DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

December 23, 2014

Claudia Schlosberg
Interim Senior Deputy Director and Medicaid Director
District of Columbia Department of Health Care Finance
441 4th Street NW, Suite 900 South
Washington, DC 20001

Dear Ms. Schlosberg:

With this letter, the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of the District's Childless Adults demonstration (project number 11-W-00251/3) until December 31, 2015. The demonstration is currently set to expire on December 31, 2014. This extension will allow for continuity of care while the District seeks approval for a State Plan Amendment (SPA) to provide coverage to individuals with incomes above 133% FPL and implement the necessary changes to its eligibility systems. The demonstration will continue to operate under the authority of section 1115(a) of the Social Security Act. The current list of waivers, expenditure authorities, and Special Terms and Conditions (STCs) will continue to apply to the demonstration until December 31, 2015.

Specifically, the current expenditure limit in effect for demonstration year (DY) 4 will remain in effect throughout the temporary extension. Budget neutrality for the period of the temporary extension will be a straightforward extension of the budget neutrality test that applies to the demonstration as currently approved. The budget neutrality limit for DY 6 (January 1, 2015 – December 31, 2015) will be equal to $19,083,599, which is the same as the current budget neutrality limit for DYs 4 and 5.

Your project officer is Ms. Elizabeth Matthews, who may be reached at (410) 786-5433. Ms. Matthews is available to answer any questions concerning your section 1115 demonstration. You may also call me if you have additional questions. I can be reached at (410) 786-5647.

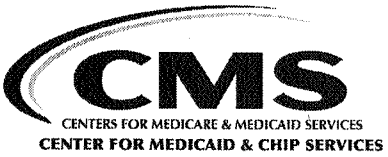
We look forward to continuing to work with your staff on the administration of this demonstration.

Sincerely,

/s/
Eliot Fishman
Director
Children and Adults Health Programs Group

cc: Francis McCollough, Associate Regional Administrator, CMS Regional Office III

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Children and Adults Health Programs Group

AUG 3 0 2013

Linda Elam
Deputy Director and Medicaid Director
District of Columbia Department of Health Care Finance
899 North Capitol Street, NE, Suite 6037
Washington, DC 20002

Dear Dr. Elam:

With this letter, the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of the District's Childless Adults demonstration until December 31, 2014. The Childless Adults demonstration is set to expire on December 31, 2013; this extension will allow for continuity of care while the District works to establish a Basic Health Plan (BHP). The current lists of waiver and expenditure authorities and special terms and conditions will continue to apply to the demonstration until December 31, 2014.

Specifically, the current expenditure limit in effect for demonstration year (DY) 4 will remain in effect throughout the temporary extension. Budget neutrality for the period of temporary extension will be a straightforward extension of the budget neutrality test that applies to the demonstration as currently approved. Demonstration year 4 will be expanded to a full 12 month period ending September 30, 2014, and its budget neutrality limit four times the current three-month total for DY 4 (i.e., $76,334,396). The budget neutrality limit for DY 5 (October-December 2014) will be equal to $19,083,599, which is the same as the current budget neutrality limit for DY 4.

Your project officer is Ms. Elizabeth Matthews, who may be reached at (410) 786-5433. Ms. Matthews is available to answer any questions concerning your section 1115 demonstration. You may also call me if you have additional questions. I can be reached at 410-786-5647.

We look forward to continuing to work with you and your staff to throughout this period.

Sincerely,

[redacted]

Eliot Fishman
Director
Children & Adults Health Programs Group

cc: Diane Gerrits, Division Director, Division of State Demonstrations and Waivers
Elizabeth Matthews, Project Officer, Division of State Demonstration and Waivers
Francis McCollough, Associate Regional Administrator, CMS Regional Office III

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

OCT 28 2010

Mr. John McCarthy
Medicaid Director
District of Columbia Department of Health Care Finance
825 North Capitol Street, NE
Washington, DC 20002

Dear Mr. McCarthy:

We are pleased to inform you that the District of Columbia's request for a new section 1115(a) Demonstration entitled "Childless Adults" (Project Number 11-W-00251/3) has been approved for the period November 1, 2010, through December 31, 2013. Through this Demonstration, the State is approved to expand health care coverage to non-pregnant, non-disabled adults ages 21 through 64 years, who are residents of the District of Columbia with household incomes that are above 133 percent of the Federal poverty level (FPL) but do not exceed 200 percent of the FPL.

