CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00214/6 (Title XIX)**
21-W-00051/6 (Title XXI)

TITLE: **Arkansas Safety Net Benefit Program**

AWARDEE: **State of Arkansas, Department of Health and Human Services**

I. PREFACE

The following are Special Terms and Conditions (STCs) for the Arkansas Safety Net Benefit Program, a title XIX and title XXI section 1115(a) Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Arkansas Division of Medical Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The effective date of the Demonstration is December 31, 2011, and is approved through December 31, 2013; however, approval of the title XXI funded components will expire on September 30, 2012, and the State must submit a separate extension request under section 2111(b)(2) of the Social Security Act (the Act) for those components to continue beyond September 30, 2012.

The STCs have been arranged into the following subject areas:

I. Preface;
II. Program Description and Objectives;
III. General Program Requirements;
IV. Eligibility;
V. Benefits;
VI. Delivery Systems;
VII. Health and Wellness Benefits Program (HWBP);
VIII. Cost Sharing;
IX. General Reporting Requirements;
X. Monitoring and Evaluation;
XI. General Financial Requirements Under Title XIX;
XII. General Financial Requirements Under Title XXI;
XIII. Monitoring Budget Neutrality; and,
XIV. Schedule of State Deliverables.

Additionally, one attachment has been included to provide supplementary guidance.

II. PROGRAM DESCRIPTION AND OBJECTIVES

This Demonstration, initially approved in 2006, transitioned the State's 1915(b) waiver Primary Care Case Management (PCCM) program – ConnectCare – to a section 1115 Demonstration. The objective of the transition was to create savings from the approximately 300,000 ConnectCare enrollees to support a new Health Insurance Flexibility and Accountability (HIFA) program developed under the Demonstration.[1]

Under the Demonstration, the savings from use of the ConnectCare program fund the Arkansas Safety Net Benefit Program, which provides coverage through a public/private partnership by providing a "safety net" benefit package to otherwise uninsured individuals. Coverage through the program is available to individuals who work for small and mid-size employers (500 or less employees) who have elected to participate in the program and who have not offered group health insurance to their employees in the past 12 months. For participating employers, 100 percent of employees whose income is up to and including 200 percent of the FPL must enroll, or demonstrate proof healthcare coverage through another source. The employer also must provide coverage through the Safety Net Benefit Program to at least 50 percent of employees whose income exceeds 200 percent of the FPL, and who do not have other insurance (excluding employees that have coverage through another source). Catastrophic plans or hospital reimbursement plans do not count as insurance coverage for the purposes of this Demonstration. The program assists in reducing the percent of working uninsured by promoting the coordination of health care between the public and private sectors.

Finally, the Demonstration provides funding for a calculated percentage of four previously State-funded tobacco cessation programs, one indigent care program and two minority health initiatives (collectively called HWBP) that are available to Demonstration enrollees.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must 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. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy Statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents, of which these terms and conditions are part, must apply to the Demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, and policy statement, come into

[1] Under the HIFA initiative, States could receive enhanced waiver flexibility to create public-private partnerships to build on employer sponsored insurance. States could develop modified benefit packages and impose cost-sharing, to extend coverage for optional and expansion populations covered under Medicaid and CHIP.

compliance with any changes in Federal law, regulation, or policy affecting the Medicaid and CHIP programs that occur during this Demonstration period, unless the provision being changed is explicitly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.**

   a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. 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 will not be required to submit title XIX or title XXI State plan amendments for changes to any populations made eligible solely through the Demonstration. If a population eligible 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 Demonstration Amendment Process.** Changes related to program design, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, employer sponsored insurance, FFP, evaluation design, sources of non-Federal share of funding, budget and allotment neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. 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 planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with the STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must be accompanied by information that includes but is not limited to the following:

a. An explanation of the public process used by the State, consistent with the requirements of paragraph 13, to reach a decision regarding the requested amendment;

b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and 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. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and,

d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Demonstration Phase-Out. The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b) Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The State must comply with all notice requirements found

in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d) Federal Financial Participation (FFP): 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.

9. **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 will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

10. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waiver 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 titles XIX or XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal close-out costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

12. **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.

13. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the public notice procedures set forth in 59 *Fed. Reg.* 49249 (1994), unless they are otherwise superseded by rules promulgated by CMS. The State must also comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American recovery and reinvestment

Act of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and/or renewal of this Demonstration.

