The State must implement the approved evaluation design and report on its progress on each of the quarterly reports. The State must submit to CMS a draft evaluation report 120 days prior to the expiration of

the Demonstration and/or with each Demonstration renewal request. CMS shall provide comments within 60 days of receipt of the report. The State must submit the final report prior to the expiration date of the Demonstration.

- 56. Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration, the State will cooperate with CMS or the independent evaluator selected by CMS. The State will submit the required data to CMS and/or the contractor.

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE TERM OF THIS DEMONSTRATION EXTENSION

Date	Deliverable
October 1, 2007	Submit Draft Evaluation Design
March 31, 2009	Submit to CMS Demonstration Extension Application 1115(a) or (e), and Interim Evaluation Report for the current extension period
Quarterly	Deliverables
	Requirements for Quarterly Report, paragraph 25
	Enrollment Reports, paragraph 25
	Enrollment Reports through SEDS for title XXI, paragraph 27
	Expenditure Reports, paragraphs 29 and 46
Annual	Deliverables
	Submit Draft Annual Reports, paragraph 26