The enclosed Special Terms and Conditions (STCs) and expenditure authority specify the agreement between the District of Columbia's Health Care Finance (the District) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth detail the nature, character, and extent of Federal involvement in the Demonstration and the District's obligations to CMS during the term of the Demonstration. This approval is subject to our receiving your written acceptance of the award letter within 30 days of the date of this letter.

Your project officer is Ms. Robin Preston, and she is available to answer any questions concerning your section 1115 Demonstration. Ms. Preston's contact information is as follows:

Ms. Robin Preston
Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3420
Facsimile: (410) 786-5882
E-mail: robin.preston@cms.hhs.gov

Official communications regarding program matters should be submitted simultaneously to Ms. Preston and to Mr. Ted Gallagher, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in the CMS Philadelphia Regional Office. Mr. Gallagher's contact information is as follows:

Mr. Ted Gallagher
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
The Public Ledger Building
150 S. Independence Mall West - Suite 216
Philadelphia, PA 19106

We extend our congratulations to you on this award, and we appreciate your cooperation throughout the review process. If you have additional questions, please contact Ms. Victoria Wachino, Director, Family and Children's Health Programs Group, Center for Medicaid, CHIP and Survey & Certification at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

Donald M. Berwick, M.D.

Enclosures

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00251/3**

TITLE: **Childless Adults Section 1115 Demonstration**

AWARDEE: **District of Columbia Medical Assistance Administration**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the District of Columbia for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration extension, be regarded as expenditures under the District's title XIX plan.

The following expenditure authority shall enable the District of Columbia to operate its section 1115 Medicaid Childless Adults Demonstration.

1. **Demonstration-Eligible Population ("Non-pregnant, Non-disabled Adults").** Expenditures for health care related costs for non-pregnant, non-disabled adults ages 21 through 64 who have family incomes above 133 percent of the Federal poverty level (FPL) and no higher than 200 percent of the FPL and are not otherwise eligible under the Medicaid State plan.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration Population beginning November 1, 2010, through December 31, 2013.

Title XIX Requirements Not Applicable to the Demonstration Population:

1. **Reasonable Promptness** **Section 1902(a)(3) and 1902(a)(8)**

   To enable the District of Columbia to cap enrollment for the Demonstration Population.

2. **Freedom of Choice** **Section 1902(a)(23)**

   To enable the District of Columbia to restrict freedom-of-choice of provider for the Demonstration Population.

3. **Retroactive Eligibility** **Section 1902(a)(34)**

   To enable the District of Columbia to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made by an individual in the Demonstration Population.

Demonstration Approval Period: November 1, 2010, through December 31, 2013

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00251/3

TITLE: District of Columbia Section 1115 for Childless Adults Demonstration

AWARDEE: District of Columbia Medical Assistance Administration

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the District of Columbia's Childless Adults section 1115(a) Medicaid Demonstration (hereinafter "the Demonstration"). To enable the District of Columbia (the District) to operate this Demonstration, the Centers for Medicare & Medicaid Services (CMS) has granted waivers of statutory Medicaid requirements permitting deviation from the approved State Medicaid plan, and expenditure authorities authorizing expenditures for costs not otherwise matchable. The STCs set forth conditions and limitations on these expenditure authorities, and detail the nature, character, and extent of Federal financial involvement in the Demonstration and the District's obligations to CMS during the life of the Demonstration. The STCs are effective November 1, 2010, unless otherwise specified. This Demonstration is approved through December 31, 2013.

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

Additionally, two attachments have been included to provide supplementary information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The District of Columbia Childless Adults Demonstration provides full Medicaid benefits to non-pregnant non-disabled adults ages 21 through 64 with incomes above 133 percent of the Federal poverty level (FPL) to 200 percent of the FPL. Benefits under the Demonstration are provided through the District's mandatory managed care delivery system authorized under section 1932(a) of the Social Security Act (the Act).