IV. ELIGIBILITY

14. Eligibility: Mandatory and optional State plan groups described below are subject to all applicable Medicaid and CHIP laws and regulations except as expressly waived. Those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid or CHIP laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. As indicated in the waiver and expenditure authorities, Medicaid and CHIP requirements apply to such Demonstration expansion populations except as expressly waived or stated not to be applicable. The criteria for the Arkansas Safety Net Benefit program eligibility groups are as follows:

ELIGIBILITY GROUPS UNDER THE DEMONSTRATION

Mandatory State Plan Groups (additional criteria as per State plan)*	**FPL Level**	**Population**
AFDC/TANF children and related populations covered by section 1931	FPL based on TANF methodology	Population III
AFDC/TANF adults and related populations covered by Section 1931	FPL based on TANF methodology	Population III
Pregnant women and infants	Up to 133 percent	Population III
Blind/disabled Adults 18 and older	Countable income below $623 (SSI level)	Population III
Blind/disabled children 0-18	Countable income below $623 (SSI level)	Population III
Aged adults 65 and older	Countable income below $623 (SSI level)	Population III
Foster Care Children	Title IV-E	Population III
Optional State Plan Groups (additional criteria as per State Plan)*		
Pregnant women and infants	133 - 185 percent of the FPL	Population III
Blind/disabled Adults 18 and older	Countable income above SSI level but below 100 percent FPL	Population III

Blind/disabled children 0-18	Countable income above SSI level but below 100 percent FPL	Population III
Aged adults 65 and older	Countable income above SSI level but below 100 percent FPL	Population III
Arkansas Safety Net Benefit Demonstration Expansion Populations (Additional Criteria as per these STCs)		
Parents and spouses (ages 19 – 64) who work for a participating employer (including self employed), or whose spouse does, and have a dependent child	Up to and including 200 percent FPL.	Population I
Childless adults and spouses (ages 19 -64) who work for a participating employer (including self employed), or whose spouse does, and are childless,	Up to and including 200 percent FPL.	Population II

* Eligible for ConnectCare PCCM Program.

a. Population I – Includes only individuals employed by participating employers (including self employed) or spouses of such employees who: (1) are aged 19-64; (2) have a dependent child; (3) have no other health insurance coverage or group health insurance coverage; (4) are not eligible for Medicaid or Medicare; (5) are not State employees; (6) are U.S. citizens or have State verification of qualified alien status in accordance with section 432 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; and (7) have family incomes up to and including 200 percent of the Federal poverty level (FPL).

b. Population II – Includes only individuals employed by participating employers (including self employed) or spouses of such employees who: (1) are aged 19 – 64; (2) are childless; (3) have no other health insurance coverage or group health insurance coverage; (4) are not eligible for Medicaid or Medicare; (5) are not State employees; (6) are U.S. citizens or have State verification of qualified alien status in accordance with section 432 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; and (7) have family incomes up to and including 200 percent of the FPL.

c. Population III – Individuals eligible to participate in the ConnectCare program, the State's PCCM Program. All persons eligible for Medicaid in the Mandatory and Optional State Plan Groups that appear in the table above are part of Population III, except for those identified as Excluded in subparagraph (d) below.

d. Excluded Populations - The following individuals are excluded from the

ConnectCare PCCM program and are excluded from this Demonstration.

i. Persons who have Medicare as their primary insurance;
ii. Persons in a long term care aid category and a resident of a nursing facility;
iii. Persons residing in an intermediate care facility for the mentally retarded (ICF/MR);
iv. Persons in a Medically Needy Spend Down eligibility category;
v. Persons who only have retroactive eligibility period
   - Medicaid does not require PCCM enrollment for the period between the beginning of the retroactive eligibility segment and the fifth day (inclusive) following the eligibility authorization date;
   - If eligibility extends beyond the fifth day following the authorization date, Medicaid requires PCCM enrollment unless the beneficiary is otherwise exempt from PCCM requirements;
vi. Persons who are in the Tuberculosis aid category; and,
vii. Persons who are in the Family Planning aid category.

15. Participating Employers. The State shall limit employer participation in the Arkansas Safety Net Demonstration to employers with no more than 500 employees. Employers are eligible to participate in the program if they have not offered group health insurance in the past 12 months. Eligible employers will voluntarily participate in the program. For the purpose of this waiver, employer is defined as a business entity with a unique State and/or Federal tax identification number and employees. For participating employers, 100 percent of employees whose income is up to and including 200 percent of the FPL must enroll. The employer also must provide coverage through the Safety Net Benefit program to at least 50 percent of employees whose income exceeds 200 percent of the FPL, and who do not have other insurance (excluding employees that have coverage through another source). Catastrophic plans or hospital reimbursement plans do not count as insurance coverage for the purposes of this Demonstration.