On June 22, 2010, CMS approved the District's State plan amendment that added non-pregnant, non-disabled adults with incomes at or below 133 percent of the FPL to the Medicaid State plan. As a result, on July 23, 2010, the District requested termination of its current section 1115 demonstration project (11-W-00139/3), and approval of a new non-pregnant, non-disabled adults demonstration that would cover similar individuals with incomes above 133 percent of the FPL to at or below 200 percent of the FPL. The demonstration will operate for 3 years (November 1,

2010 through December 31, 2013), and will serve as the District's bridge to healthcare reform in 2014.

The District estimates that there are fewer than 12,000 District non-pregnant, non-disabled adult residents with incomes above 133 percent of the FPL but at or below 200 percent of the FPL. A portion of this population currently receives funding through the District-funded DC Healthcare Alliance program (Alliance). The Alliance program has similar benefits to the DC Medicaid program, except that mental health services and transportation are not provided, and pharmacy services are limited to seven locations. By transitioning the Alliance program members to the demonstration, they will have access to full Medicaid benefits.

The District is building upon the success of its initial Childless Adult Demonstration by providing full Medicaid benefits to non-pregnant, non-disabled adults with incomes above 133 percent and at or below 200 percent of FPL.

The District's goals for the new non-pregnant, non-disabled adult demonstration are to:

1. Improve access to health care;
2. Increase the health insurance rate; and
3. Provide continuity of health insurance (i.e., children aging out of the Children's Health Insurance Program (CHIP)).

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The District 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 Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, unless specified otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as not applicable, shall apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The District must, within the time frames specified in law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

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

    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 District must 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.

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

5. **State Plan Amendments.** The District shall not be required to submit Title XIX State plan amendments for changes to Demonstration populations made eligible solely 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 may be required except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-Federal share of funding, budget 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 District 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. **Demonstration 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 and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

a) An explanation of the public process used by the State, consistent with the requirements of paragraph 12, 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 the impact of the amendment;

c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d) A description of how the evaluation design shall be modified to incorporate the amendment provisions, if applicable.

8. **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 District has materially failed to comply with the terms of the project. CMS shall promptly notify the District in writing of the determination and the reasons for the suspension or termination, together with the effective date.

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

10. **Withdrawal of Waiver Authority.** CMS reserves the right to 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 of the Act. CMS shall promptly notify the District in writing of the determination and the reasons for the withdrawal, together with the effective date, and shall afford the District 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 closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

11. **Adequacy of Infrastructure.** The District must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; and reporting on financial and other Demonstration components. The District must have a Medicaid Management Information System (MMIS) in place that will allow for accurate claims adjudication and the accurate reporting of expenditures under the established budget neutrality agreement.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The District must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994), unless they are otherwise superseded by rules promulgated by CMS. Further, the District must 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 (ARRA) of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 7, are proposed by the State.

13. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

14. **Demonstration Eligibility.** The individuals described below who are made eligible for the Demonstration by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this Demonstration.

a) To be eligible under this Demonstration, an applicant must:

- Be a U.S. citizen;
- Be non-pregnant;
- Have income above 133 percent and at or below 200 percent of the FPL;
- Be ages 21 through 64;
- Be ineligible for Title XIX and/or Title XXI;
- Be ineligible for Medicare; and
- Not reside in long-term care, mental health, or penal institutions.

b) Applicants do not have to be uninsured at the time of application in order to be eligible for the Demonstration.

c) In determining eligibility, the District shall apply a $100 earned income disregard to gross income.

15. **Benefits.** Enrollees in the Demonstration receive full Medicaid benefits as identified in the Medicaid State Plan. *Attachment A* provides an overview of the services in the Medicaid State plan. There is no cost sharing charged to Demonstration enrollees for any service except for eyeglasses and prescription drugs. The cost sharing for eyeglasses is $2 co-pay per pair of eyeglasses, while the cost sharing for prescription drugs is $1 co-pay per prescription.

16. **Enrollment Procedures**. Individuals applying for the Demonstration are required to submit the Combined Application for DC Medical Assistance, Food Stamps, and Cash Assistance in person or by mail. Applicants are screened for eligibility for Medicaid before they are enrolled in the Demonstration. The application process will include a citizenship verification process as required by Federal law.

a) Upon being determined eligible for the Demonstration, the District-contracted enrollment broker will notify participants about the contracted managed care organization (MCO) plans. The participant must be given no less than 30 days to select an MCO plan. If the participant fails to select a plan, he or she will be automatically assigned to an MCO.

b) Redeterminations will be conducted on an annual basis following the date of initial enrollment. The District's Income Maintenance Administration (IMA), which is responsible for determining Medicaid eligibility in the District, will send Notices of Redetermination to Demonstration beneficiaries in the same manner in which information is sent to all other Medicaid beneficiaries. An enrollee must affirmatively confirm that the information previously provided to the District is still accurate.

17. **Enrollment Cap.** The District is permitted to implement a cap on the number of enrollees in order to ensure that expenditures do not exceed the available funding for Demonstration expenditures.

a) The enrollment cap for each Demonstration year is as follows:
   i. Demonstration Year 1: 4,900
   ii. Demonstration Year 2: 8,100
   iii. Demonstration Year 3: 11,200
   iv. Demonstration Year 4: 13,300

b) The District must notify CMS at least 60 days before affirmatively implementing the caps authorized in subparagraph (a).

c) If the District imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the Demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the District will enroll based on date of birth starting with the oldest applicant.

V. DELIVERY SYSTEMS

18. **Service Delivery.** Services for the Demonstration will be provided using the same managed care delivery system that is used for Medicaid-eligible individuals in the District. Enrollees will be permitted to choose among participating MCOs, and will be auto-assigned if a selection is not made by the enrollee. Demonstration beneficiaries will receive mental health rehabilitation services on a fee-for-service basis as these services are carved out of the MCO contracts for both the Medicaid-eligible individuals and Demonstration beneficiaries.

19. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the District with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHCs) shall continue in force.

    Payments under contracts with public agencies, not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

VI. GENERAL REPORTING REQUIREMENTS

20. **General Financial Requirements.** The District must comply with all general financial requirements under Title XIX of the Act set forth in section VII of these STCs.

21. **Managed Care Reporting Requirements.** The District must comply with all managed care reporting regulations at 42 CFR 438.

22. **Reporting Requirements Related to Budget Neutrality.** The District must comply with all reporting requirements for monitoring budget neutrality set forth in section VIII of these STCs.

23. **Quarterly Calls.** CMS will schedule quarterly conference calls with the District. 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, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any Demonstration amendments the District is considering submitting. CMS shall update the District on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The District and CMS shall jointly develop the agenda for the calls.

24. **Quarterly Operational Reports.** The District must submit progress reports in the format and with the content specified in *Attachment B* no later than 60 days following the end of each Federal fiscal year (FFY) quarter as specified below. The intent of these reports is to present the current status of the Demonstration. The content and/or format of these reports will be specified by the Project Officer, in consultation with the District.

    The quarterly report for the quarter ending December 31 is due February 28;
    The quarterly report for the quarter ending March 31 is due May 31;
    The quarterly report for the quarter ending June 30 is due August 31; and
    The quarterly report for the quarter ending September 30 is due November 30.

25. **Annual Report.** The District 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 (if relevant), policy and administrative difficulties in the operation of the Demonstration, and systems and reporting issues. The District must submit the draft annual report no later than March 1, after the close of each year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

26. **Transition Plan.** The District is required to prepare, 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 State must submit a draft to CMS by July 1, 2012, with progress updates (and revisions as necessary) included in each quarterly report.

27. **Final Evaluation Report.** The District shall submit a Final Evaluation Report pursuant to the requirements of section 1115 of the Act.

VII. GENERAL FINANCIAL REQUIREMENTS

28. **Quarterly Expenditure Reports.** The District must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided through this Demonstration under the authority of section 1115 of the Act. 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 VIII of these STCs.