V. BENEFITS

16. Benefits for Population III (Connect Care Enrollees). ConnectCare enrollees receive Medicaid State plan services and additionally receive care coordination and health education services not provided under the State plan.

17. Benefits for Arkansas Safety Net Benefit Expansion Populations I and II.

a. Basic Benefits: The safety net benefit package for Populations I and II (defined in paragraph 14) consists of a total of 15 days of service: 7 days inpatient coverage per year; 6 physician office visits per year; 2 outpatient hospital visits per year (including emergency room); and 2 prescriptions per month. Lab and x-ray are inclusive on the date of service and do not count as a day of service provided that the service is received on the same day as further described in the employer sponsored insurance

package.

b. Access to HWBP. The State must assure that Demonstration populations have access to the services provided under the Health and Wellness Benefits Program as geographically provided and available throughout the State. The State must develop and implement a plan to be included under the Cost-Containment Strategy Plan referenced in paragraph 23, to provide programs and opportunities for Demonstration populations to access and benefit from HWBP services. The plan must include how the State will educate and reach out to beneficiaries and providers and ensure utilization of HWBP services.

18. HWBP Programs. The programs are summarized as follows:

i. Community Programs - Smoking prevention and control activities provided through approximately 30 community programs. Activities include youth and adult prevention, educating the community about the dangers of secondhand smoke, identifying and eliminating the disparities related to tobacco use, and promoting cessation activities.
ii. Chronic Disease Programs – Includes the Governor's Council on Fitness whose mission is to encourage health and wellness for all individuals in Arkansas by promoting healthy lifestyles through increased levels of physical activity.
iii. Statewide Programs – Includes the Coalition for Tobacco Free Arkansas which provides education and supports local efforts to pass anti-tobacco ordinances and the Arkansas Cancer Coalition which supports the establishment and maintenance of smoke-free State education facilities.
iv. Cessation Programs – Includes public awareness and health promotion campaigns, and the Arkansas Tobacco Quitline.
v. Minority Initiatives – Includes support for the Minority Initiatives Sub-recipient Grant Office which coordinates grants for education on the effects of second-hand smoke; reductions in youth access; decreasing the advertising and promotion of tobacco products; and the promotion of smoking cessation.
vi. Arkansas Minority Health Commission – Conducts campaigns to increase awareness of hypertension, strokes, and other disorders disproportionately critical to minorities by utilizing approaches that include but are not limited to: advertisements, distribution of educational materials, and providing medications for high risk minority populations.
vii. Arkansas Rural Health Education Centers "Indigent Care Program" – Comprised of seven Area Health Education Centers (AHECs) healthcare services and teaching centers geographically dispersed throughout Arkansas. These facilities provide healthcare for patients regardless of ability to pay and serve as training sites for students in the fields of medicine, nursing, pharmacy, and various allied professions.

VI. DELIVERY SYSTEMS

19. Delivery System for Population III (Connect Care Program). The State may

require individuals receiving services through Connect Care to select a PCCM, or may assign them to a PCCM. Reimbursement for services will be on a fee-for-service basis. These enrollees have access to the State plan Medicaid delivery system, which must ensure adequate choice for ConnectCare enrollees. Enrollees must be permitted to disenroll from their PCCMs or transfer between PCCMs. Enrollees are allowed to terminate or change their enrollment for any stated reason at any time. The disenrollment/transfer must be effective immediately at the time the enrollee makes the request.

20. **Self Referrals under Connect Care Program.** Connect Care enrollees may self-refer under the following circumstances or for the following services. The circumstances or services may be revised by the State provided a 60 day notice is made to CMS in advance of the revision.