29. **Reporting Expenditures Subject to the Budget Neutrality Agreement.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

    a) In order to track expenditures under this Demonstration, the District 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 must be reported each quarter on separate Forms CMS-64.9 Waiver and/or CMS-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 payments were made).

    b) To ensure accurate reporting during the Demonstration approval period, DYs are identified as follows:

        i. Demonstration Year 1: 11/1/10 – 9/30/11 (11 months)
        ii. Demonstration Year 2: 10/1/11 – 9/30/12
        iii. Demonstration Year 3: 10/1/12 – 9/30/13
        iv. Demonstration Year 4: 10/1/13 – 12/31/13 (3 months)

    c) For monitoring purposes, cost settlements related to the Demonstration must be recorded on Line 10.B, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on Lines 9 or 10.C, as instructed in the State Medicaid Manual.

    d) For each DY, two separate waiver Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver must be completed, using the waiver name in italics below, to report the following expenditures under the Demonstration:

        i. ***Childless Adults* (Demonstration Population):** Health care services provided to non-pregnant, non-disabled adults with incomes above 133 percent of the FPL but at or below 200 percent of the FPL.

        ii. ***State Plan Disproportionate Share Hospital (DSH)*:** All DSH expenditures under the approved State plan population.

30. **Expenditures Subject to the Budget Neutrality Agreement.** The term, "expenditures subject to the budget neutrality agreement" will include all demonstration expenditures.

31. **Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the District must separately track and report additional administrative

costs that are directly attributable to the Demonstration. All administrative costs will be identified on the Forms CMS-64.10 Waiver and/or CMS-64.10P Waiver.

32. **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 District 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 District must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on Form CMS-64 Waiver in order to properly account for these expenditures in determining budget neutrality.

33. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the Demonstration. The District must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality agreement must be separately reported by quarter for each FFY on the form CMS-37.12 for both the medical assistance program and administrative costs. CMS shall make Federal funds available based upon the District's estimate, as approved by CMS. Within 30 days after the end of each quarter, the District 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 District, and include the reconciling adjustment in the finalization of the grant award to the District.

34. **Extent of FFP for the Demonstration.** 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 Demonstration as a whole as outlined below, subject to the limits described in section VIII of these STCs:

    a) Administrative costs, including those associated with the administration of the Demonstration;

    b) Net expenditures and prior period adjustments, made under approved expenditure authorities granted through section 1115(a)(2) of the Act for non-pregnant, non-disabled adults, with dates of service during the operation of the Demonstration; and

    c) All expenditures made using the District's DSH allotment that <u>are not</u> expenditures for the Demonstration population.

35. **Sources of Non-Federal Share.** The District certifies that the matching non-Federal share of funds for the Demonstration is District/local monies. The District further certifies 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 the sources of the non-Federal share of funding for the Demonstration at any time. The District agrees that all funding sources deemed unacceptable by CMS shall be addressed within the timeframes set by CMS.

b) Any amendments that impact the financial status of the program shall require the District to provide information to CMS regarding all sources of the non-Federal share of funding.

c) 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 District 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.

36. **Monitoring the Demonstration.** The District will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.

VIII. MONITORING BUDGET NEUTRALITY

37. **Limit on Federal Title XIX funding.** The District will be subject to a limit on the amount of Federal Title XIX funding that the District may receive for demonstration expenditures subject to the budget neutrality agreement during the Demonstration approval period. Total computable expenditures for which Federal Title XIX funding is available for each DY shall be the lesser of: 1) the total computable expenditures for each Demonstration year that could be made based on the Federal share allotment for DSH expenditures by the District reduced by the total computable DSH payments under the approved State plan for that year; and 2) the total computable expenditures for each demonstration year limitation set forth in the chart below:

DY	Expenditure Limit
1	$23,324,086
2	$41,265,280
3	$61,700,806
4	$19,083,599

38. **Risk.** The District shall be at risk for both the number of enrollees in the Demonstration, as well as the per capita cost for demonstration eligibles under this budget neutrality agreement.