    - Anesthesia services, excluding outpatient pain management;
    - Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists. The physician and facility assessment services do not require a PCCM referral (if the Medicaid beneficiary is enrolled with a PCCM);
    - Dental services;
    - Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS;
    - Emergency services in an acute care hospital emergency department, including emergency physician services;
    - Family planning services;
    - Gynecological care;
    - Inpatient hospital admissions on the effective date of PCCM enrollment or on the day after the effective date of PCCM enrollment;
    - Mental Health services as follows:
        - Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner;
        - Rehabilitative services for persons with mental illness (RSPMI Program) age 21 or older, or for specified procedures for persons under age 21 as listed in the RSPMI provider manual;
        - Rehabilitative Services for Youth and Children (RSYC) Program;
    - Obstetric (antepartum, delivery and postpartum) services:
        - Only obstetric-gynecologic services are exempt from the PCCM referral requirement;
        - The obstetrician or the PCCM may order home health care for antepartum or postpartum complications;
        - The PCCM must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider;
    - Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye;
    - Optometry services;
    - Pharmacy services;

- Physician services for inpatients in an acute care hospital. This includes:
    - Direct patient care (initial and subsequent evaluation and management services, surgery, etc), and
    - Indirect care (pathology, interpretation of X-rays, etc.);
- Hospital non-emergency or outpatient clinic services on the effective date of PCCM enrolment or on the day after the effective date of PCCM enrollment
- Physician visits (except consultations) in the outpatient departments of acute care hospital:
    - Medicaid will cover these services without a PCCM referral only if the Medicaid beneficiary is enrolled with a PCCM, and the services are within applicable benefit limitations;
    - Consultations require PCCM referral;
- Professional components of diagnostic laboratory, radiology and machine tests in the outpatient departments of acute care hospitals. Medicaid covers these services without a PCCM referral only:
    - If the Medicaid beneficiary is enrolled with a PCCM, and
    - The services are within applicable benefit limitations; and
- Other services such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity, or would create unnecessary hardship.

21. Delivery Systems for Arkansas Safety Net Benefit Demonstration Expansion. The State contracts with an administrator who must provide a statewide provider network for the delivery of the safety net benefit package. The plan administrator pays provider claims for covered services furnished to Arkansas Safety Net Benefit Demonstration enrollees. Provider reimbursement rates are based on contracts between providers and the plan administrator and do not exceed the plan administrator's usual and customary payment rates.

VII. HEALTH AND WELLNESS BENEFITS PROGRAM (HWBP)

22. HWBP Maintenance of Effort and Matching of State-Funded Program: FFP is available as matching funds for a percentage of the HWBPs described in paragraph 18. The Demonstration increases the amount and scope of publicly funded health care services in the State.

a. **HWBP Maintenance of Effort.** The amount of State fiscal year (SFY) 2006 State funds expended for the HWBP for the programs described above will be maintained or increased above the SFY 2006 level during the operation of the Demonstration. State expenditures for the parent and childless adult expansion and the HWBP will count toward meeting the maintenance of effort requirement.

b. **Match for HWBP State-Funded Program.** HWBP expenditures related to appropriate services for Demonstration target populations are eligible for

Federal matching funds through this Demonstration. No other current or previous State-funded program is eligible for Federal matching funds. Under the authority granted in this Demonstration, the availability of Demonstration funding the State may use to pay for HWBP costs will extend through December 31, 2013, pursuant to section XII.

c. **Available FFP for HWBP.** Annually, FFP is authorized to pay for HWBP costs during the Demonstration period. The State shall be limited to the following cumulative amounts as based on actual HWBP costs (i.e., costs authorized for FFP for HWBP should not exceed $5,250,000 in Demonstration year (DY) 6 and DY 7 and total costs should not exceed $11,812,500 through December 31, 2013).

Demonstration Year	**DY 6 (10/1/2011 – 9/30/2012**	**DY 7 (10/1/2012 – 9/30/2013**	**DY 7 (10/1/2013 – 12/30/2013**
Maximum Cumulative Amount of Funds Available for FFP	$5,250,000	$10,500,000	11,812,500

d. **Reporting HWBP Payments.** The State will report all expenditures for HWBP payments to the above listed programs under this Demonstration on the Forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name HWBP, as well as on the appropriate forms CMS-64.9I and CMS-64.9PI.

e. **Monitoring HWBP.** The State must provide to CMS the annual Tobacco Settlement Commission report made to the Arkansas General Assembly including external evaluation results, programmatic performance assessments, and fiscal accountability reports for component programs of the state's Tobacco Settlement Act (TSA) related to the Demonstration. In addition, CMS may conduct a review of the HWBP to assess continued expenditure of funds for appropriate services to target populations.

23. Cost-containment Strategy Plan and Implementation. The State must provide to CMS a comprehensive cost-containment strategy, which demonstrates the State's commitment to achieving Medicaid savings, within 60 days of approval of the 2011 Demonstration extension. Cost containment initiatives must include, but is not limited to, programs to make HWBP services accessible to Demonstration populations. Initiatives could also include population focused improvements that enhance the delivery of care and/or provide education for the highest burden (morbidity, cost, prevalence, etc.) conditions/services present for Demonstration populations. CMS will provide comments to the State within 30 days and the State must submit the final plan within 30 days of receiving CMS' comments. The State must fully implement the cost-containment plan within 180 days of approval by CMS.

VIII. COST SHARING

24. Cost Sharing. The following cost sharing will be imposed under the Demonstration.

a. Connect Care Program: Cost sharing on each population shall be consistent with the cost sharing permitted under the approved State plan.
b. Arkansas Safety Net Benefit Program – The following cost sharing is assessed for each enrollee without regard to family income: $100 deductible; 15 percent coinsurance for all services except pharmacy; $1,000 annual out-of-pocket maximum for coinsurance and deductible. Payments toward tiered drug co-payments are subject to co-pays ($5 generic, $15 brand formulary, and $30 non-brand formulary), but not to a deductible, and do not count toward the out-of-pocket maximum. A $25 monthly premium is required which participating employers are encouraged to pay on behalf of employees. Self-employed individuals are subject to a $35 monthly premium. Expenditures claimed by the plan administrator must be reduced by any premiums paid be enrollees.

25. Enrollment and Disenrollment. When the Safety Net Benefit Program enrollee becomes ineligible (either because of non-payment of premium, income, or other factors including that the employer ceases to qualify as a participating employer), then coverage will end on the last day of the month in which the premiums have been paid. Affected employees must be notified promptly of their ineligibility. If the enrollee, before the later of that date or 15 days following notification, corrects any deficiency (either though payment of the premium or other means), or demonstrates an error in the notification, the enrollee will be retroactively reinstated.

IX. GENERAL REPORTING REQUIREMENTS

26. **General Financial Requirements.** The State must comply with all general financial requirements set forth in Section XI and Section XII.

27. Reporting Requirements Relating to Budget Neutrality. The State must comply with all reporting requirements set forth in Section XIII.

28. Quarterly Progress Reports. The State must submit quarterly progress reports, to include the items outlined below (see also Attachment A), 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 under the demonstration. These quarterly reports must include, but are not limited to:

a. An updated budget neutrality monitoring spreadsheet including enrollment data, member month data, and expenditure data in the format provided by CMS;
b. A discussion of 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, geographic expansion, benefits; enrollment and

disenrollment; grievances; quality of care; access; pertinent legislative or litigation activity, and other operational issues;

c. Action plans for addressing any policy, administrative, or budget issues identified;
d. Progress toward reducing the rate of uninsurance including the monitoring of substitution coverage (i.e. participants dropping private coverage);
e. A reporting of all employees that are earning greater than 200 percent of the FPL that are being covered through the Safety Net Benefit Program for whom the State is not claiming FFP; and
f. Descriptions of and updates on HWBP program operations and spending.

29. **Quarterly Enrollment Reports.** Each quarter the State will provide CMS with an enrollment report, by Demonstration population, which shows the end of quarter actual and unduplicated ever-enrolled figures. Enrollment data for Demonstration Population I will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. The State will provide enrollment information for Demonstration Populations II and III as described in Section XI and Section XII.

30. **Monthly Calls.** CMS will schedule monthly 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, program operations, health care delivery, enrollment (including the State's progress on enrolling individuals into the Safety Net Benefit program), cost sharing, quality of care, access, the benefit package, HWBP services, audits, lawsuits, financial reporting and budget neutrality issues, 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 (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

31. **Annual Report.** The State must submit an annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy, administrative difficulties in the operation of the Demonstration. The report must also contain a discussion of the items that must be included in the quarterly reports required under paragraph 28, including a detailed analysis of administrative costs as part of budget neutrality. The State must submit this report no later than 90 days after the close of each DY. The Annual Report for DY 6 must include an analysis comparing per capita administrative costs for Medicaid State plan services with the per capita administrative costs for the Safety Net Benefit Program, including an explanation for any difference between the two.

32. **Transition Plan**. On or before July 1, 2012, the State is required to submit a draft and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the State plans

to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in paragraphs 9(a)-(f) outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

a. Seamless Transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

   i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

   ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

   iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

   iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

   v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

b. Cost-sharing Transition: The Plan must include the State's process to come into compliance with all applicable Federal cost-sharing requirements, including the section 1916(f) requirements that apply to the childless adult population when it becomes a mandatory State plan population on January 1, 2014.

c. Access to Care and Provider Payments and System Development or Remediation: The State should assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. Additionally, the Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care

Act and other Federal legislation.

d. Progress Updates: After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

e. Implementation:

i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

X. MONITORING AND EVALUATION

33. Submission of Draft Evaluation Design. The State must submit to CMS for approval, within 120 days from the award of the Demonstration extension, a draft evaluation design update. At a minimum, the draft design update must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on target populations for the 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. The evaluation must include a survey of participating employers and employees to determine satisfaction levels with the program. 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 other initiatives occurring in the State. Specifically, the State must identify the applicable effects of HWBP on the access to care, quality and efficiency of care, benefits associated with care, and the cost of care. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

34. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design update within 60 days of receipt, and the State must submit a final design within 60 days of receipt of CMS' comments. The State must implement the updated evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the current Demonstration period, which will summarize all findings from the evaluation. The State must submit the final evaluation report within 60 days after receipt of CMS' comments.

35. **Cooperation with Federal Evaluators.** Should CMS conduct an evaluation of the Demonstration, the State must fully cooperate with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

36. **Quality Monitoring Plan**. The State must maintain a quality assurance monitoring plan which at a minimum, includes the following: Quality indicators to be employed to monitor service delivery under the Demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program; quality monitoring surveys, and the monitoring and corrective action plans to be triggered by the surveys; and fraud control provisions and monitoring.

37. **Monitoring of Employer-Sponsored Insurance (ESI**). The State must monitor the extent to which employers may decrease or cease to provide ESI. This monitoring can be accomplished by tracking changes in employer contribution levels towards ESI and/or by measuring the degree of substitution of ESI coverage by employers with the Demonstration benefit package. The State shall not only monitor such changes, but shall be prepared to address substantial decreases in employer contribution levels as well as data delineating significant substitution of coverage. This information will be included in the State's Demonstration annual report.

XI. GENERAL FINANCIAL REPORTING REQUIREMENTS UNDER TITLE XIX

38. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. 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 XIII.

39. **Reporting Expenditures Subject to the Budget Neutrality Expenditure Limit.** All expenditures for health care for Demonstration participants and categories, as described in section (d), are subject to the budget neutrality agreement. The following describes the reporting of expenditures subject to the budget neutrality agreement:

    a. Tracking Expenditures. In order to track expenditures, the State must report Demonstration expenditures through the Medicaid and 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 expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year (DY) in which services were rendered or for which

capitation or ESI support payments were paid).

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

c. Cost-Sharing Adjustments. Premiums and other applicable cost sharing contributions that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the Demonstration premium and cost-sharing collections (both total computable and Federal share) should also be reported on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to Demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.

d. For each DY, three separate waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter, using the waiver names listed below. The waiver names designate the waiver forms in the MBES/CBES system to report title XIX expenditures associated with the Demonstration.

    i. **Childless Adults**: Defined as Population II (see STC 14) and includes all healthcare expenditures for the expansion population "childless adults";
    ii. **PCCM/Medicaid**: Defined as Population III (see STCS 14) and includes all expenditures for ConnectCare Demonstration enrollees; and
    iii. **HWBP**: Defined as expenditures for the Health and Wellness Benefits Program
    iv. **2013 Parents**: Defined as Population I (see STC 14) and includes healthcare expenditures incurred in October, November, and December 2013 for the expansion population "parents."

e. The State must assure CMS that no payments duplicative of Federal expenditures will be made for individuals enrolled in the State's Medicaid or CHIP programs. The State will do a quarterly reconciliation to ensure that duplicative payments are not made.

f. Title XIX Administrative Costs. The State must separately track and report additional administrative costs that are directly attributable to the

demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. Expenditures necessary for the administration of the title XIX funded portion of the Safety Net Benefit Program are subject to budget neutrality. Other demonstration-related administrative expenditures must be reported separately, but are not subject to budget neutrality. For purposes of tracking, the State must use the following waiver names to identify demonstration related administrative expenditures.

i. "Childless Adults": Administrative expenditures for Population II, and

ii. "PCCM/Medicaid": Administrative expenditures for Population III.

g. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (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 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 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

40. Expenditures Subject to the Budget Neutrality Cap. For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all of the following:

- Expenditures for medical assistance provided to Population II and Population III,
- Administrative expenditures for Population II incurred on or after December 1, 2011,
- Expenditures for medical assistance and administrative expenditures for Population I incurred in October, November, and December 2013, and
- All Medicaid expenditures for HWBP.

All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver (or, in the case of administrative costs, Forms CMS-64.10 Waiver and/or 64.10P Waiver).

41. Reporting Member Months: The following describes the reporting of member months for Demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the State must provide to CMS on a quarterly basis the actual number of eligible member months for the Demonstration Eligibility Groups (EGs) listed in paragraph 59. This information must be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report. To permit full recognition of "in-process" eligibility, reported counts of member

months must be subject to minor revisions for an additional 180 days after the end of each quarter.

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 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.

42. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year (FFY) on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administration Costs. CMS shall 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 shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

43. Extent of FFP: Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in section XIV.

a. Administrative costs associated with the administration of the Demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; with dates of service during the operation of the Demonstration; and,

c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

44. Sources of Non-Federal Share. The State provides assurance that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further assures that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time 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. The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.

c. The State assures that all health care related taxes comport with section 1903(w) of the Act and all other applicable Federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

45. State Certification of Funding Conditions. The State must certify that the following conditions for non-Federal share of the 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; and,

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as

payments related to taxes, including health care provider-related taxes, fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

46. MSIS Data Submission. The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards.

47. **Monitoring the Demonstration.** The State must provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.

48. Program Integrity. The State must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the Demonstration

49. Administrative Cost Claiming Protocol. The State must maintain a CMS approved Administrative Cost Claiming Protocol (Attachment B) which explains the process the State will use to determine administrative costs incurred by the State for administering the Safety Net Benefit Program, including how the State distinguishes the portion claimed as a Medicaid administrative expenditure from the portion claimed as a CHIP administrative expenditure.

a. The Administrative Cost Claiming Protocol must be submitted to CMS for review and approval by April 1, 2012.
b. CMS will provide FFP to the State at the regular 50 percent match rate for administrative costs as described in the approved Administrative Cost Claiming Protocol.
c. The protocol must describe the administrative costs for which the State will seek FFP. The administrative costs eligible for match under this section must be for the efficient administration of the State plan and in accordance with OMB Circular A-87.

XII. GENERAL FINANCIAL REPORTING REQUIREMENTS UNDER TITLE XXI

50. Quarterly Expenditure Reports. In order to track title XXI expenditures under this Demonstration, the State reports quarterly Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64.21 reporting instructions as outlined in sections 2115 of the State Medicaid Manual. This reporting requirement applies to Demonstration Population I enrollees (Waiver Name: Parents). Title XXI expenditures must be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver, identified by the Demonstration Project number assigned by CMS (including project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made). Once the appropriate waiver form is selected for reporting expenditures, the State will be required to identify the program code and coverage (children or adults).

51. Claiming Period. 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, on the Form CMS-21, net expenditures related to dates of service during the operation of the Demonstration.

a. The standard CHIP funding process will be used during the Demonstration. Arkansas must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the Demonstration 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-21 quarterly CHIP 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.

b. The State will certify that State/local monies are used as matching funds for the Demonstration. The State further certifies that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

c. Arkansas continues to be subject to a limit on the amount of Federal title XXI funding that the State may receive on Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment. 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 the approved title XXI separate child health program or for the ARKids B Medicaid Expansion Demonstration until the next allotment becomes available.

53. Limitation on Title XXI Funding. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan AR Kids B) are restricted to the State's available allotment and reallocated funds. Title XXI funds must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining allotment funds.

54. Administrative Costs. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan, title XXI ARKids B, and this Demonstration that are applied against the State's title XXI allotment, may not exceed 10 percent of total title XXI expenditures.

55. Exhaustion of Title XXI Funds. If the State exhausts the available title XXI Federal funds in a FFY during the period of the Demonstration, the State will continue to provide coverage to the approved title XXI State plan separate child health program

population, ARKids B, and Demonstration Population I with State funds.

56. All Federal Rules Shall Continue To Apply If Title XXI Funds Are Exhausted.

a. All Federal rules shall continue to apply during the period of the Demonstration that State or title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the Demonstration Population I. Before closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.

b. The State may receive title XIX funds to continue coverage for Population I in October, November, and December 2013 under the Expenditure Authority provided for this purpose, but only if both conditions below are met.
   i. The State must have received approval from CMS to provide title XXI funded coverage to Population I through September 30, 2013 under section 2111(b)(1)(B) of the Act.
   ii. On or before March 31, 2013, the State must submit a budget neutrality assessment and projection to CMS that shows that the Demonstration as a whole will be budget neutral through December 31, 2013, inclusive of Population I expenditures for October, November, and December 2013, and with no alteration of the budget neutrality expenditure limit as defined in Section XIII (i.e., there must be sufficient savings to offset expenditures for Population I). The State may not receive FFP for Population I expenditures for October, November, and December 2013 unless CMS approves the State's assessment and projection.

XIII. MONITORING BUDGET NEUTRALITY

57. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on the Medicaid and Demonstration expenditures identified in paragraph 40 during the approval period of the Demonstration. The limit is determined by using a Per Member Per Month (PMPM) method. The budget neutrality targets are set on a yearly basis with a cumulative budget limit for the length of the entire Demonstration. All data supplied by the State is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality limit. CMS' assessment of the State's compliance with these limits will be done using the CMS-64 Report from the MBES/CBES System.

58. Risk. The State shall be at risk for the per capita cost of Demonstration enrollees under this budget neutrality agreement, but not for the number of Demonstration enrollees. By providing FFP for all Demonstration enrollees, the State will not be at risk for changing economic conditions which impact enrollment levels. However, by placing the State at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

59. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit for the Demonstration. Demonstration eligibles are defined under the following Eligibility Groups (EGs).

a. EG 1 – ConnectCare Aged
b. EG 2 – ConnectCare Disabled
c. EG 3 – ConnectCare Child
d. EG 4 – ConnectCare Adult

For the purpose of calculating the overall PMPM expenditure limit for the Demonstration, separate budget estimates will be calculated for each year on a DY basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire Demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the extension period for the types of Medicaid expenditures for the four EGs. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

a. Each EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 42 for that EG, times the appropriate estimated per member per month (PMPM) cost from the table in (paragraph f) below.

b. The budget neutrality ceiling is the sum of the annual PMPM limits for the Demonstration period. The Federal share of the budget neutrality ceiling represents the maximum amount of FFP that the State may receive for Demonstration expenditures described in paragraph 40 on behalf of eligibles during the Demonstration period.

c. The following are the ceiling PMPM costs for the calculation of the budget neutrality expenditure ceiling for the demonstration enrollees under this section 1115 demonstration:

	Trend Rate	DY 5	DY 6	DY 7	DY 8
Aged	3.3 percent	$413.95	$427.61	$ 441.72	$ 456.30
Disabled	6.0 percent	$903.12	$957.31	$1,014.75	$1,075.63
Child	4.9 percent	$292.22	$306.54	$ 321.56	$ 337.32
Adults	5.3 percent	$409.98	$431.71	$ 454.59	$ 478.68

60. Impermissible DSH, Taxes or Donations. CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through State Medicaid Director letters, other memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in

violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

61. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

DY	Cumulative target definition	Percentage
DY 6	Years 1 – 6 combined budget neutrality cap plus	1 percent
DY 7	Years 1 – 7 combined budget neutrality cap plus	0.5 percent
DY 8	Years 1 – 8 combined budget neutrality cap plus	0 percent

62. Exceeding Budget Neutrality. If, at the end of this Demonstration period the budget neutrality limit has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XIV. SCHEDULE OF STATE DELIVERABLES

Date	**Deliverable**
Monthly	Enrollment Reports
Within 90 days of demonstration approval	Evaluation Design
60 days after end of each operational Demonstration year	Draft Annual Report
Within 120 days of Demonstration expiration	Draft Evaluation Report
Quarterly	**Deliverables**
Quarterly basis	Reporting on member months
Due 60 days after the end of each quarter	Quarterly Progress Reports
Due 30 days after the end of each quarter	Quarterly Enrollment Reports
Quarterly basis	Quarterly Expenditure Reports

ATTACHMENT A

Under paragraph 28, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT

Title Line One – AR Safety Net Benefit Program

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 6 (10/1/2011 – 9/30/2012)
Federal Fiscal Quarter: 1/2012 (10/1/2011 – 12/31/2011)

Introduction

Please provide information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0". Enrollment counts should be person counts.

Demonstration Populations	Total as of end of Current Quarter	Voluntary Disenrolled in Current Quarter	Involuntary Disenrolled in Current Quarter
Population I			
Population II			
Population III			

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes,

and legislative activity.

Consumer Issues

Provide a summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance /Monitoring Activities

Identify any quality assurance/monitoring activity in the current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and Form CMS-64 reporting for the current quarter. Identify the State's actions to address these issues.

Enclosures/Attachments
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B

PLACEHOLDER FOR ADMINISTRATIVE COST CLAIMING PROTOCOL