39. **Budget Neutrality Expenditure Limit.** The following describes the method for calculating the budget neutrality agreement for the Demonstration:

a) For each DY, the District may receive FFP for no more than the amounts listed in STC 37 in total computable health care expenditures for the Demonstration population (non-pregnant, non-disabled adults with incomes above 133 percent of the FPL to 200 percent of the FPL), as reported under STC 29(d)(i).

b) The amount of FFP for the Demonstration population will be added to FFP for expenditures made using the District's DSH allotment that are not expenditures for the demonstration population for each FFY.

c) The combined amount of FFP received by the District in each FFY on expenditures for the demonstration population and DSH may not exceed the allowable aggregate Federal share DSH allotment for the District under section 1923(f) of the Act. The District must continue to comply with the hospital-specific limits as provided in the Omnibus Budget Reconciliation Act of 1993 for DSH payments under the plan; for purposes of these hospital-specific limits, individuals eligible only under the Demonstration shall be considered "eligible for medical assistance under the District plan."

40. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality on an *annual* basis. If the District exceeds the annual budget neutrality expenditure limit in any given DY, the District must submit a corrective action plan to CMS for approval and will repay (without deferral or disallowance) the Federal share of the amount by which the budget neutrality agreement has been exceeded.

41. **Impermissible DSH, Taxes, or Donations**. The CMS reserves the right to adjust the budget neutrality expenditure limit in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if CMS determines that any health care-related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is in violation of the provider-donation and health care-related tax provisions of section 1903(w) of the Act. Adjustments to the budget neutrality agreement will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

IX. EVALUATION OF THE DEMONSTRATION

42. **Submission of Draft Evaluation Design.** The District must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than March 1, 2011. At a minimum, the draft design must include a discussion of the goals of the Demonstration, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. In addition, the draft design shall 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 must be isolated from other initiatives occurring in the

District. The draft design must identify whether the District will conduct the evaluation, or select an outside contractor for the evaluation.

43. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design within 60 days of receipt, and the District shall submit a final design within 60 days after receipt of CMS' comments. The District must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.

44. **Final Evaluation Report**. The District must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The District must submit the final evaluation report within 60 days after receipt of CMS' comments.

45. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, the District shall cooperate fully with CMS or the independent evaluator selected by CMS. The District shall submit the required data to CMS or the contractor.

X. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date	Deliverable	STC Reference
3/1/2011	Submit Draft Evaluation Design	Section IX, STC 42

	Deliverable	STC Reference
Annual	By March 1st - Draft Annual Report	Section VI, STC 25
Quarterly		
	Quarterly Operational Reports	Section VI, STC 24
	Quarterly Expenditure Reports	Section VII, STC 28

ATTACMENT A

DEMONSTRATION BENEFITS

This population will receive the following State plan benefits.

Inpatient hospital services
Outpatient hospital services
Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual.
Laboratory and X-ray services
Home health services
Family planning services and supplies
Physicians' services including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing, and language therapy
Prescription drugs, over-the-counter drugs, and medical supplies
Durable medical equipment, including prosthetic and orthotic devices, hearing aids, and prescription shoes
Vision care services, including eyeglasses
Podiatrists' services
Optometrists' services
Nursing facility services
Personal care services
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services, including emergency transportation
Renal dialysis
Non–emergency transportation
Experimental or investigational treatment (covered on a case-by-case basis)

ATTACHMENT B

QUARTERLY OPERATIONAL REPORT FORMAT AND CONTENT

Under Section VI, paragraph 24, the District 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 District. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – DC 1115 for Childless Adults Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 1 (11/1/2010 – 9/30/2011)
Federal Fiscal Quarter: 1/2011 (11/1/2010-12/31/2010)

Introduction

Information describing the goal of the Demonstration, for example, 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 District should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the District should indicate that by "0."

Enrollment Count

Note: Enrollment counts should be person counts, not member months.

Demonstration Populations (as hard coded in the CMS-64)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
Childless Adults		

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.

Financial/Budget Neutrality Developments/Issues:

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the District's actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

Consumer Issues:

Include 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 Activity:

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation:

Discuss progress of evaluation design and planning.

Enclosures/Attachments:

Identify by Title any attachments along with a brief description of the information contained in the document.

State Contact(s):

Identify individuals by name, Title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS: