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

September 24, 2013

Richard Armstrong
Director
Department of Health and Welfare Towers Building
P.O. Box 83720
Boise, ID 83720-0036

Dear Mr. Armstrong:

This letter is to inform you that Idaho's request to amend its Title XIX section 1115 demonstration, the *Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration)*, number 11-W-00245/10, has been approved in order to not disrupt the coverage currently afforded in Idaho as the state continues to consider its coverage options. The demonstration will receive federal financial participation at the state's regular federal medical assistance percentage from October 1, 2013 through September 30, 2014.

As agreed, in light of the coverage options that will be available to residents of Idaho beginning January 1, 2014, as of that date the demonstration will be limited to certain adults with incomes under 100 percent of the federal poverty level. We will continue to work with you on a transition plan to facilitate a seamless transfer of coverage for those currently enrolled in the demonstration with incomes above that level. As of October 1, 2013, Idaho will cease to claim Title XXI federal match for the parent population, and will instead begin claiming Title XIX federal match. (Please refer to the Title XXI companion letter on this matter). For these parents, this change from Title XXI to Title XIX funding should be a seamless transition.

Our approval of this demonstration is subject to the limitations specified in the enclosed approved expenditure and waiver authorities, and special terms and conditions (STCs). These documents specify the agreement between the Idaho Department of Health and Welfare and the Centers for Medicare and Medicaid Services (CMS). The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as granted expenditure authority or waived. All requirements of the Medicaid programs as expressed in law, regulation, and policy statement not expressly identified as waived or made not applicable in the enclosed authorities shall apply.

This approval is also conditioned upon continued compliance with the enclosed STCs which set forth in detail the nature, character, and extent of federal involvement in this demonstration and the state's obligations to CMS, including an evaluation of this demonstration, during the term of the approval period. This award letter is subject to our receipt of your written acceptance of the award, including the waiver and expenditure authorities and the STCs, within 30 days of the date of this letter.

Your project officer is Kelly Heilman. Kelly is available to answer any questions concerning your section 1115 demonstration, and may be reached by phone at 410-786-1451 or by email at kelly.heilman@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted at the following address:

Kelly Heilman, PhD, MBA
Division of State Demonstrations & Waivers
Center for Medicaid and CHIP Services
Mailstop: S2-01-16
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Official communications regarding program matters should be submitted simultaneously to Ms. Carol Peverly, Associate Regional Administrator in our Seattle Regional Office. Ms. Peverly's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
2201 6th Avenue
Mail Stop RX-43
Seattle, Washington 90121

If you have additional concerns regarding CMS oversight of the demonstration or questions, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, at 410-786-5647.

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

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Carol Peverly, ARA, Region X
Janice Adams, Health Insurance Specialist, Seattle Regional Office

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

September 24, 2013

Richard Armstrong
Director
Department of Health and Welfare
Towers Building
Tenth Floor P.O. Box 83720
Boise, ID 83720-0036

Dear Mr. Armstrong:

This letter is to inform you that Idaho's request to renew and amend its Title XXI Section 1115 demonstration, *Idaho Children's Access Card* (waiver No. 21-W-00018/10 & No. 11-W-00187/10), has been approved for the period of October 1, 2013 through December 31, 2013. This demonstration renewal permits the state to continue to offer premium assistance to children with family income at or below 185 percent of the federal poverty level (FPL). The children covered in this demonstration are eligible for the state's Title XXI Child Health Insurance Program (CHIP) or Title XIX Medicaid expansion. Families elect to obtain their children's Medicaid or CHIP coverage through private health insurance carriers in the individual market or through employer-sponsored-insurance under a premium assistance delivery system model.

As part of this amendment, the state will transition children currently in premium assistance (Demonstration Populations 1 and 2 described below) to enrollment in direct coverage under the existing authorities in the Medicaid and CHIP state plans beginning on January 1, 2014. As specified in Special Term and Condition (STC) VII 3(a), the state is required to submit a proposed plan for CMS review that outlines how the state will operationalize the transition of children from the section 1115 demonstration to the Medicaid and CHIP state plans. The plan must include a description of the proposed process and timeline for informing families in premium assistance of this change, including changes to benefits, cost sharing, health care plans, and providers. This process must minimize burden on the enrollees.

Under a separate approval, the state will continue to cover parents previously covered with Title XXI funds in this demonstration under a Title XIX demonstration after September 30, 2013 (please see the Title XIX approval letter for an amendment under waiver number 11-W-00245/10 for more information on this matter).

Idaho is subject to the existing STCs through September 30, 2013. The state is subject to the amended STCs below from October 1, 2013 through December 31, 2013. CMS will

continue to monitor the demonstration. In addition, as specified in STC XIII(4), the state must submit to CMS for approval a final evaluation report on the demonstration no later than 120 days after the end of the demonstration. CMS is required to provide comments on the materials within 60 days of receipt from the state. The state must submit the final evaluation report within 60 days after receipt of CMS' comments.

All requirements of the Medicaid and CHIP programs, as well as of the section 1115 demonstration project No. 21-W-00018/10 and No. 11-W-00187/10, expressed in law, regulation, and policy statement that are not expressly waived or identified as not applicable in the attached comprehensive list of waiver and expenditure authorities, shall apply to coverage of services for the demonstration populations.

The attached waiver and expenditure authorities and STCs are incorporated in their entirety into this approval letter and supersede all previously granted authorities and STCs. We have enclosed a complete copy of the revised STCs.

Your technical director is Stacey Green. Ms. Green is available to answer questions concerning the demonstration project and may be contacted as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mailstop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-6102
Facsimile: (410) 786-5882
E-mail: stacey.green@cms.hhs.gov

Official communications regarding program matters should be submitted simultaneously to Ms. Carol Peverly, Associate Regional Administrator in our Seattle Regional Office. Ms. Peverly's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
2201 6th Avenue
Mail Stop RX-43
Seattle, Washington 98121

If you have additional concerns regarding CMS oversight of this demonstration or questions, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Carol Peverly, ARA, Region X
Janice Adams, Health Insurance Specialist, Seattle Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES

COSTS NOT OTHERWISE MATCHABLE AUTHORITIES

NUMBERS: 21-W-00018/10 (XXI) & 11-W-00187/10 (XIX)

TITLE: Idaho Children's Access Card Demonstration

AWARDEE: Idaho Department of Health & Welfare

Medicaid Costs Not Otherwise Matchable

Under the authority of Section 1115(a)(2) of the Act, state expenditures for the provision and administration of medical assistance to the demonstration populations described below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period of the project, be regarded as expenditures under the state's Title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditures, except those specified below as not applicable to these expenditure authorities.

Demonstration Population 1: Until January 1, 2014, children ages 6 through 18 years with family incomes above 100 percent of the FPL through 133 percent of the FPL who meet the eligibility standards for Idaho's Title XXI Medicaid Expansion and were not eligible under the Medicaid state plan as of March 31, 1997. The families of these children have the option to enroll in Medicaid, but instead choose to enroll in premium assistance.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply to Demonstration Population 1, except the following:

1. Eligibility-Section 1902(a)(l0)

To enable the state to limit this eligibility group to a subset that would not otherwise be considered a reasonable category of those who meet the applicable income and age requirements based on the applicant's choice not to receive direct coverage that is otherwise offered under the state plan.

2. Amount, Duration and Scope of Services (Comparability)- Section 1902(a)(10)(B)

To enable the state to modify the Medicaid benefit package in order to offer a different benefit package that would otherwise be required under the state plan. This authority is granted only to the extent necessary to allow certain optional Medicaid eligibles (as described in the application and in the STCs) to elect to receive coverage through a private or employer-sponsored insurance plan, which may offer a different benefit package than

the package available through the state plan. As described in the STCs, such enrollment in a private or employer-sponsored plan is voluntary and the child may elect to switch to direct state coverage at any time. Families will be fully informed of the implications of choosing premium assistance rather than direct state coverage for their children

3. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - Section 1902(a)(43)(A)

To permit the state to not provide EPSDT services to children enrolled in premium assistance outside of the coverage available through the underlying individual or employer-sponsored insurance plan, which may not offer the full range of EPSDT services. As described in the STCs, such enrollment in a private or employer-sponsored plan is voluntary and the child may elect to switch to direct coverage at any time, and then children will be fully informed of the implications of choosing premium assistance rather than direct state coverage.

4. Cost Sharing - Section 1902(a)(l4)

For the period during which an eligible individual elects to receive coverage through a private or employer-sponsored insurance plan, these requirements do not apply, to the extent a private or employer plan would require cost sharing in excess of the limits outlined in statute.

5. Retroactive Coverage - Section 1902(a)(34)

Individuals who elect the *Children's Access Card* program will not be retroactively eligible.

6. Qualified Employer Sponsored Coverage Section under 1906(A)

To permit the state to offer a premium assistance subsidy that does not meet the requirements of section 1906(A).

CHIP Costs Not Otherwise Matchable

In addition, under the authority of Section 1115(a)(2) of the Act as incorporated into Title XXI by Section 2106(e) of the Act, state expenditures for the provision and administration of child health assistance to the demonstration populations described below (which would not otherwise be included as matchable expenditures under Title XXI), shall for the period of this project and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's Title XXI plan. All requirements of the Title XXI statute will be applicable to such expenditures, except specified below as not applicable to these expenditure authorities.

Demonstration Population 2: Until January 1, 2014, children from birth through 18 years with family incomes above 133 percent of the FPL through 185 percent of the FPL meet the standards for eligibility for Idaho's Title XXI Separate Child Health Program but elect not to enroll in that program, and instead elect to enroll under the demonstration for

premium assistance benefits (as defined in the STCs).

CHIP Requirements Not Applicable to the CHIP Expenditure Authorities:

All CHIP requirements apply, except for the following requirements that are not applicable:

1. Cost Sharing-Section 2103(e)

Rules governing cost sharing under section 2103(e) of the Act shall not apply to the demonstration populations to the extent necessary to enable the state to impose cost sharing in private or employer-sponsored insurance plans.

2. Cost Sharing Exemption for American Indian/Alaskan Native (AI/AN) Children - Section 2102(b)(3)(D), 42 CFR 457.535

To the extent necessary to permit the state to impose cost sharing on AI/AN children who elect to enroll in the premium assistance program.

3. Benefit Package Requirements-Section 2103

To permit the state to offer a benefit package that does not meet the requirements of section 2103 at 42 CFR 457.410(b)(1).

4. General Requirements, Eligibility and Outreach-Section 2102

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

5. Federal Matching Payment and Family Coverage Limits-Section 2105

Federal matching payment is available in excess of the 10 percent cap for expenditures related to the demonstration populations and limits on family coverage are not applicable with respect to the demonstration populations. Federal matching payments remain limited by the allotment determined under section 2104. Expenditures other than for coverage of the demonstration populations remain limited in accordance with section 2105(c)(2).

6. Qualified Employer Sponsored Coverage Section under 2105(c)(10)

To permit the state to offer a premium assistance subsidy that does not meet the requirements of section 2105(c)(10).

CENTERS FOR MEDICARE & MEDICAID SERVICES
COSTS NOT OTHERWISE MATCHABLE AUTHORITIES

NUMBERS: 11-W-00245/10 (Title XIX)

TITLE: Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration)

AWARDEE: Idaho Department of Health & Welfare

Medicaid Costs Not Otherwise Matchable Authority

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this demonstration, be regarded as matchable expenditures under the State's Medicaid Title XIX State plan:

1. (PA Childless Adults Group I and II). For the period of January 1, 2010 through September 30, 2013 (inclusive), expenditures for premium assistance payments to or on behalf of uninsured, non-pregnant childless individuals age 18 and above with countable gross family income at or below 185 percent of the federal poverty level (FPL), who are employed by a small business (2-50 employees) or are the spouse of an employee working for a small business, who are not otherwise eligible for Medicaid and are not eligible for Medicare or Veterans benefits, for a 12-month guaranteed period (but no later than September 30, 2013). Payments are limited to some or all of the cost of the employee share of employer sponsored health insurance.

    a. (PA Childless Adults Group I). For the period of October 1, 2013 through September 30, 2014 (inclusive), expenditures for premium assistance payments to or on behalf of uninsured, non-pregnant childless individuals age 18 and above with modified adjusted gross income (MAGI) determined income below 100 percent of the FPL, who are employed by a small business (2-50 employees) or are the spouse of an employee working for a small business, who are not otherwise eligible for Medicaid and are not eligible for Medicare or Veterans benefits, for a 12-month guaranteed period (but no later than September 30, 2014). Payments are limited to some or all of the cost of the employee share of qualifying employer sponsored health insurance.

    b. (PA Childless Adults Group II). For the period of October 1, 2013 through December 31, 2013 (inclusive), expenditures for premium assistance payments to or on behalf of uninsured, non-pregnant childless individuals age 18 and above with MAGI-determined income at or above 100 percent of the federal poverty level (FPL) and countable gross family income at or below 185 percent of the federal poverty level (FPL), who are employed by a small business (2-50 employees) or are the spouse of an employee working for a small business, who are not otherwise eligible for Medicaid and are not eligible for Medicare or Veterans benefits, for a 12-month guaranteed period (but no later than December 31, 2013). Payments are limited to

some or all of the cost of the employee share of qualifying employer sponsored health insurance.

2. (PA Parents Group I). Expenditures for the period of October 1, 2013 through October 1, 2014 for premium assistance payments to or on behalf of uninsured parents who are age 18 and above with MAGI-determined income below 100 percent of the FPL); who are employed by a small business (2-50 employees) or are the spouse of an employee working for a small business; who are not otherwise eligible for Medicaid and are not eligible for Medicare or Veterans benefits. Payments are limited to some or all of the cost of the employee share of qualifying employer sponsored health insurance.

3. (PA Parents Group II). Expenditures for the period of October 1, 2013 through December 31, 2013 for premium assistance payments to or on behalf of uninsured parent(s); who are age 18 and above; with MAGI-determined income at or above 100 percent of the FPL and countable gross family income at or below 185 percent of the federal poverty level (FPL); who are employed by a small business (2-50 employees) or are the spouse of an employee working for a small business; who are not otherwise eligible for Medicaid and are not eligible for Medicare or Veterans benefits. Payments are limited to some or all of the cost of the employee share of qualifying employer sponsored health insurance.

Medicaid Requirements Not Applicable to the Demonstration Eligible Population:
All requirements of the Medicaid statute will be applicable to those individuals who are made eligible for services solely by virtue of the demonstration project, for whom, under the expenditure authority listed above, the state will receive federal financial participation in its expenditures, except those requirements specified below:

1. **Amount Duration and Scope** **Section 1902(a)(10)(B)**
   To permit the state to offer benefits limited to premium assistance for employer health sponsored coverage that meets minimum qualifications.

2. **Retroactive Eligibility** **Section 1902(a)(34)**
   To permit the state not to offer retroactive eligibility for individuals in the PA Childless Adults Group I and II, and the PA Parents Groups I and II.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: **11-W-00245/10**

TITLE: **Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration)**

AWARDEE: **Idaho Department of Health & Welfare**

DEMONSTRATION PERIOD: **January 1, 2010, through September 30, 2014**
As amended on September 6, 2013

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I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Idaho Medicaid Non-pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration) (hereinafter referred to as "demonstration" or "program") for the waiver under Section 1115(a) of the Social Security Act (the Act) for the period of January 1, 2010, through September 30, 2014. The parties to this agreement are the Idaho Department of Health & Welfare ("state") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid and Children's Health Insurance Programs (CHIP) expressed in law, regulation, and policy statement not expressly waived or made not applicable in the list of Waivers and Expenditure Authorities, will apply to the demonstration project.

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. The STCs are effective as of the approval letter's date, unless otherwise specified. Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval will be directed to the CMS Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter. This demonstration is approved through September 30, 2014. The STCs have been arranged into the following subject areas: program description and objectives; general program requirements; eligibility; benefits; enrollment; cost sharing; delivery systems; general reporting requirements; general financial requirements under Title XIX; monitoring budget neutrality for the demonstration; evaluation of the demonstration; and schedule of state deliverables during the demonstration.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration) is a statewide Section 1115 demonstration to make health insurance more affordable by providing premium subsidy to individuals with incomes at or below 185 percent of the federal poverty level (FPL). This program is targeted at small businesses (2-50 employees) that do not offer a health benefit plan.

The Idaho Children's Access Card demonstration was approved by CMS in 2004, to allow the state to provide an alternative premium assistance program to children eligible for the state's Children's Health Insurance Program (CHIP). This demonstration was amended in July of 2005 to add a coverage program for adults, that provided up to $100 per month per enrolled adult beneficiary (for a qualifying employee or the spouse of the employee) toward the individual's share of the employer-sponsored health insurance premium. In July 2006, the program was amended to require a 50 percent employer contribution toward the cost of the health benefit plan.

The Idaho premium assistance program, entitled Access to Health Insurance, was funded in part by the federal government through Title XXI funding. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), required the state to remove the childless adults from Title XXI funding no later than December 31, 2009. In response, the state submitted a proposal to CMS to move the eligible non-pregnant childless adults into a new Section 1115

demonstration under authority and funding of Title XIX. CMS approved the Idaho's Premium Assistance to Childless Adults Demonstration under Section 1115(a) of the Act for the period of January 1, 2010, through September 30, 2014. This essentially left Idaho with two waivers, one under Title XXI for children and parents, and one under Title XIX for non-pregnant childless adults.

CHIPRA also changed states' authority to cover parents under a Title XXI program. Specifically, CHIPRA added Section 2111(b)(2) of the Act, which permitted a state with existing authority (prior to the passage of CHIPRA) to continue Title XXI parents coverage, through September 30, 2013. This Title XIX demonstration is amended to provide Access to Health Insurance coverage for the parents (for the period of October 1, 2013 until January 1, 2014 when these individuals with MAGI-based incomes at or above 100 percent of the federal poverty level (FPL) will be eligible for a premium subsidy through the state's health insurance exchange, in accord with the Affordable Care Act). For those parents not eligible for a premium subsidy through the state's health insurance exchange, due to MAGI-determined incomes below 100 percent of the FPL, this Title XIX demonstration is amended to provide Access to Health Insurance coverage for the period of October 1, 2013 until October 1, 2014. Because Childless Adults with MAGI-based at or above 100 percent of the FPL will also be eligible for a premium subsidy through the state's health insurance exchange as of January 1, 2014, these individuals (hereafter referred to as Childless Adults II) will no longer be covered under this demonstration after December 31, 2013.

The following Special Terms and Conditions and the approved Costs Not Otherwise Matchable apply to the demonstration.

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 Law, Regulation, and Policy.** All requirements of the Medicaid program 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 Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, 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 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 the implementation of the change.

    b. If mandated changes in 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 affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate 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, 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 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 these 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 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 15, 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 will include current federal share "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. An up-to-date CHIP allotment neutrality worksheet, if necessary;

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

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

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under Sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

   As part of the demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

   a. Demonstration Summary and Objectives: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met, as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of each change and desired outcomes must be included.

   b. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time. Consistent with federal law, CMS reserves the right to deny approval for a requested extension based on non-compliance with these 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.

   c. Waiver and Expenditure Authorities: The state must provide a list, along with a programmatic description, of the waivers and expenditure authorities that are being requested in the extension.

   d. Quality: The state must provide summaries of External Quality Review Organization reports, managed care organization, and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

e. Compliance with the Budget Neutrality Cap: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In addition, the state must provide up-to-date responses to the CMS Financial Management standard questions. If Title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

f. Draft report with Evaluation Status and Findings: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, at any time prior to the date of expiration. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the state elects to phase out the demonstration, the state must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10 a phase-out plan will not be shorter than 6 months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the state, FFP will be limited to normal closeout costs associated with terminating the demonstration, including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out.** If the state elects to suspend, terminate, or not renew this demonstration as described in paragraph 9, during the last 6 months of the demonstration, individuals who would not be eligible for Medicaid under the current Medicaid state plan must not be enrolled unless the demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the state in writing that the demonstration will not be renewed.

11. **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.

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

13. **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. 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 closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The state must 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.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and 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 STC 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. In the event that the state conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS.

16. **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

1. **Eligibility Criteria.** The demonstration-eligible populations consist entirely of persons who are not otherwise eligible for Medicaid through the state plan.

2. The Idaho Section 1115 demonstration is comprised of the following Eligibility Groups:

a. <u>Premium Assistance to Non-Pregnant Childless Adults (collectively referred to as PA Childless Adults) is comprised of the following two components:</u>

   i. Premium Assistance for Non-Pregnant Childless Adults I (PA Childless Adults I): This Group is comprised of non-pregnant childless individuals age 18 and above, who meet the following qualifications:
   - Have MAGI-based income below 100 percent of the FPL;
   - U.S. citizens/legal residents,
   - Residents of Idaho,
   - Not otherwise eligible for Medicaid through the state plan,

- Not qualified for Medicare or Veterans benefits,
- Not currently participating in any insurance plan that meets the definition of a health benefit plan (as defined in state statute),
- Employed by a small business (2-50 employees) or are the spouse of an employee in a small business, and
There is no resource limit for this demonstration population.

ii. Premium Assistance for Non-Pregnant Childless Adults II (PA Childless Adults II):
This Group is comprised of non-pregnant childless individuals age 18 and above, who meet the following qualifications:
- Have MAGI-based income at or above 100 percent of the FPL and countable gross family income at or below 185 percent of the FPL;
- U.S. citizens/legal residents,
- Residents of Idaho,
- Not otherwise eligible for Medicaid through the state plan,
- Not qualified for Medicare or Veterans benefits,
- Not currently participating in any insurance plan that meets the definition of a health benefit plan (as defined in state statute),
- Employed by a small business (2-50 employees) or are the spouse of an employee in a small business, and
There is no resource limit for this demonstration population.

b. The PA Childless Adults II will cease to be an eligible population under this demonstration on January 1, 2014, and Medicaid title XIX expenditure authority will no longer be provided. The state must describe in its Transition Plan how it will conduct eligibility redeterminations to determine whether PA Childless Adults will meet the eligibility criteria for PA Childless Adults I or other open title XIX groups in January 2014, and for those that do not, assist them in obtaining other health care coverage (including coverage purchased through the state's health insurance exchange).

c. The term "non-pregnant childless adult" will mean any adult that is not pregnant, and is not a parent or caretaker relative as such terms are used in Section 1931 of the Act.

d. For the period of this demonstration, there is an average annual enrollment limit of 350 for the PA Childless Adults Group. Both adult employees and their spouses count against the cap. The state may establish a limit of less than 350 individuals, if necessary, to ensure that program expenditures do not exceed the budget neutrality annual limit. The state must notify CMS at least 60 days in advance of any change in the enrollment limit. The state will maintain open enrollment into the PA Childless Adults Group I and II, unless the enrollment limit has been reached or the state has elected to phase out the demonstration (in accord with section III, paragraph 10).

e. <u>Premium Assistance to Access to Health Insurance Parents (collectively referred to as PA Parents) is comprised of the following two components:</u>

i. Premium Assistance to Access to Health Insurance Parents (PA Parents I)
This Group is comprised of individuals who are:
- age 18 and above,
- not eligible for Medicaid under the state plan, and
- have a MAGI-based income up to 100 percent of the FPL,

and who are:
- The parents of a Medicaid or CHIP eligible child/children,
- U.S. citizens/legal residents,
- Residents of Idaho,
- Not otherwise eligible through the Medicaid state plan,
- Not qualified for Medicare or Veterans benefits,
- Not currently participating in any insurance plan that meets the definition of a health benefit plan (as defined in state statute),
- Employed by a small business (2-50 employees) or are the spouse of an employee in a small business, and
- Not otherwise eligible for Medicaid through the state plan.
There is no resource limit for this demonstration population.

ii. Premium Assistance to Access to Health Insurance Parents (PA Parents II)
This Group is comprised of individuals age 18 and above with MAGI-based income at or above 100 percent of the FPL and countable gross family income at or below 185 percent of the FPL who are:
- The parents of a Medicaid or CHIP eligible child/children,
- U.S. citizens/legal residents,
- Residents of Idaho,
- Not otherwise eligible through the Medicaid state plan,
- Not qualified for Medicare or Veterans benefits,
- Not currently participating in any insurance plan that meets the definition of a health benefit plan (as defined in state statute),
- Employed by a small business (2-50 employees) or are the spouse of an employee in a small business, and
- Not otherwise eligible for Medicaid through the state plan.
There is no resource limit for this demonstration population.

f. PA Parents I and II enrolled in the Idaho Title XXI Children's Access Card demonstration on September 30, 2013 will be moved into this demonstration effective October 1, 2013.

g. For the remainder of the period (October 1, 2013 through September 30, 2014, inclusive), the PA Parents Group I will remain open for new enrollment.

h. For the remainder of the period (October 1, 2013 through December 31, 2013), the PA Parents Group II will remain open for new enrollment. As of January 1, 2014, the Parents Group II will cease to be an eligible population under this demonstration, and Medicaid Title XIX expenditure authority will no longer be

provided. (Refer to claiming details in Section X General Financial Reporting Under Title XIX below.) The state must describe in its Transition Plan how it will conduct eligibility redeterminations to determine whether PA Parents will meet the eligibility criteria for PA Parents I or other open title XIX groups in January 2014, and for those that do not, assist them in obtaining other health care coverage (including coverage purchased through the state's health insurance exchange).

V. BENEFITS

1. **Benefit Definition.** The sole benefit provided to persons eligible as PA Childless Adults or PA Parents is assistance in paying the employee's share of the monthly premium cost of qualifying employer-sponsored insurance (ESI) plans.

2. **Qualifying Employer Sponsored Insurance Plans.** Qualifying ESI plans are offered by a qualified employer, meet the conditions set forth in V.7 and include coverage for:

    a. Preventive services
    b. Maternity services
    c. Inpatient and outpatient hospital services
    d. Physicians' medical and surgical services
    e. Hospice Care
    f. Ambulance services
    g. Durable Medical Equipment
    h. Psychiatric and Substance Abuse services
    i. Prescription Drugs

3. Benefits furnished by qualifying ESI plans are not benefits under this demonstration; as indicated in V.1, the only benefit under this demonstration is premium assistance. Qualifying employer sponsored plans are not restricted from offering additional benefits, at the option of the plan, that may vary by the plan offered by the employer.

4. An eligible individual or family may enroll in any qualifying ESI plan that is offered to the individual or family by a qualified employer based on the employment of the individual or a family member.

5. Eligible individuals and families who enroll in a qualifying health benefit plan will receive premium assistance, under the following conditions:

    a. In accord with the enrollment and implementation procedures as defined in Section VI, the state will provide an eligible and enrolled childless adult, childless family, or parent(s) a premium assistance subsidy.

    b. The premium assistance is the amount of the employee share of the premium for the qualified ESI plan, subject to the limits in c. and d. below.

c. The maximum subsidy limit is $100 per eligible enrolled childless or parent adult per month, with a maximum of $200 per household for an eligible childless or parent family.

d. The premium assistance subsidy must not exceed the amount of the participant's share of the premium.

e. The premium assistance subsidy may be paid directly to the individual/family or to the insurance carrier up to the maximum amount specified in subparagraph b. above.

f. Individuals and families that qualify for premium assistance through this demonstration can receive assistance for as long as the individual (or any individual in the family) continues to be employed by a qualifying employer, participates in a qualifying health benefit plan, and continues to meet other program eligibility requirements.

6. **Qualifying employer.** In order to participate in this demonstration, the following qualifications must be met:

   a. The business must have 2-50 employees and must have one adult eligible to participate in the program;

   b. Prior to participating in the program, the small business did not offer insurance to its employees;

   c. The employer must begin offering the health benefit plan to all its employees, both those who receive the premium assistance subsidy and those who do not;

   d. The employer must contribute at least 50 percent of the premium cost for participating employees;

   e. The employer must otherwise meet the insurance carriers' contribution and participation requirements as specified in the Idaho Code; and

   f. Employers must register their intent to participate in the program using the program Web site.

7. **Other requirements for qualified employer-sponsored insurance plans.**

   a. Qualified ESI plans must be regulated as a Small Business Group Plan as specified in Chapter 47, Title 41 of Idaho Statute. Small Business Group Plan benefits and cost-sharing provisions are further regulated by Administrative Code, specifically IDAPA 18.01.70 "Small Employer Health Insurance Availability Act Plan Design."

b. Qualified ESI plans must provide enrollees with hospital or medical policy or certificate of insurance, which can include a subscriber contract provided by a hospital or professional service corporation, or a managed care organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issued for a period of 12 months or less.

8. **Continuing Employer Participation.** Any employer that qualifies to participate and begins participation in the Program may continue to participate, so long as it continues to offer its employees a qualifying health benefit plan as indicated in Section V.7, and continues to meet the criteria in Sections V.6. Should an employer fail to meet any of the conditions, the state must terminate the employer's participation in the Program, and disenroll all participating employees from this demonstration.

VI. ENROLLMENT AND IMPLEMENTATION

1. **General Requirements**

a. Unless otherwise specified in these STCs, all processes (e.g., eligibility, enrollment, redeterminations, terminations, appeals), must comply with federal law and regulations governing Medicaid and CHIP.

b. The state will adhere to the demonstration population enrollment limits presented in Section IV, *Eligibility*.

2. **Enrollment of Businesses in the Idaho Adult Access Card Demonstration**.

a. Once a small businesses that does currently offer any health benefit plan registers its intent to participate in the program (Section V.6(f)), the business will contact an insurance agent/broker for an Idaho Small Group Insurance plan (as defined in state regulations and regulated by the State Insurance Commissioner).

b. The insurance agent/broker will work with the employer to ensure that the health benefit plan meets the requirements to be a qualified ESI plan.

c. The insurance agent/broker is responsible for forwarding the documents to the Idaho Department of Health & Welfare for processing.

d. The insurance broker may work with the employer to estimate the numbers of eligible employees. After the cost of the premiums and the eligible applicants are determined, the employer makes the decision regarding actual participation in the program.

e. If coverage is offered, the eligible applicants are enrolled in the program.

f. The state will monitor, at least annually, the continuing eligibility of the employer (refer to Section V.8).

g. The state will offer agents/brokers training on the Idaho Adult Access Card Demonstration. The state must furnish copies of all insurance agent/broker training materials to CMS upon request.

3. **Enrollment of Individuals in the Demonstration**.

a. Individuals applying for the program must be screened by the state for eligibility in Medicaid and CHIP, and enrolled in Medicaid or CHIP if determined eligible.

b. If an applicant is determined not to be eligible for other coverage (as specified in (a) above) and meets all of the eligibility criteria for the demonstration, and the demonstration is open to new enrollment at the time of the determination, the applicant may be enrolled.

c. Enrollment into the program is on a "first-come, first-served" basis.

d. This demonstration may be closed to new enrollment because the enrollment limit specified in these STCs has been reached. If the program is closed to new enrollment, a statewide waiting list will be established and administered by the Department. Within 90 days of approval of this demonstration, the state will submit, for CMS approval, a plan for the operation of the statewide waiting list.

e. The state will notify CMS in writing at least 30 days prior to the closing of enrollment and include the estimated date when enrollment will be reopened as well as a brief description of how the state plans to manage the waiting list and how enrollment may eventually be reopened. The state will notify CMS in writing within 10 days of the state actually reopening enrollment, and, if applicable, the estimated date when enrollment will again be closed.

The state will provide for a redetermination of eligibility at least once every 12 months. Application and renewal of an employer's qualifying health plan will determine the program start date and redetermination date for participants. At each redetermination, participants must be screened for Medicaid or CHIP eligibility.

f. Interaction with Medicaid.

i. Individuals enrolled in this demonstration may at any time apply for Medicaid or CHIP, and if determined eligible, be enrolled in direct coverage.

ii. The state must remind each participant at least every 6 months, by mail, through an eligibility redetermination, or other comparable means that he or she is entitled

to apply for Medicaid or CHIP and provide directions on how to initiate an application. In particular, the reminder must point out that the participant is likely to qualify for Medicaid if pregnant.

iii. Within 60 days of the award of this demonstration, the state will submit a plan, for CMS approval, that addresses the state's process for transitioning individuals – demonstration-enrolled individuals who become eligible for Medicaid – into direct coverage.

g. The state must establish and maintain procedures for all individuals receiving premium assistance subsidies from the state (which may be done through rulemaking) that will:

i. Ensure that at least one adult family member is employed by a qualifying employer (as defined in Section V.6), that the employer offers health insurance as a benefit through a qualifying health benefit plan (as defined in Section V.5), that the benefit qualifies for the subsidy (as defined in Section V.1-3), and that the employee maintains participation in the plan;

ii. Prior to moving forward with the state's concept of making payments directly to demonstration-enrolled individuals in order to reimburse them for the allowable cost of the premium assistance payment, the state must submit, for CMS' prior approval, a plan that addresses how the state will:

a. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled and receiving health benefit coverage through a qualifying plan and the individual's/family's share of the premium and a quality control plan for cross checking the verification system (e.g., if the information is obtained from the insurance carrier then crosscheck with the employee or employer). This plan may also include requesting information directly from participants in the form of pay stubs showing withholding for health insurance;

b. Require clients to notify the Idaho Department of Health & Welfare within 10 days if they change their plan, there is a change in the amount of their premium, or their health care benefit is terminated;

c. Ensure that the total amount of premium assistance subsidies provided to an demonstration-eligible individual or family does not exceed the amount of the employee's financial obligation toward their coverage; and

d. Provide for recovery of payments made for months in which the childless individual or family did not receive coverage through a qualifying health benefit plan. The federal share must be returned within the timeframes established in statute and regulations.

e. The state will only reimburse individuals directly when an employer makes such a request in writing on the basis of their wish not to engage in accounting for the premium subsidy.

VII. COST SHARING

1. **Cost Sharing.** The state will not impose cost sharing as a condition of premium assistance under this demonstration. This demonstration will not affect any requirements for coverage imposed by qualified ESI plans on enrollees (including American Indian/Alaskan Native enrollees).

VIII. DELIVERY SYSTEMS

1. **Premium Assistance Delivery Systems.** PA Childless Adults or PA Parents (individuals or families) enrolled in the Idaho Adult Access Card Demonstration will receive premium assistance either through payment to the qualified ESI plan by the state, or in the circumstances described in VI.3.h.ii above.

IX. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements.** The state must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in Section X. The state must submit any corrected budget and/or allotment neutrality data upon request.

2. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the state must report demonstration enrollment figures for the month just completed to the CMS Project Officer and Regional Office contact via e-mail, using the table below. The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A under Enrollment Count, except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	**Point In Time Enrollment** (last day of month)	**Newly Enrolled Last Month**	**Disenrolled Last Month**
PA Childless Adults I and II			
PA Parents I and II			

3. **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, 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 state is considering submitting. CMS will provide updates 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 will jointly develop the agenda for the calls.

4. **Quarterly Progress Reports.** The state must submit progress reports in accordance with the guidelines in 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. These Quarterly Reports must include, but not be limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    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: benefits, enrollment and disenrollment, grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

    c. Action plans for addressing any policy, administrative, or budget issues identified;

    d. Quarterly enrollment reports for demonstration-eligibles, that include the member months and end of quarter, point-in-time enrollment for each demonstration population, and other statistical reports listed in Attachment A; and

    e. Evaluation activities and interim findings.

5. **Annual Report.**

    a. The state must submit a draft Annual Report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.

    b. The state will continually monitor the costs of providing premium assistance and of direct coverage and report the comparative assessment in the Annual Report.

    c. The state must submit the draft annual report no later than 120 days after the close of the demonstration year (DY).

    d. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

X. GENERAL FINANCIAL REQUIREMENTS

1. **Quarterly Expenditure Reports for Title XIX.** The state must provide quarterly expenditure reports using Form CMS-64 to separately 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 will provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI.

2. **Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** All expenditures for health care services for demonstration participants (as defined in Section IV above) are subject to the budget neutrality expenditure limit.

3. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

    a. **Use of Waiver Forms.** In order to track expenditures under this demonstration, 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 (SMM). 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 (11-W-00245/10) assigned by CMS.

    b. **Reporting By Date of Service.** In each quarter, demonstration expenditures (including prior period adjustments) must be totaled and reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver by DY. The DY for which expenditures are reported is identified using the project number extension (a 2-digit number appended to the demonstration Project Number). Expenditures are to be assigned to DYs on the basis of date of service. The date of service for premium or premium assistance payments is identified as the DY that accounts for the larger share of the coverage period for which the payment is made. DY 1 will correspond with federal fiscal year (FFY) 2010, DY 2 with FFY 2011, and so on.

    c. **Waiver Name.** The state must identify separate Forms CMS-64.9 Waiver and/or 64.9P Waiver that report demonstration population expenditures, using waiver name "Childless Adults" to identify expenditures for PA Childless Adults I and II, and "Parents" to identify expenditures for PA Parents I and PA Parents II.

4. **Title XIX Administrative Costs.** Administrative costs will not be subject to the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All such

administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using waiver name "Childless Adults."

5. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (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 Section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

6. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used during the demonstration. The state 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 will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

7. **Extent of Title XIX FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section XI:

    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 all childless adults (PA Childless Adults I and II), with dates of service between January 1, 2010 and September 30, 2013 (inclusive).

    c. Net expenditures incurred between October 1, 2013 and September 30, 2014 (inclusive) for Childless Adults who are ineligible for premium tax credits through the state's health insurance exchange (PA Childless Adults I), made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act.

    d. Net expenditures incurred between October 1, 2013 and December 31, 2013 (inclusive) for Childless Adults who are transitioning into the Insurance Exchange

(PA Childless Adults II), made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act.

e. Net expenditures incurred between October 1, 2013 and September 30, 2014 (inclusive) for parents who are ineligible for premium tax credits through the state's health insurance exchange (PA Parents I), made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act.

f. Net expenditures incurred between October 1, 2013 and December 31, 2013 (inclusive) for former CHIP Parents who are transitioning into the Insurance Exchange (PA Parents II), made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act.

8. **Sources of Non-Federal Share.** The state certifies that the source of non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds will not be used as the non-federal share for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with Title XIX of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

   a. CMS will review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS will be addressed within the time frames set by CMS.

   b. The state will 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. Under all circumstances, health insurance carriers and program participants receiving payments directly from the state must retain 100 percent of the payment amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the recipients of payments and the state and/or local government to return and/or redirect any portion of the Medicaid or demonstration payments. This confirmation of Medicaid and demonstration 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 or the demonstration and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid or demonstration payment.

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

XI. MONITORING BUDGET NEUTRALITY

1. **Limit on Federal Title XIX funding.** The state will be subject to annual limits on the amount of federal Title XIX funding that the state may receive for expenditures subject to the budget neutrality agreement.

2. **Risk.** For the PA Childless Adult group, the state will be at risk for both the number of enrollees in the demonstration as well as the per capita cost for demonstration-eligible childless adults under this budget neutrality agreement. For the PA Parents Group (PA Parents I and II), the state will be at risk for the per capita cost (as determined by the method described below), but not at risk for the number of demonstration-eligible parents.

3. **Calculation of the Budget Neutrality Limit: General.** Separate budget neutrality limits will be calculated for PA Childless Adults I and II, and PA Parents I and II, respectively.

4. **Budget Neutrality Expenditure Limit for the PA Childless Adults.** The following describes how the annual budget neutrality expenditure limits are determined for the PA Childless Adult group (PA Childless Adults I and II), consistent with Section 2111(a)(3)(C) of the Act.

    a. **Record of Budget Neutrality Expenditure Limit.** Attachment B provides a table that gives preliminary Annual Limits (defined below) for all of the approved DYs, based on information available at the time of the initial award of this demonstration. The table also provides a framework for organizing and documenting updates to the Annual Limits as new information is received, and for eventual publication of the final Annual Limit for each DY. Updated versions of Attachment B may be approved by CMS through letter correspondence, and do not require that the demonstration be amended.

    b. **Budget Neutrality Update.** Prior to April 1 of each year, the state must submit to CMS an updated budget neutrality analysis, which includes the following elements:

        i. Projected expenditures and Annual Limits for each DY through the end of the approval period (DYs are on a FFY basis);

        ii. A proposed computation of the Trend Factor (defined below) that will be used to calculate the Annual Limit for the DY immediately following, and the Annual Limit for the immediately following DY that would be determined by that Trend Factor;

        iii. A proposed updated version of Attachment B.

        iv. The annual budget neutrality limit for each DY will be finalized by CMS by the later of the following dates: (1) 120 days prior to the start of the DY, or (2) 2 months following the date of the most recent publication of the National

Health Expenditure projections occurring prior to the start of the DY.

The state may request technical assistance from CMS for the calculation of the Annual Limits and Trend Factors prior to its submission of the updated budget neutrality analysis. CMS will respond by either confirming the state's calculations or will work with the state to determine an accurate calculation of the Trend Factor and Annual Limit for the coming DY. CMS will ensure that the final Trend Factors for each DY are the same for all CHIPRA Medicaid childless adult waivers.

c. **FFY 2009 Base Year Expenditure.** The Base Year Expenditure will be equal to the total amount of FFP paid to the state for health care services or coverage provided to non-pregnant childless adults under the Idaho Adult Access Card Demonstration (21-W-00018/10 and 11-W-187/10), as reported on CMS-21 and 21P Waiver forms submitted by the state in the four quarters of FFY 2009. A preliminary Base Year Expenditure total appears in Attachment B. A final Base Year Expenditure total will be determined by CMS following CMS receipt of the Budget Neutrality Update that the state must provide by April 1, 2010.

d. **Adjustments to the Base Year Expenditure.** CMS reserved the right to adjust the Base Year Expenditure in the event that any future audit or examination shows that any of the expenditures included in the Base Year Expenditure total were not expenditures for health care services, health insurance premiums, or premium assistance for non-pregnant childless adults participating in the Idaho Adult Access Card Demonstration (21-W-00018/10 and 11-W-187/10), or that otherwise were not approved demonstration expenditures.

e. **Special Calculation for FFY 2010.** The FFY 2010 Expenditure Projection will be equal to the Base Year Expenditure increased by 3.7 percent, which is the percentage increase in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as published by the Secretary in February 2009.

f. **Annual Limit for DY 1.** To account for the fact that this demonstration will be active for only three-quarters of FFY 2010, the Annual Limit for DY 1 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e)) multiplied by 75 percent. The Annual Limit for DY 1 will be finalized at the same time that the Base Year Expenditure is finalized.

g. **Annual Limit for DY 2.** The Annual Limit for DY 2 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e), and prior to multiplication by three-quarters as indicated in subparagraph (f)), increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2011 over 2010, as published by the Secretary in February 2010. The Annual Limit for DY 2 can be finalized once the Trend Factor for DY 2 is finalized.

h. **Annual Limit for DY 3 and Subsequent Years.** The Annual Limit for DY 3 and the DYs that follow will be equal to the prior year's Annual Limit, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of the DY over the year preceding that year, as published by the Secretary in the February prior to the start of the DY.

i. **Calculation of the Trend Factor.** The percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of a DY (PERCAPYEAR2) over the preceding year (PERCAPYEAR1) (to be referred to as the Trend Factor) will be calculated to one decimal place of precision (example: 3.7 percent) using computer spreadsheet rounding. (A sample formula for this calculation in Microsoft Excel reads as follows:

"=ROUND(100*(PERCAP2-PERCAP1)/PERCAP1,1))"

5. **Budget Neutrality Expenditure Limit for the PA Parents.** The following describes how the method for calculating the annual budget neutrality expenditure limit for the Parents group, consistent with the Expenditure Authorities granting FFP for Costs Not Otherwise Matchable for this group.

a. **"Hypothetical" Eligibility Group.** The budget neutrality of PA Parents expenditures will be established by considering the PA Parents to be a hypothetical group, consisting of individuals who could have been made eligible under the Medicaid state plan. This arrangement does not allow the state to access any budget neutrality "savings" from the PA Parents group. A prospective per capita cap on federal financial risk is established for the PA Parents group based on the costs that the population is expected to incur under the demonstration.

b. A separate annual budget neutrality expenditure cap is calculated by summing expenditures for Parents I and II for the first quarter of federal fiscal year 2014 (October 1, 2013 through December 31, 2013) with the expenditures cap for PA Parents I for the second through fourth quarters of federal fiscal year 2014 (January 1, 2014 through September 30, 2014). An annual estimate for the PA Parents Group must be calculated as a product of the number of eligible member months reported by the State under STC VII.4(d) for the demonstration population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (c) below.

c. The trend rates and per capita cost estimates for the PA Parents eligibility group (EG) is listed in the table below. The PA Parents population is a "pass-through" or "hypothetical" population. Therefore, the State may not derive savings for this population. The state may not receive FFP for expenditures for PA Parents in

excess of the federal share of the budget neutrality limit, which will be the total computable budget neutrality limit times the FMAP for Idaho for FY 2014.

Demonstration Period	Parents (PMPM)	Trend Rate	Total "Parents" Budget Limit
October 1, 2013 through September 30, 2014	$ 88.26	2.30 %	$ 212,342

6. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality on an annual basis. Separate budget neutrality determinations will be made for PA Childless Adults and PA Patents. The amount of FFP that the state receives for demonstration expenditures each DY and for each population cannot exceed the Annual Limit applicable to that DY and population. If, for any DY, the state receives FFP in excess of the Annual Limit, the state must return the excess funds to CMS. All expenditures above the Annual Limit applicable to each DY will be the sole responsibility of the state.

7. **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 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 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.

XII. EVALUATION OF THE DEMONSTRATION

1. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after the effective date of the demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, 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. 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 must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

2. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of Section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

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

4. **Final Evaluation Report**. The state must submit to CMS a draft of the final evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS' comments. The state will submit a revised evaluation plan that examines the transfer of PA Parents between the various changes in coverage within 60 days of the associated amendment to the demonstration.

5. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to CMS or the contractor.

XI. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

STC	Deliverable
Within 30 days of the date of award	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities (approval letter)
Within 30 days of the date of an amendment	State acceptance of amended demonstration Waivers, STCs, and Expenditure Authorities (approval letter)
In compliance with paragraph XII.1.	Submit Draft Design for Final Evaluation Report
In compliance with paragraph XII.1.	Submit a revised Draft Design for Final Evaluation Report
In compliance with paragraph III.8.	Submit demonstration Extension Application
In compliance with paragraph VI.3(e).	Submit a plan for the operation of a statewide waiting list.
In compliance with paragraph XII.2.	Submit Interim Evaluation Report
Monthly Deliverables	**Deliverable**
In compliance with	Monitoring Call

paragraph IX.3.	
In compliance with paragraph IX.2.	Monthly Enrollment Report
Quarterly **Due 60 days after the end of each quarter, except the 4th quarter**	**Deliverable**
In compliance with paragraph IX.4.	Quarterly Progress Reports
In compliance with paragraph IX.4(d).	Quarterly Enrollment Reports
In compliance with Section VIII.	Quarterly Expenditure Reports
Annual	**Deliverable**
In compliance with paragraph IX.5.	Draft and Final Annual Reports (Annual Progress Reports and Annual Expenditure Reports)
Other	**Deliverable**
In compliance with paragraph VI.3(h)(ii)	Submit a plan for making premium assistance payments directly to individuals.
1 year before expiration of the demonstration, per paragraph III.8 or III.9.	Submit a request for extension or a phase-out plan
120 days after expiration of the demonstration, per paragraph X.4.	Submit Draft Final Evaluation Report
Within 60 days after receipt of CMS comments, per paragraph X.4.	Submit Final Evaluation Report

ATTACHMENT A

QUARTERLY REPORT FORMAT AND CONTENT

Under Section IX.4, 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 – Idaho Adult Access Card Demonstration
Title Line Two - Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 1 (January 1, 2010 – December 31, 2010)
Federal Fiscal Quarter: 01/01/2010 – 03/31/2010

Introduction

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 Count

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

Demonstration Populations (as hard coded in the CMS 64)	**Current Enrollment** (last day of quarter)	**Newly Enrolled in Current Quarter**	**Disenrolled in Current Quarter**
PA Childless Adults I and II			
PA Parents I and II			

Member Month Reporting
Enter the member months for the quarter.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
PA Childless Adults I and II				
PA Parents I and II				

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 state's actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

Consumer Issues:
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.

Status of Benefits and Cost Sharing:
Provide update regarding any changes to benefits or cost sharing during the quarter.

Demonstration Evaluation:
Discuss progress of evaluation design and planning.

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

RECORD OF BUDGET NEUTRALITY EXPENDITURE LIMIT FOR CHILDLESS ADULTS
Approval Date of This Version: October 9, 2012

A blank preceding a percent sign (%) or following a dollar sign ($) or "Recorded On" indicates that a value is to be entered there some time in the future.

	Initial Preliminary Estimates		**Revised Preliminary Estimates**		**Final Amounts**	
	Trend Factor	**Amount**	**Trend Factor**	**Amount**	**Trend Factor**	**Amount**
Base Year Expenditure (Paragraphs XI.3(c) and (d))	N/A	$76,703 Recorded On: 12/23/2009	N/A	N/A	N/A	$76,703 Recorded On: 6/1/2010
FFY 2010 Expenditure Projection (Paragraph XI.3(e))	3.7% Recorded On: 12/23/2009	$79,541 Recorded On: 12/23/2009	N/A	N/A	3.7% Recorded On: 12/23/2009	$79,541 Recorded On: 6/1/2010
Annual Limit, DY 1 (Paragraph XI.3(f))	N/A	$59,656 Recorded On: 12/23/2009	N/A	N/A	N/A	$59,656 Recorded On: 6/1/2010

Annual Limit, DY 2 (Paragraphs XI.3(g) and (i))	4.6% Recorded On: 12/23/2009	$83,200 Recorded On: 12/23/2009	N/A	N/A	4.3% Recorded On: 6/1/2010	$82,961 Recorded On: 6/1/2010
Annual Limit, DY 3 (Paragraphs XI.3(h) and (i))	4.9% Recorded On: 12/23/2009	$87,277 Recorded On: 12/23/2009	4.5% Recorded On: 6/1/2010	$86,694 Recorded On: 6/1/2010	3.3% Recorded On: 8/11/2011	$85,699 Recorded On: 8/11/2011
Annual Limit, DY 4 (Paragraphs XI.3(h) and (i))	5.2% Recorded On: 12/23/2009	$91,815 Recorded On: 12/23/2009	4.6% Recorded On: 8/11/2011	$89,641 Recorded On: 8/11/2011	2.9% Recorded On: 10/9/2012	$88,184 Recorded On: 10/9/2012
Annual Limit, DY 5 (Paragraphs XI.3(h) and (i))	5.6% Recorded On: 12/23/2009	$96,957 Recorded On: 12/23/2009	6.4% Recorded On: 10/9/2012	$93,828 Recorded On: 10/9/2012	% Recorded On:	$ Recorded On:

The "Recorded On" date indicates the date in which a particular number or percentage was first incorporated (or, "recorded") into an approved version of Attachment B.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: **11-W-00245/10**

TITLE: **Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration)**

AWARDEE: **Idaho Department of Health & Welfare**

DEMONSTRATION PERIOD: **January 1, 2010, through September 30, 2014 - as amended on September 24, 2013**

TABLE OF CONTENTS

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Idaho Medicaid Non-pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration) (hereinafter referred to as "demonstration" or "program") for the waiver under Section 1115(a) of the Social Security Act (the Act) for the period of January 1, 2010, through September 30, 2014. The parties to this agreement are the Idaho Department of Health & Welfare ("state") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid and Children's Health Insurance Programs (CHIP) expressed in law, regulation, and policy statement not expressly waived or made not applicable in the list of Waivers and Expenditure Authorities, will apply to the demonstration project.

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. The STCs are effective as of the approval letter's date, unless otherwise specified. Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval will be directed to the CMS Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter. This demonstration is approved through September 30, 2014. The STCs have been arranged into the following subject areas: program description and objectives; general program requirements; eligibility; benefits; enrollment; cost sharing; delivery systems; general reporting requirements; general financial requirements under Title XIX; monitoring budget neutrality for the demonstration; evaluation of the demonstration; and schedule of state deliverables during the demonstration.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration) is a statewide Section 1115 demonstration to make health insurance more affordable by providing premium subsidy to individuals with incomes at or below 185 percent of the federal poverty level (FPL). This program is targeted at small businesses (2-50 employees) that do not offer a health benefit plan.

The Idaho Children's Access Card demonstration was approved by CMS in 2004, to allow the state to provide an alternative premium assistance program to children eligible for the state's Children's Health Insurance Program (CHIP). This demonstration was amended in July of 2005 to add a coverage program for adults, that provided up to $100 per month per enrolled adult beneficiary (for a qualifying employee or the spouse of the employee) toward the individual's share of the employer-sponsored health insurance premium. In July 2006, the program was amended to require a 50 percent employer contribution toward the cost of the health benefit plan.

The Idaho premium assistance program, entitled Access to Health Insurance, was funded in part by the federal government through Title XXI funding. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), required the state to remove the childless adults from Title XXI funding no later than December 31, 2009. In response, the state submitted a proposal to CMS to move the eligible non-pregnant childless adults into a new Section 1115

demonstration under authority and funding of Title XIX. CMS approved the Idaho's Premium Assistance to Childless Adults Demonstration under Section 1115(a) of the Act for the period of January 1, 2010, through September 30, 2014. This essentially left Idaho with two waivers, one under Title XXI for children and parents, and one under Title XIX for non-pregnant childless adults.

CHIPRA also changed states' authority to cover parents under a Title XXI program. Specifically, CHIPRA added Section 2111(b)(2) of the Act, which permitted a state with existing authority (prior to the passage of CHIPRA) to continue Title XXI parents coverage, through September 30, 2013. This Title XIX demonstration is amended to provide Access to Health Insurance coverage for the parents (for the period of October 1, 2013 until January 1, 2014 when these individuals with MAGI-based incomes at or above 100 percent of the federal poverty level (FPL) will be eligible for a premium subsidy through the state's health insurance exchange, in accord with the Affordable Care Act). For those parents not eligible for a premium subsidy through the state's health insurance exchange, due to MAGI-determined incomes below 100 percent of the FPL, this Title XIX demonstration is amended to provide Access to Health Insurance coverage for the period of October 1, 2013 until October 1, 2014. Because Childless Adults with MAGI-based at or above 100 percent of the FPL will also be eligible for a premium subsidy through the state's health insurance exchange as of January 1, 2014, these individuals (hereafter referred to as Childless Adults II) will no longer be covered under this demonstration after December 31, 2013.

The following Special Terms and Conditions and the approved Costs Not Otherwise Matchable apply to the demonstration.

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 Law, Regulation, and Policy.** All requirements of the Medicaid program 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 Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, 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 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 the implementation of the change.

    b. If mandated changes in 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 affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate 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, 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 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 these 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 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 15, 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 will include current federal share "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. An up-to-date CHIP allotment neutrality worksheet, if necessary;

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

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

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under Sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

   As part of the demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

   a. Demonstration Summary and Objectives: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met, as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of each change and desired outcomes must be included.

   b. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time. Consistent with federal law, CMS reserves the right to deny approval for a requested extension based on non-compliance with these 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.

   c. Waiver and Expenditure Authorities: The state must provide a list, along with a programmatic description, of the waivers and expenditure authorities that are being requested in the extension.

   d. Quality: The state must provide summaries of External Quality Review Organization reports, managed care organization, and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

e. Compliance with the Budget Neutrality Cap: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In addition, the state must provide up-to-date responses to the CMS Financial Management standard questions. If Title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

f. Draft report with Evaluation Status and Findings: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, at any time prior to the date of expiration. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the state elects to phase out the demonstration, the state must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10 a phase-out plan will not be shorter than 6 months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the state, FFP will be limited to normal closeout costs associated with terminating the demonstration, including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out.** If the state elects to suspend, terminate, or not renew this demonstration as described in paragraph 9, during the last 6 months of the demonstration, individuals who would not be eligible for Medicaid under the current Medicaid state plan must not be enrolled unless the demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the state in writing that the demonstration will not be renewed.

11. **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.

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

13. **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. 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 closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The state must 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.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and 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 STC 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. In the event that the state conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS.

16. **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

1. **Eligibility Criteria.** The demonstration-eligible populations consist entirely of persons who are not otherwise eligible for Medicaid through the state plan.

2. The Idaho Section 1115 demonstration is comprised of the following Eligibility Groups:

a. <u>Premium Assistance to Non-Pregnant Childless Adults (collectively referred to as PA Childless Adults) is comprised of the following two components:</u>

   i. Premium Assistance for Non-Pregnant Childless Adults I (PA Childless Adults I): This Group is comprised of non-pregnant childless individuals age 18 and above, who meet the following qualifications:
   - Have MAGI-based income below 100 percent of the FPL;
   - U.S. citizens/legal residents,
   - Residents of Idaho,
   - Not otherwise eligible for Medicaid through the state plan,

- Not qualified for Medicare or Veterans benefits,
- Not currently participating in any insurance plan that meets the definition of a health benefit plan (as defined in state statute),
- Employed by a small business (2-50 employees) or are the spouse of an employee in a small business, and
There is no resource limit for this demonstration population.

ii. Premium Assistance for Non-Pregnant Childless Adults II (PA Childless Adults II):
This Group is comprised of non-pregnant childless individuals age 18 and above, who meet the following qualifications:
- Have MAGI-based income at or above 100 percent of the FPL and countable gross family income at or below 185 percent of the FPL;
- U.S. citizens/legal residents,
- Residents of Idaho,
- Not otherwise eligible for Medicaid through the state plan,
- Not qualified for Medicare or Veterans benefits,
- Not currently participating in any insurance plan that meets the definition of a health benefit plan (as defined in state statute),
- Employed by a small business (2-50 employees) or are the spouse of an employee in a small business, and
There is no resource limit for this demonstration population.

b. The PA Childless Adults II will cease to be an eligible population under this demonstration on January 1, 2014, and Medicaid title XIX expenditure authority will no longer be provided. The state must describe in its Transition Plan how it will conduct eligibility redeterminations to determine whether PA Childless Adults will meet the eligibility criteria for PA Childless Adults I or other open title XIX groups in January 2014, and for those that do not, assist them in obtaining other health care coverage (including coverage purchased through the state's health insurance exchange).

c. The term "non-pregnant childless adult" will mean any adult that is not pregnant, and is not a parent or caretaker relative as such terms are used in Section 1931 of the Act.

d. For the period of this demonstration, there is an average annual enrollment limit of 350 for the PA Childless Adults Group. Both adult employees and their spouses count against the cap. The state may establish a limit of less than 350 individuals, if necessary, to ensure that program expenditures do not exceed the budget neutrality annual limit. The state must notify CMS at least 60 days in advance of any change in the enrollment limit. The state will maintain open enrollment into the PA Childless Adults Group I and II, unless the enrollment limit has been reached or the state has elected to phase out the demonstration (in accord with section III, paragraph 10).

e. <u>Premium Assistance to Access to Health Insurance Parents (collectively referred to as PA Parents) is comprised of the following two components:</u>

i. Premium Assistance to Access to Health Insurance Parents (PA Parents I)
This Group is comprised of individuals who are:
- age 18 and above,
- not eligible for Medicaid under the state plan, and
- have a MAGI-based income up to 100 percent of the FPL,

and who are:
- The parents of a Medicaid or CHIP eligible child/children,
- U.S. citizens/legal residents,
- Residents of Idaho,
- Not otherwise eligible through the Medicaid state plan,
- Not qualified for Medicare or Veterans benefits,
- Not currently participating in any insurance plan that meets the definition of a health benefit plan (as defined in state statute),
- Employed by a small business (2-50 employees) or are the spouse of an employee in a small business, and
- Not otherwise eligible for Medicaid through the state plan.
There is no resource limit for this demonstration population.

ii. Premium Assistance to Access to Health Insurance Parents (PA Parents II)
This Group is comprised of individuals age 18 and above with MAGI-based income at or above 100 percent of the FPL and countable gross family income at or below 185 percent of the FPL who are:
- The parents of a Medicaid or CHIP eligible child/children,
- U.S. citizens/legal residents,
- Residents of Idaho,
- Not otherwise eligible through the Medicaid state plan,
- Not qualified for Medicare or Veterans benefits,
- Not currently participating in any insurance plan that meets the definition of a health benefit plan (as defined in state statute),
- Employed by a small business (2-50 employees) or are the spouse of an employee in a small business, and
- Not otherwise eligible for Medicaid through the state plan.
There is no resource limit for this demonstration population.

f. PA Parents I and II enrolled in the Idaho Title XXI Children's Access Card demonstration on September 30, 2013 will be moved into this demonstration effective October 1, 2013.

g. For the remainder of the period (October 1, 2013 through September 30, 2014, inclusive), the PA Parents Group I will remain open for new enrollment.

h. For the remainder of the period (October 1, 2013 through December 31, 2013), the PA Parents Group II will remain open for new enrollment. As of January 1, 2014, the Parents Group II will cease to be an eligible population under this demonstration, and Medicaid Title XIX expenditure authority will no longer be

provided. (Refer to claiming details in Section X General Financial Reporting Under Title XIX below.) The state must describe in its Transition Plan how it will conduct eligibility redeterminations to determine whether PA Parents will meet the eligibility criteria for PA Parents I or other open title XIX groups in January 2014, and for those that do not, assist them in obtaining other health care coverage (including coverage purchased through the state's health insurance exchange).

V. BENEFITS

1. **Benefit Definition.** The sole benefit provided to persons eligible as PA Childless Adults or PA Parents is assistance in paying the employee's share of the monthly premium cost of qualifying employer-sponsored insurance (ESI) plans.

2. **Qualifying Employer Sponsored Insurance Plans.** Qualifying ESI plans are offered by a qualified employer, meet the conditions set forth in V.7 and include coverage for:

    a. Preventive services
    b. Maternity services
    c. Inpatient and outpatient hospital services
    d. Physicians' medical and surgical services
    e. Hospice Care
    f. Ambulance services
    g. Durable Medical Equipment
    h. Psychiatric and Substance Abuse services
    i. Prescription Drugs

3. Benefits furnished by qualifying ESI plans are not benefits under this demonstration; as indicated in V.1, the only benefit under this demonstration is premium assistance. Qualifying employer sponsored plans are not restricted from offering additional benefits, at the option of the plan, that may vary by the plan offered by the employer.

4. An eligible individual or family may enroll in any qualifying ESI plan that is offered to the individual or family by a qualified employer based on the employment of the individual or a family member.

5. Eligible individuals and families who enroll in a qualifying health benefit plan will receive premium assistance, under the following conditions:

    a. In accord with the enrollment and implementation procedures as defined in Section VI, the state will provide an eligible and enrolled childless adult, childless family, or parent(s) a premium assistance subsidy.

    b. The premium assistance is the amount of the employee share of the premium for the qualified ESI plan, subject to the limits in c. and d. below.

c. The maximum subsidy limit is $100 per eligible enrolled childless or parent adult per month, with a maximum of $200 per household for an eligible childless or parent family.

d. The premium assistance subsidy must not exceed the amount of the participant's share of the premium.

e. The premium assistance subsidy may be paid directly to the individual/family or to the insurance carrier up to the maximum amount specified in subparagraph b. above.

f. Individuals and families that qualify for premium assistance through this demonstration can receive assistance for as long as the individual (or any individual in the family) continues to be employed by a qualifying employer, participates in a qualifying health benefit plan, and continues to meet other program eligibility requirements.

6. **Qualifying employer.** In order to participate in this demonstration, the following qualifications must be met:

   a. The business must have 2-50 employees and must have one adult eligible to participate in the program;

   b. Prior to participating in the program, the small business did not offer insurance to its employees;

   c. The employer must begin offering the health benefit plan to all its employees, both those who receive the premium assistance subsidy and those who do not;

   d. The employer must contribute at least 50 percent of the premium cost for participating employees;

   e. The employer must otherwise meet the insurance carriers' contribution and participation requirements as specified in the Idaho Code; and

   f. Employers must register their intent to participate in the program using the program Web site.

7. **Other requirements for qualified employer-sponsored insurance plans.**

   a. Qualified ESI plans must be regulated as a Small Business Group Plan as specified in Chapter 47, Title 41 of Idaho Statute. Small Business Group Plan benefits and cost-sharing provisions are further regulated by Administrative Code, specifically IDAPA 18.01.70 "Small Employer Health Insurance Availability Act Plan Design."

b. Qualified ESI plans must provide enrollees with hospital or medical policy or certificate of insurance, which can include a subscriber contract provided by a hospital or professional service corporation, or a managed care organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issued for a period of 12 months or less.

8. **Continuing Employer Participation.** Any employer that qualifies to participate and begins participation in the Program may continue to participate, so long as it continues to offer its employees a qualifying health benefit plan as indicated in Section V.7, and continues to meet the criteria in Sections V.6. Should an employer fail to meet any of the conditions, the state must terminate the employer's participation in the Program, and disenroll all participating employees from this demonstration.

VI. ENROLLMENT AND IMPLEMENTATION

1. **General Requirements**

a. Unless otherwise specified in these STCs, all processes (e.g., eligibility, enrollment, redeterminations, terminations, appeals), must comply with federal law and regulations governing Medicaid and CHIP.

b. The state will adhere to the demonstration population enrollment limits presented in Section IV, *Eligibility*.

2. **Enrollment of Businesses in the Idaho Adult Access Card Demonstration**.

a. Once a small businesses that does currently offer any health benefit plan registers its intent to participate in the program (Section V.6(f)), the business will contact an insurance agent/broker for an Idaho Small Group Insurance plan (as defined in state regulations and regulated by the State Insurance Commissioner).

b. The insurance agent/broker will work with the employer to ensure that the health benefit plan meets the requirements to be a qualified ESI plan.

c. The insurance agent/broker is responsible for forwarding the documents to the Idaho Department of Health & Welfare for processing.

d. The insurance broker may work with the employer to estimate the numbers of eligible employees. After the cost of the premiums and the eligible applicants are determined, the employer makes the decision regarding actual participation in the program.

e. If coverage is offered, the eligible applicants are enrolled in the program.

f. The state will monitor, at least annually, the continuing eligibility of the employer (refer to Section V.8).

g. The state will offer agents/brokers training on the Idaho Adult Access Card Demonstration. The state must furnish copies of all insurance agent/broker training materials to CMS upon request.

3. **Enrollment of Individuals in the Demonstration**.

a. Individuals applying for the program must be screened by the state for eligibility in Medicaid and CHIP, and enrolled in Medicaid or CHIP if determined eligible.

b. If an applicant is determined not to be eligible for other coverage (as specified in (a) above) and meets all of the eligibility criteria for the demonstration, and the demonstration is open to new enrollment at the time of the determination, the applicant may be enrolled.

c. Enrollment into the program is on a "first-come, first-served" basis.

d. This demonstration may be closed to new enrollment because the enrollment limit specified in these STCs has been reached. If the program is closed to new enrollment, a statewide waiting list will be established and administered by the Department. Within 90 days of approval of this demonstration, the state will submit, for CMS approval, a plan for the operation of the statewide waiting list.

e. The state will notify CMS in writing at least 30 days prior to the closing of enrollment and include the estimated date when enrollment will be reopened as well as a brief description of how the state plans to manage the waiting list and how enrollment may eventually be reopened. The state will notify CMS in writing within 10 days of the state actually reopening enrollment, and, if applicable, the estimated date when enrollment will again be closed.

The state will provide for a redetermination of eligibility at least once every 12 months. Application and renewal of an employer's qualifying health plan will determine the program start date and redetermination date for participants. At each redetermination, participants must be screened for Medicaid or CHIP eligibility.

f. Interaction with Medicaid.

i. Individuals enrolled in this demonstration may at any time apply for Medicaid or CHIP, and if determined eligible, be enrolled in direct coverage.

ii. The state must remind each participant at least every 6 months, by mail, through an eligibility redetermination, or other comparable means that he or she is entitled

to apply for Medicaid or CHIP and provide directions on how to initiate an application. In particular, the reminder must point out that the participant is likely to qualify for Medicaid if pregnant.

iii. Within 60 days of the award of this demonstration, the state will submit a plan, for CMS approval, that addresses the state's process for transitioning individuals – demonstration-enrolled individuals who become eligible for Medicaid – into direct coverage.

g. The state must establish and maintain procedures for all individuals receiving premium assistance subsidies from the state (which may be done through rulemaking) that will:

i. Ensure that at least one adult family member is employed by a qualifying employer (as defined in Section V.6), that the employer offers health insurance as a benefit through a qualifying health benefit plan (as defined in Section V.5), that the benefit qualifies for the subsidy (as defined in Section V.1-3), and that the employee maintains participation in the plan;

ii. Prior to moving forward with the state's concept of making payments directly to demonstration-enrolled individuals in order to reimburse them for the allowable cost of the premium assistance payment, the state must submit, for CMS' prior approval, a plan that addresses how the state will:

a. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled and receiving health benefit coverage through a qualifying plan and the individual's/family's share of the premium and a quality control plan for cross checking the verification system (e.g., if the information is obtained from the insurance carrier then crosscheck with the employee or employer). This plan may also include requesting information directly from participants in the form of pay stubs showing withholding for health insurance;

b. Require clients to notify the Idaho Department of Health & Welfare within 10 days if they change their plan, there is a change in the amount of their premium, or their health care benefit is terminated;

c. Ensure that the total amount of premium assistance subsidies provided to an demonstration-eligible individual or family does not exceed the amount of the employee's financial obligation toward their coverage; and

d. Provide for recovery of payments made for months in which the childless individual or family did not receive coverage through a qualifying health benefit plan. The federal share must be returned within the timeframes established in statute and regulations.

e. The state will only reimburse individuals directly when an employer makes such a request in writing on the basis of their wish not to engage in accounting for the premium subsidy.

VII. COST SHARING

1. **Cost Sharing.** The state will not impose cost sharing as a condition of premium assistance under this demonstration. This demonstration will not affect any requirements for coverage imposed by qualified ESI plans on enrollees (including American Indian/Alaskan Native enrollees).

VIII. DELIVERY SYSTEMS

1. **Premium Assistance Delivery Systems.** PA Childless Adults or PA Parents (individuals or families) enrolled in the Idaho Adult Access Card Demonstration will receive premium assistance either through payment to the qualified ESI plan by the state, or in the circumstances described in VI.3.h.ii above.

IX. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements.** The state must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in Section X. The state must submit any corrected budget and/or allotment neutrality data upon request.

2. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the state must report demonstration enrollment figures for the month just completed to the CMS Project Officer and Regional Office contact via e-mail, using the table below. The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A under Enrollment Count, except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	**Point In Time Enrollment** (last day of month)	**Newly Enrolled Last Month**	**Disenrolled Last Month**
PA Childless Adults I and II			
PA Parents I and II			

3. **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, 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 state is considering submitting. CMS will provide updates 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 will jointly develop the agenda for the calls.

4. **Quarterly Progress Reports.** The state must submit progress reports in accordance with the guidelines in 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. These Quarterly Reports must include, but not be limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    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: benefits, enrollment and disenrollment, grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

    c. Action plans for addressing any policy, administrative, or budget issues identified;

    d. Quarterly enrollment reports for demonstration-eligibles, that include the member months and end of quarter, point-in-time enrollment for each demonstration population, and other statistical reports listed in Attachment A; and

    e. Evaluation activities and interim findings.

5. **Annual Report.**

    a. The state must submit a draft Annual Report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.

    b. The state will continually monitor the costs of providing premium assistance and of direct coverage and report the comparative assessment in the Annual Report.

    c. The state must submit the draft annual report no later than 120 days after the close of the demonstration year (DY).

    d. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

X. GENERAL FINANCIAL REQUIREMENTS

1. **Quarterly Expenditure Reports for Title XIX.** The state must provide quarterly expenditure reports using Form CMS-64 to separately 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 will provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI.

2. **Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** All expenditures for health care services for demonstration participants (as defined in Section IV above) are subject to the budget neutrality expenditure limit.

3. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

    a. **Use of Waiver Forms.** In order to track expenditures under this demonstration, 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 (SMM). 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 (11-W-00245/10) assigned by CMS.

    b. **Reporting By Date of Service.** In each quarter, demonstration expenditures (including prior period adjustments) must be totaled and reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver by DY. The DY for which expenditures are reported is identified using the project number extension (a 2-digit number appended to the demonstration Project Number). Expenditures are to be assigned to DYs on the basis of date of service. The date of service for premium or premium assistance payments is identified as the DY that accounts for the larger share of the coverage period for which the payment is made. DY 1 will correspond with federal fiscal year (FFY) 2010, DY 2 with FFY 2011, and so on.

    c. **Waiver Name.** The state must identify separate Forms CMS-64.9 Waiver and/or 64.9P Waiver that report demonstration population expenditures, using waiver name "Childless Adults" to identify expenditures for PA Childless Adults I and II, and "Parents" to identify expenditures for PA Parents I and PA Parents II.

4. **Title XIX Administrative Costs.** Administrative costs will not be subject to the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All such

administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using waiver name "Childless Adults."

5. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (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 Section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

6. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used during the demonstration. The state 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 will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

7. **Extent of Title XIX FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section XI:

    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 all childless adults (PA Childless Adults I and II), with dates of service between January 1, 2010 and September 30, 2013 (inclusive).

    c. Net expenditures incurred between October 1, 2013 and September 30, 2014 (inclusive) for Childless Adults who are ineligible for premium tax credits through the state's health insurance exchange (PA Childless Adults I), made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act.

    d. Net expenditures incurred between October 1, 2013 and December 31, 2013 (inclusive) for Childless Adults who are transitioning into the Insurance Exchange

(PA Childless Adults II), made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act.

e. Net expenditures incurred between October 1, 2013 and September 30, 2014 (inclusive) for parents who are ineligible for premium tax credits through the state's health insurance exchange (PA Parents I), made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act.

f. Net expenditures incurred between October 1, 2013 and December 31, 2013 (inclusive) for former CHIP Parents who are transitioning into the Insurance Exchange (PA Parents II), made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act.

8. **Sources of Non-Federal Share.** The state certifies that the source of non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds will not be used as the non-federal share for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with Title XIX of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

   a. CMS will review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS will be addressed within the time frames set by CMS.

   b. The state will 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. Under all circumstances, health insurance carriers and program participants receiving payments directly from the state must retain 100 percent of the payment amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the recipients of payments and the state and/or local government to return and/or redirect any portion of the Medicaid or demonstration payments. This confirmation of Medicaid and demonstration 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 or the demonstration and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid or demonstration payment.

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

XI. MONITORING BUDGET NEUTRALITY

1. **Limit on Federal Title XIX funding.** The state will be subject to annual limits on the amount of federal Title XIX funding that the state may receive for expenditures subject to the budget neutrality agreement.

2. **Risk.** For the PA Childless Adult group, the state will be at risk for both the number of enrollees in the demonstration as well as the per capita cost for demonstration-eligible childless adults under this budget neutrality agreement. For the PA Parents Group (PA Parents I and II), the state will be at risk for the per capita cost (as determined by the method described below), but not at risk for the number of demonstration-eligible parents.

3. **Calculation of the Budget Neutrality Limit: General.** Separate budget neutrality limits will be calculated for PA Childless Adults I and II, and PA Parents I and II, respectively.

4. **Budget Neutrality Expenditure Limit for the PA Childless Adults.** The following describes how the annual budget neutrality expenditure limits are determined for the PA Childless Adult group (PA Childless Adults I and II), consistent with Section 2111(a)(3)(C) of the Act.

    a. **Record of Budget Neutrality Expenditure Limit.** Attachment B provides a table that gives preliminary Annual Limits (defined below) for all of the approved DYs, based on information available at the time of the initial award of this demonstration. The table also provides a framework for organizing and documenting updates to the Annual Limits as new information is received, and for eventual publication of the final Annual Limit for each DY. Updated versions of Attachment B may be approved by CMS through letter correspondence, and do not require that the demonstration be amended.

    b. **Budget Neutrality Update.** Prior to April 1 of each year, the state must submit to CMS an updated budget neutrality analysis, which includes the following elements:

        i. Projected expenditures and Annual Limits for each DY through the end of the approval period (DYs are on a FFY basis);

        ii. A proposed computation of the Trend Factor (defined below) that will be used to calculate the Annual Limit for the DY immediately following, and the Annual Limit for the immediately following DY that would be determined by that Trend Factor;

        iii. A proposed updated version of Attachment B.

        iv. The annual budget neutrality limit for each DY will be finalized by CMS by the later of the following dates: (1) 120 days prior to the start of the DY, or (2) 2 months following the date of the most recent publication of the National

Health Expenditure projections occurring prior to the start of the DY.

The state may request technical assistance from CMS for the calculation of the Annual Limits and Trend Factors prior to its submission of the updated budget neutrality analysis. CMS will respond by either confirming the state's calculations or will work with the state to determine an accurate calculation of the Trend Factor and Annual Limit for the coming DY. CMS will ensure that the final Trend Factors for each DY are the same for all CHIPRA Medicaid childless adult waivers.

c. **FFY 2009 Base Year Expenditure.** The Base Year Expenditure will be equal to the total amount of FFP paid to the state for health care services or coverage provided to non-pregnant childless adults under the Idaho Adult Access Card Demonstration (21-W-00018/10 and 11-W-187/10), as reported on CMS-21 and 21P Waiver forms submitted by the state in the four quarters of FFY 2009. A preliminary Base Year Expenditure total appears in Attachment B. A final Base Year Expenditure total will be determined by CMS following CMS receipt of the Budget Neutrality Update that the state must provide by April 1, 2010.

d. **Adjustments to the Base Year Expenditure.** CMS reserved the right to adjust the Base Year Expenditure in the event that any future audit or examination shows that any of the expenditures included in the Base Year Expenditure total were not expenditures for health care services, health insurance premiums, or premium assistance for non-pregnant childless adults participating in the Idaho Adult Access Card Demonstration (21-W-00018/10 and 11-W-187/10), or that otherwise were not approved demonstration expenditures.

e. **Special Calculation for FFY 2010.** The FFY 2010 Expenditure Projection will be equal to the Base Year Expenditure increased by 3.7 percent, which is the percentage increase in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as published by the Secretary in February 2009.

f. **Annual Limit for DY 1.** To account for the fact that this demonstration will be active for only three-quarters of FFY 2010, the Annual Limit for DY 1 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e)) multiplied by 75 percent. The Annual Limit for DY 1 will be finalized at the same time that the Base Year Expenditure is finalized.

g. **Annual Limit for DY 2.** The Annual Limit for DY 2 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e), and prior to multiplication by three-quarters as indicated in subparagraph (f)), increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2011 over 2010, as published by the Secretary in February 2010. The Annual Limit for DY 2 can be finalized once the Trend Factor for DY 2 is finalized.

h. **Annual Limit for DY 3 and Subsequent Years.** The Annual Limit for DY 3 and the DYs that follow will be equal to the prior year's Annual Limit, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of the DY over the year preceding that year, as published by the Secretary in the February prior to the start of the DY.

i. **Calculation of the Trend Factor.** The percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of a DY (PERCAPYEAR2) over the preceding year (PERCAPYEAR1) (to be referred to as the Trend Factor) will be calculated to one decimal place of precision (example: 3.7 percent) using computer spreadsheet rounding. (A sample formula for this calculation in Microsoft Excel reads as follows:

"=ROUND(100*(PERCAP2-PERCAP1)/PERCAP1,1))"

5. **Budget Neutrality Expenditure Limit for the PA Parents.** The following describes how the method for calculating the annual budget neutrality expenditure limit for the Parents group, consistent with the Expenditure Authorities granting FFP for Costs Not Otherwise Matchable for this group.

a. **"Hypothetical" Eligibility Group.** The budget neutrality of PA Parents expenditures will be established by considering the PA Parents to be a hypothetical group, consisting of individuals who could have been made eligible under the Medicaid state plan. This arrangement does not allow the state to access any budget neutrality "savings" from the PA Parents group. A prospective per capita cap on federal financial risk is established for the PA Parents group based on the costs that the population is expected to incur under the demonstration.

b. A separate annual budget neutrality expenditure cap is calculated by summing expenditures for Parents I and II for the first quarter of federal fiscal year 2014 (October 1, 2013 through December 31, 2013) with the expenditures cap for PA Parents I for the second through fourth quarters of federal fiscal year 2014 (January 1, 2014 through September 30, 2014). An annual estimate for the PA Parents Group must be calculated as a product of the number of eligible member months reported by the State under STC VII.4(d) for the demonstration population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (c) below.

c. The trend rates and per capita cost estimates for the PA Parents eligibility group (EG) is listed in the table below. The PA Parents population is a "pass-through" or "hypothetical" population. Therefore, the State may not derive savings for this population. The state may not receive FFP for expenditures for PA Parents in

excess of the federal share of the budget neutrality limit, which will be the total computable budget neutrality limit times the FMAP for Idaho for FY 2014.

Demonstration Period	Parents (PMPM)	Trend Rate	Total "Parents" Budget Limit
October 1, 2013 through September 30, 2014	$ 88.26	2.30 %	$ 212,342

6. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality on an annual basis. Separate budget neutrality determinations will be made for PA Childless Adults and PA Patents. The amount of FFP that the state receives for demonstration expenditures each DY and for each population cannot exceed the Annual Limit applicable to that DY and population. If, for any DY, the state receives FFP in excess of the Annual Limit, the state must return the excess funds to CMS. All expenditures above the Annual Limit applicable to each DY will be the sole responsibility of the state.

7. **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 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 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.

XII. EVALUATION OF THE DEMONSTRATION

1. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after the effective date of the demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, 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. 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 must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

2. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of Section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

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

4. **Final Evaluation Report**. The state must submit to CMS a draft of the final evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS' comments. The state will submit a revised evaluation plan that examines the transfer of PA Parents between the various changes in coverage within 60 days of the associated amendment to the demonstration.

5. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to CMS or the contractor.

XI. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

STC	Deliverable
Within 30 days of the date of award	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities (approval letter)
Within 30 days of the date of an amendment	State acceptance of amended demonstration Waivers, STCs, and Expenditure Authorities (approval letter)
In compliance with paragraph XII.1.	Submit Draft Design for Final Evaluation Report
In compliance with paragraph XII.1.	Submit a revised Draft Design for Final Evaluation Report
In compliance with paragraph III.8.	Submit demonstration Extension Application
In compliance with paragraph VI.3(e).	Submit a plan for the operation of a statewide waiting list.
In compliance with paragraph XII.2.	Submit Interim Evaluation Report
Monthly Deliverables	**Deliverable**
In compliance with	Monitoring Call

paragraph IX.3.	
In compliance with paragraph IX.2.	Monthly Enrollment Report
Quarterly **Due 60 days after the end of each quarter, except the 4th quarter**	**Deliverable**
In compliance with paragraph IX.4.	Quarterly Progress Reports
In compliance with paragraph IX.4(d).	Quarterly Enrollment Reports
In compliance with Section VIII.	Quarterly Expenditure Reports
Annual	**Deliverable**
In compliance with paragraph IX.5.	Draft and Final Annual Reports (Annual Progress Reports and Annual Expenditure Reports)
Other	**Deliverable**
In compliance with paragraph VI.3(h)(ii)	Submit a plan for making premium assistance payments directly to individuals.
1 year before expiration of the demonstration, per paragraph III.8 or III.9.	Submit a request for extension or a phase-out plan
120 days after expiration of the demonstration, per paragraph X.4.	Submit Draft Final Evaluation Report
Within 60 days after receipt of CMS comments, per paragraph X.4.	Submit Final Evaluation Report

ATTACHMENT A

QUARTERLY REPORT FORMAT AND CONTENT

Under Section IX.4, 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 – Idaho Adult Access Card Demonstration
Title Line Two - Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 1 (January 1, 2010 – December 31, 2010)
Federal Fiscal Quarter: 01/01/2010 – 03/31/2010

Introduction

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 Count

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

Demonstration Populations (as hard coded in the CMS 64)	**Current Enrollment** (last day of quarter)	**Newly Enrolled in Current Quarter**	**Disenrolled in Current Quarter**
PA Childless Adults I and II			
PA Parents I and II			

Member Month Reporting
Enter the member months for the quarter.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
PA Childless Adults I and II				
PA Parents I and II				

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 state's actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

Consumer Issues:
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.

Status of Benefits and Cost Sharing:
Provide update regarding any changes to benefits or cost sharing during the quarter.

Demonstration Evaluation:
Discuss progress of evaluation design and planning.

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

RECORD OF BUDGET NEUTRALITY EXPENDITURE LIMIT FOR CHILDLESS ADULTS
Approval Date of This Version: October 9, 2012

A blank preceding a percent sign (%) or following a dollar sign ($) or "Recorded On" indicates that a value is to be entered there some time in the future.

	Initial Preliminary Estimates		**Revised Preliminary Estimates**		**Final Amounts**	
	Trend Factor	**Amount**	**Trend Factor**	**Amount**	**Trend Factor**	**Amount**
Base Year Expenditure (Paragraphs XI.3(c) and (d))	N/A	$76,703 Recorded On: 12/23/2009	N/A	N/A	N/A	$76,703 Recorded On: 6/1/2010
FFY 2010 Expenditure Projection (Paragraph XI.3(e))	3.7% Recorded On: 12/23/2009	$79,541 Recorded On: 12/23/2009	N/A	N/A	3.7% Recorded On: 12/23/2009	$79,541 Recorded On: 6/1/2010
Annual Limit, DY 1 (Paragraph XI.3(f))	N/A	$59,656 Recorded On: 12/23/2009	N/A	N/A	N/A	$59,656 Recorded On: 6/1/2010

Annual Limit, DY 2 (Paragraphs XI.3(g) and (i))	4.6% Recorded On: 12/23/2009	$83,200 Recorded On: 12/23/2009	N/A	N/A	4.3% Recorded On: 6/1/2010	$82,961 Recorded On: 6/1/2010
Annual Limit, DY 3 (Paragraphs XI.3(h) and (i))	4.9% Recorded On: 12/23/2009	$87,277 Recorded On: 12/23/2009	4.5% Recorded On: 6/1/2010	$86,694 Recorded On: 6/1/2010	3.3% Recorded On: 8/11/2011	$85,699 Recorded On: 8/11/2011
Annual Limit, DY 4 (Paragraphs XI.3(h) and (i))	5.2% Recorded On: 12/23/2009	$91,815 Recorded On: 12/23/2009	4.6% Recorded On: 8/11/2011	$89,641 Recorded On: 8/11/2011	2.9% Recorded On: 10/9/2012	$88,184 Recorded On: 10/9/2012
Annual Limit, DY 5 (Paragraphs XI.3(h) and (i))	5.6% Recorded On: 12/23/2009	$96,957 Recorded On: 12/23/2009	6.4% Recorded On: 10/9/2012	$93,828 Recorded On: 10/9/2012	% Recorded On:	$ Recorded On:

The "Recorded On" date indicates the date in which a particular number or percentage was first incorporated (or, "recorded") into an approved version of Attachment B.

Mr. Richard Armstrong
Director
Department of Health and Welfare
Towers Building – Tenth Floor
P.O. Box 83720
Boise, ID 83720-0036

Dear Mr. Armstrong:

We are pleased to inform you that Idaho's Section 1115 Medicaid Demonstration project entitled Non-Pregnant Childless Adults (Idaho Adult Access Card Demonstration) has been approved as project number 11-W-00245/10. The approved Demonstration is under the authority of section 1115(a) of the Social Security Act (the Act) beginning January 1, 2010, and ending September 30, 2014.

Section 2111(a)(3)(C) of the Act and this new demonstration will allow Idaho to continue offering premium assistance (up to $100 per individual per month) to low-income, non-pregnant childless adults (at or below 185 percent of the Federal poverty level) who are employees (or the spouse of an employee) of a participating small business (2-50 employees) in order to reduce the cost of employer-sponsored insurance (ESI).

With respect to expenditures for dates of service that were incurred prior to the approval of this Demonstration, the State must follow routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual.

Our approval of the Idaho section 1115(a) Demonstration is limited to the extent of granting approval for the necessary title XIX requirements not applicable and expenditure authorities in the accompanying list, and is conditioned upon compliance with the enclosed Special Terms and Conditions (STCs). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration. The STCs are effective January 1, 2010, unless otherwise specified. All the requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the enclosed expenditure authority list, shall apply to the Demonstration.

Your project officer is Kelly Heilman, Ph.D. She is available to answer questions concerning this demonstration project. Dr. Heilman's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard, S2-01-16
Baltimore, MD 21244-1850

Telephone: (410) 786-1451
Facsimile: (410) 786-5882
E-mail: kelly.heilman@cms.hhs.gov

Official communications regarding program matters should be submitted simultaneously to Dr. Heilman, and to Ms. Gloria Nagle, Associate Regional Administrator in our San Francisco Regional Office. Ms. Nagle's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health
90 7th Street, #5-300 (SW)
San Francisco, CA 94103-6706

If you have additional concerns regarding the Centers for Medicare & Medicaid Services' oversight of this demonstration or questions, please contact Ms. Victoria Wachino, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

Sincerely,

Charlene Frizzera
Acting Administrator

Enclosures

cc: Gloria Nagle, ARA, Region X
Janice Adams, Health Insurance Specialist, San Francisco Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES
COSTS NOT OTHERWISE MATCHABLE AUTHORITIES

NUMBERS: 11-W-00245/10 (Title XIX)

TITLE: Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration)

AWARDEE: Idaho Department of Health & Welfare

Medicaid Costs Not Otherwise Matchable Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this Demonstration, be regarded as matchable expenditures under the State's Medicaid title XIX State plan:

1. (Demonstration Population I). Expenditures for premium assistance payments to or on behalf of uninsured, non-pregnant childless individuals age 18 and above with countable gross family income at or below 185 percent of the Federal poverty level (FPL), who are employed by a small business (2-50 employees) or are the spouse of an employee working for a small business, who are not otherwise eligible for Medicaid and are not eligible for Medicare or Veterans benefits, for a 12-month guaranteed period. Payments are limited to some or all of the cost of the employee share of employer sponsored health insurance.

Medicaid Requirements Not Applicable to the Demonstration Eligible Population:

All requirements of the Medicaid statute will be applicable to those individuals who are made eligible for services solely by virtue of the demonstration project, for whom, under the expenditure authority listed above, the State will receive Federal financial participation in its expenditures, except those requirements specified below:

1. Amount Duration and Scope **Section 1902(a)(10)(B)**

To permit the State to offer benefits limited to premium assistance for employer health sponsored coverage that meets minimum qualifications.

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

To permit the State not to offer retroactive eligibility for individuals in Demonstration Population I.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: **11-W-00245/10**

TITLE: **Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration)**

AWARDEE: **Idaho Department of Health & Welfare**

DEMONSTRATION PERIOD: **January 1, 2010, through September 30, 2014**

TABLE OF CONTENTS

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Idaho Medicaid Non-pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration) (hereinafter referred to as "Demonstration" or "program") for the waiver under section 1115(a) of the Social Security Act (the Act) for the period of January 1, 2010, through September 30, 2014. The parties to this agreement are the Idaho Department of Health & Welfare ("State") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid and Childrens Health Insurance Programs (CHIP) expressed in law, regulation, and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, will apply to the Demonstration project.

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. The STCs are effective as of the approval letter's date, unless otherwise specified. Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval will be directed to the CMS Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter. This Demonstration is approved through September 30, 2014. The STCs have been arranged into the following subject areas: program description and objectives; general program requirements; eligibility; benefits; enrollment; cost sharing; delivery systems; general reporting requirements; general financial requirements under title XIX; monitoring budget neutrality for the Demonstration; evaluation of the Demonstration; and schedule of State deliverables during the Demonstration.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration) is a statewide section 1115 Demonstration to make health insurance more affordable by providing premium subsidy to individuals with incomes at or below 185 percent of the Federal poverty level (FPL). This program is targeted at small businesses (2-50 employees) that do not offer a health benefit plan.

The Idaho program for adults was implemented in July of 2005, and provides up to $100 per month per enrolled adult (for a qualifying employee or the spouse of the employee) toward the individual's share of the employer-sponsored health insurance premium. In July 2006, the program was amended to require a 50 percent employer contribution toward the cost of the health benefit plan.

The Idaho premium assistance program, entitled Access to Health Insurance, was funded in part by the Federal Government through title XXI funding. With the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the State was required to remove the childless adults from title XXI funding no later than December 31, 2009. In response, the State submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) to move the eligible non-pregnant childless adults into a section 1115 Demonstration. CMS approved the Idaho's Premium Assistance to Childless Adults Demonstration under section

1115(a) of the Act for the period of January 1, 2010, through September 30, 2014. The following Special Terms and Conditions, and the approved Costs Not Otherwise Matchable apply to the Demonstration.

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 Law, Regulation, and Policy.** All requirements of the Medicaid program 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 Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, 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 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 the implementation of the change.

    b. If mandated changes in 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 affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate 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, 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 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 these 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 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 15, 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 will include current Federal share "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. An up-to-date CHIP allotment neutrality worksheet, if necessary;

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

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

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

    As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

a. Demonstration Summary and Objectives: The State must provide a narrative summary of the Demonstration project, reiterate the objectives set forth at the time the Demonstration was proposed, and provide evidence of how these objectives have been met, as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of each change and desired outcomes must be included.

b. Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time. Consistent with Federal law, CMS reserves the right to deny approval for a requested extension based on non-compliance with these 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.

c. Waiver and Expenditure Authorities: The State must provide a list, along with a programmatic description, of the waivers and expenditure authorities that are being requested in the extension.

d. Quality: The State must provide summaries of External Quality Review Organization reports, managed care organization, and State quality assurance monitoring, and any other documentation of the quality of care provided under the Demonstration.

e. Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In addition, the State must provide up-to-date responses to the CMS Financial Management standard questions. If title XXI funding is used in the Demonstration, a CHIP Allotment Neutrality worksheet must be included.

f. Draft report with Evaluation Status and Findings: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10 a phase-out plan will not be shorter than 6 months unless such action is necessitated by emergent

circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP will be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. **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.

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

13. **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. 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 closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The State must 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.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and 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 STC 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. In the event that the State conducts additional

consultation activities consistent with these requirements prior to the implementation of the Demonstration, documentation of these activities must be provided to CMS.

16. **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

1. **Eligibility Criteria.** The demonstration-eligible population consists entirely of persons who are not otherwise eligible for Medicaid through the State Plan, and who are only covered under Medicaid through the section 1115 Demonstration.

2. The Idaho section 1115 Demonstration is comprised of the following Eligibility Group:

   a. Premium Assistance to Non-Pregnant Childless Adults is comprised of non-pregnant childless individuals age 18 and above with countable gross family income at or below 185 percent of the FPL, who are U.S. citizens/legal residents, are residents of Idaho, are not otherwise eligible for Medicaid through the State plan, do not qualify for Medicare or Veterans benefits, do not currently participate in any insurance plan that meets the definition of a health benefit plan (as defined in State statute), are employed by a small business (2-50 employees) or are the spouse of an employee in a small business, and who are only covered under Medicaid through the section 1115 Demonstration. There is no resource limit for this demonstration population.

3. The term "non-pregnant childless adult" has the meaning given such term by section 2107(f).

4. For the period of this demonstration, there is an average annual enrollment limit of 350 for the non-pregnant childless adult population. Both adult employees and their spouses count against the cap. The State may establish a limit of less than 350 individuals, if necessary, to ensure that program expenditures do not exceed the budget neutrality annual limit. The State must notify CMS at least 60 days in advance of any change in the enrollment limit.

V. BENEFITS

1. **Benefit Definition.** The sole benefit provided to persons eligible as Premium Assistance Childless Adults is assistance in paying the employee's share of the monthly premium cost of qualifying employer-sponsored insurance (ESI) plans.

2. **Qualifying Employer Sponsored Insurance Plans.** Qualifying ESI plans are offered by a qualified employer, meet the conditions set forth in V.7 and include coverage for:

   a. Preventive services

b. Maternity services
c. Inpatient and outpatient hospital services
d. Physicians' medical and surgical services
e. Hospice Care
f. Ambulance services
g. Durable Medical Equipment
h. Psychiatric and Substance Abuse services
i. Pharmacy

3. Benefits furnished by qualifying ESI plans are not benefits under this Demonstration; as indicated in V.1, the only benefit under this Demonstration is premium assistance. Qualifying employer sponsored plans are not restricted from offering additional benefits, at the option of the plan, that may vary by the plan offered by the employer.

4. An eligible individual or family may enroll in any qualifying ESI plan that is offered to the individual or family by a qualified employer based on the employment of the individual or a family member.

5. Eligible individuals and families who enroll in a qualifying health benefit plan will receive premium assistance, under the following conditions:

   a. In accord with the enrollment and implementation procedures as defined in section VI, the State will provide an eligible and enrolled childless adult or childless family a premium assistance subsidy.

   b. The premium assistance is the amount of the employee share of the premium for the qualified ESI plan, subject to the limits in c. and d. below.

   c. The maximum subsidy limit is $100 per eligible enrolled adult per month, with a maximum of $200 per household for an eligible childless family.

   d. The premium assistance subsidy must not exceed the amount of the participant's share of the premium.

   e. The premium assistance subsidy may be paid directly to the individual/family or to the insurance carrier up to the maximum amount specified in subparagraph b. above.

   f. Individuals and families that qualify for premium assistance through this Demonstration can receive assistance for as long as the individual (or any individual in the family) continues to be employed by a qualifying employer, participates in a qualifying health benefit plan, and continues to meet other program eligibility requirements.

6. **Qualifying employer.** In order to participate in this Demonstration, the following qualifications must be met:

a. The business must have 2-50 employees and must have one adult eligible to participate in the program;

b. Prior to participating in the program, the small business did not offer insurance to its employees;

c. The employer must begin offering the health benefit plan to all its employees, both those who receive the premium assistance subsidy and those who do not;

d. The employer must contribute at least 50 percent of the premium cost for participating employees;

e. The employer must otherwise meet the insurance carriers' contribution and participation requirements as specified in the Idaho Code; and

f. Employers must register their intent to participate in the program using the program Web site.

7. **Other requirements for qualified employer-sponsored insurance plans.**

   a. Qualified ESI plans must be regulated as a Small Business Group Plan as specified in Chapter 47, Title 41 of Idaho Statute. Small Business Group Plan benefits and cost-sharing provisions are further regulated by Administrative Code, specifically IDAPA 18.01.70 "Small Employer Health Insurance Availability Act Plan Design."

   b. Qualified ESI plans must provide enrollees with hospital or medical policy or certificate of insurance, which can include a subscriber contract provided by a hospital or professional service corporation, or a managed care organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issued for a period of 12 months or less.

8. **Continuing Employer Participation.** Any employer that qualifies to participate and begins participation in the Program may continue to participate, so long as it continues to offer its employees a qualifying health benefit plan as indicated in section V.7, and continues to meet the criteria in sections V.6. Should an employer fail to meet any of the conditions, the State must terminate the employer's participation in the Program, and disenroll all participating employees from this Demonstration.

VI. ENROLLMENT AND IMPLEMENTATION

1. **General Requirements**

   a. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, appeals, etc. must comply with Federal law and regulations governing Medicaid and CHIP.

   b. The State will adhere to the demonstration population enrollment limits presented in Section IV, *Eligibility*.

2. **Enrollment of Businesses in the Idaho Adult Access Card Demonstration**.

   a. Once a small businesses that does currently offer any health benefit plan registers its intent to participate in the program (section V.6(f)), the business will contact an insurance agent/broker for an Idaho Small Group Insurance plan (as defined in State regulations and regulated by the State Insurance Commissioner).

   b. The insurance agent/broker will work with the employer to ensure that the health benefit plan meets the requirements to be a qualified ESI plan.

   c. The insurance agent/broker is responsible for forwarding the documents to the Idaho Department of Health & Welfare for processing.

   d. The insurance broker may work with the employer to estimate the numbers of eligible employees. After the cost of the premiums and the eligible applicants are determined, the employer makes the decision regarding actual participation in the program.

   e. If coverage is offered, the eligible applicants are enrolled in the program.

   f. The State will monitor, at least annually, the continuing eligibility of the employer (refer to section V.8).

   g. The State will offer agents/brokers training on the Idaho Adult Access Card Demonstration. The State must furnish copies of all insurance agent/broker training materials to CMS upon request.

3. **Enrollment of Individuals in the Demonstration**.

   a. Individuals applying for the program must be screened by the State for eligibility in Medicaid and CHIP, and enrolled in Medicaid or CHIP if determined eligible.

   b. If an applicant is determined not to be eligible for other coverage (as specified in (a) above) and meets all of the eligibility criteria for the demonstration, and the demonstration is open to new enrollment at the time of the determination, the applicant may be enrolled.

c. Enrollment into the program is on a "first-come, first-served" basis.

d. This Demonstration may be closed to new enrollment because the enrollment limit specified in these STCs has been reached. If the program is closed to new enrollment, a statewide waiting list will be established and administered by the Department. Within 90 days of approval of this Demonstration, the State will submit, for CMS approval, a plan for the operation of the statewide waiting list.

e. The State will notify CMS in writing at least 30 days prior to the closing of enrollment and include the estimated date when enrollment will be reopened as well as a brief description of how the State plans to manage the waiting list and how enrollment may eventually be reopened. The State will notify CMS in writing within 10 days of the State actually reopening enrollment, and, if applicable, the estimated date when enrollment will again be closed.

The State will provide for a redetermination of eligibility at least once every 12 months. Application and renewal of an employer's qualifying health plan will determine the program start date and redetermination date for participants. At each redetermination, participants must be screened for Medicaid or CHIP eligibility.

f. Interaction with Medicaid.

i. Individuals enrolled in this Demonstration may at any time apply for Medicaid or CHIP, and if determined eligible, be enrolled in direct coverage.

ii. The State must remind each participant at least every 6 months, by mail, through an eligibility redetermination, or other comparable means that he or she is entitled to apply for Medicaid or CHIP and provide directions on how to initiate an application. In particular, the reminder must point out that the participant is likely to qualify for Medicaid if pregnant.

iii. Within 60 days of the award of this Demonstration, the State will submit a plan, for CMS approval, that addresses the State's process for transitioning individuals – demonstration-enrolled individuals who become eligible for Medicaid – into direct coverage.

g. The State must establish and maintain procedures for all individuals receiving premium assistance subsidies from the State (which may be done through rulemaking) that will:

i. Ensure that at least one adult family member is employed by a qualifying employer (as defined in section V.6), that the employer offers health insurance as a benefit through a qualifying health benefit plan (as defined in section V.5), that the benefit qualifies for the subsidy (as defined in section V.1-3), and that the employee maintains participation in the plan;

ii. Prior to moving forward with the State's concept of making payments directly to demonstration-enrolled individuals in order to reimburse them for the allowable cost of the premium assistance payment, the State must submit, for CMS' prior approval, a plan that addresses how the State will:

a. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled and receiving health benefit coverage through a qualifying plan and the individual's/family's share of the premium and a quality control plan for cross checking the verification system (e.g., if the information is obtained from the insurance carrier then crosscheck with the employee or employer). This plan may also include requesting information directly from participants in the form of pay stubs showing withholding for health insurance;

b. Require clients to notify the Idaho Department of Health & Welfare within 10 days if they change their plan, there is a change in the amount of their premium, or their health care benefit is terminated;

c. Ensure that the total amount of premium assistance subsidies provided to an childless individual or family does not exceed the amount of the employee's financial obligation toward their coverage; and

d. Provide for recovery of payments made for months in which the childless individual or family did not receive coverage through a qualifying health benefit plan. The Federal share must be returned within the timeframes established in statute and regulations.

e. The State will only reimburse individuals directly when an employer makes such a request in writing on the basis of their wish not to engage in accounting for the premium subsidy.

VII. COST SHARING

1. **Cost Sharing.** The State will not impose cost sharing as a condition of premium assistance under this Demonstration. This Demonstration will not affect any requirements for coverage imposed by qualified ESI plans on enrollees (including American Indian/Alaskan Native enrollees).

VI. DELIVERY SYSTEMS

1. **Premium Assistance Delivery Systems.** Individuals or families enrolled in the Idaho Adult Access Card Demonstration will receive premium assistance either through payment to the qualified ESI plan by the State, or in the circumstances described in VI.3.h.ii above.

VII. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements.** The State must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in Section X. The State must submit any corrected budget and/or allotment neutrality data upon request.

2. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the State must report Demonstration enrollment figures for the month just completed to the CMS Project Officer and Regional Office contact via e-mail, using the table below. The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A under Enrollment Count, except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	**Point In Time Enrollment** (last day of month)	**Newly Enrolled Last Month**	**Disenrolled Last Month**
Childless Adults			

3. **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, 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 State is considering submitting. CMS will provide updates 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 will jointly develop the agenda for the calls.

4. **Quarterly Progress Reports.** The State must submit progress reports in accordance with the guidelines in 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. These quarterly reports must include, but not be limited to:

    a. An updated budget neutrality monitoring spreadsheet;

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: benefits, enrollment and disenrollment, grievances, quality of care, and access that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;

c. Action plans for addressing any policy, administrative, or budget issues identified;

d. Quarterly enrollment reports for Demonstration eligibles, that include the member months and end of quarter, point-in-time enrollment for each Demonstration population, and other statistical reports listed in Attachment A; and

e. Evaluation activities and interim findings.

5. **Annual Report.**

a. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration.

b. The State will continually monitor the costs of providing premium assistance and of direct coverage and report the comparative assessment in the Annual Report.

c. The State must submit the draft annual report no later than 120 days after the close of the Demonstration year (DY).

d. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

I. GENERAL FINANCIAL REQUIREMENTS

1. **Quarterly Expenditure Reports for Title XIX.** The State must provide quarterly expenditure reports using Form CMS-64 to separately 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 will provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI.

2. **Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** All expenditures for health care services for Demonstration participants (as defined in section IV above) are subject to the budget neutrality expenditure limit.

3. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Use of Waiver Forms.** In order to track expenditures under this Demonstration, 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 (SMM). 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 (11-W-00245/10) assigned by CMS.

b. **Reporting By Date of Service.** In each quarter, Demonstration expenditures (including prior period adjustments) must be totaled and reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver by DY. The DY for which expenditures are reported is identified using the project number extension (a 2-digit number appended to the Demonstration Project Number). Expenditures are to be assigned to DYs on the basis of date of service. The date of service for premium or premium assistance payments is identified as the DY that accounts for the larger share of the coverage period for which the payment is made. DY 1 will correspond with Federal fiscal year (FFY) 2010, DY 2 with FFY 2011, and so on.

c. **Waiver Name.** The State must identify the Forms CMS-64.9 Waiver and/or 64.9P Waiver that report Demonstration population expenditures by using waiver name "Childless Adults."

4. **Title XIX Administrative Costs.** Administrative costs will not be subject to the budget neutrality expenditure limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All such administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using waiver name "Childless Adults."

5. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (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 section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

6. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used during the Demonstration. The State 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 will

make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

7. **Extent of Title XIX FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS will provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section XI:

    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 childless adults, with dates of service during the operation of the Demonstration

8. **Sources of Non-Federal Share.** The State certifies that the source of non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds will not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with title XIX of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a. CMS will review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS will be addressed within the time frames set by CMS.

    b. The State will 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. Under all circumstances, health insurance carriers and program participants receiving payments directly from the State must retain 100 percent of the payment amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the recipients of payments and the State and/or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid and Demonstration 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 or the Demonstration and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

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

I. MONITORING BUDGET NEUTRALITY

1. **Limit on Federal Title XIX funding.** The State will be subject to annual limits on the amount of Federal title XIX funding that the State may receive for expenditures subject to the budget neutrality agreement.

2. **Risk.** The State will 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.

3. **Budget Neutrality Expenditure Limit.** The following describes how the annual budget neutrality expenditure limits are determined, consistent with section 2111(a)(3)(C) of the Act.

    a. **Record of Budget Neutrality Expenditure Limit.** Attachment B provides a table that gives preliminary Annual Limits (defined below) for all of the approved DYs, based on information available at the time of the initial award of this Demonstration. The table also provides a framework for organizing and documenting updates to the Annual Limits as new information is received, and for eventual publication of the final Annual Limit for each DY. Updated versions of Attachment B may be approved by CMS through letter correspondence, and do not require that the Demonstration be amended.

    b. **Budget Neutrality Update.** Prior to April 1 of each year, the State must submit to CMS an updated budget neutrality analysis, which includes the following elements:

        i. Projected expenditures and Annual Limits for each DY through the end of the approval period (DYs are on a FFY basis);

        ii. A proposed computation of the Trend Factor (defined below) that will be used to calculate the Annual Limit for the DY immediately following, and the Annual Limit for the immediately following DY that would be determined by that Trend Factor;

        iii. A proposed updated version of Attachment B.

        iv. The annual budget neutrality limit for each DY will be finalized by CMS by the later of the following dates: (1) 120 days prior to the start of the DY, or (2) 2 months following the date of the most recent publication of the National Health Expenditure projections occurring prior to the start of the DY.

The State may request technical assistance from CMS for the calculation of the Annual Limits and Trend Factors prior to its submission of the updated budget neutrality analysis. CMS will respond by either confirming the State's calculations or will work with the State to determine an accurate calculation of the Trend Factor and Annual Limit for the coming DY. CMS will ensure that the final Trend Factors for each DY are the same for all CHIPRA Medicaid childless adult waivers.

c. **FFY 2009 Base Year Expenditure.** The Base Year Expenditure will be equal to the total amount of FFP paid to the State for health care services or coverage provided to non-pregnant childless adults under the Idaho Adult Access Card Demonstration (21-W-00018/10 and 11-W-187/10), as reported on CMS-21 and 21P Waiver forms submitted by the State in the four quarters of FFY 2009. A preliminary Base Year Expenditure total appears in Attachment B. A final Base Year Expenditure total will be determined by CMS following CMS receipt of the Budget Neutrality Update that the State must provide by April 1, 2010.

d. **Adjustments to the Base Year Expenditure.** CMS reserved the right to adjust the Base Year Expenditure in the event that any future audit or examination shows that any of the expenditures included in the Base Year Expenditure total were not expenditures for health care services, health insurance premiums, or premium assistance for non-pregnant childless adults participating in the Idaho Adult Access Card Demonstration (21-W-00018/10 and 11-W-187/10), or that otherwise were not approved Demonstration expenditures.

e. **Special Calculation for FFY 2010.** The FFY 2010 Expenditure Projection will be equal to the Base Year Expenditure increased by 3.7 percent, which is the percentage increase in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as published by the Secretary in February 2009.

f. **Annual Limit for DY 1.** To account for the fact that this Demonstration will be active for only three-quarters of FFY 2010, the Annual Limit for DY 1 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e)) multiplied by 75 percent. The Annual Limit for DY 1 will be finalized at the same time that the Base Year Expenditure is finalized.

g. **Annual Limit for DY 2.** The Annual Limit for DY 2 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e), and prior to multiplication by three-quarters as indicated in subparagraph (f)), increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2011 over 2010, as published by the Secretary in February 2010. The Annual Limit for DY 2 can be finalized once the Trend Factor for DY 2 is finalized.

h. **Annual Limit for DY 3 and Subsequent Years.** The Annual Limit for DY 3 and the DYs that follow will be equal to the prior year's Annual Limit, increased by the

percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of the DY over the year preceding that year, as published by the Secretary in the February prior to the start of the DY.

i. **Calculation of the Trend Factor.** The percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of a DY (PERCAPYEAR2) over the preceding year (PERCAPYEAR1) (to be referred to as the Trend Factor) will be calculated to one decimal place of precision (example: 3.7 percent) using computer spreadsheet rounding. (A sample formula for this calculation in Microsoft Excel reads as follows:

"=ROUND(100*(PERCAP2-PERCAP1)/PERCAP1,1))"

4. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality on an annual basis. The amount of FFP that the State receives for Demonstration expenditures each DY cannot exceed the Annual Limit applicable to that DY. If, for any DY, the State receives FFP in excess of the Annual Limit, the State must return the excess funds to CMS. All expenditures above the Annual Limit applicable to each DY will be the sole responsibility of the State.

5. **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 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 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.

I. EVALUATION OF THE DEMONSTRATION

1. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after the effective date of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, 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. 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 must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

2. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

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

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

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

XI. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

STC	Deliverable
Within 30 days of the date of award	State acceptance of Demonstration Waivers, STCs, and Expenditure Authorities (approval letter)
In compliance with paragraph XII.1.	Submit Draft Design for Final Evaluation Report
In compliance with paragraph III.8.	Submit Demonstration Extension Application
In compliance with paragraph VI.3(e).	Submit a plan for the operation of a statewide waiting list.
In compliance with paragraph XII.2.	Submit Interim Evaluation Report
Monthly Deliverables	**Deliverable**
In compliance with paragraph IX.3.	Monitoring Call
In compliance with paragraph IX.2.	Monthly Enrollment Report

Quarterly **Due 60 days after the end of each quarter, except the 4th quarter**	**Deliverable**
In compliance with paragraph IX.4.	Quarterly Progress Reports
In compliance with paragraph IX.4(d).	Quarterly Enrollment Reports
In compliance with section VIII.	Quarterly Expenditure Reports
Annual	**Deliverable**
In compliance with paragraph IX.5.	Draft and Final Annual Reports (Annual Progress Reports and Annual Expenditure Reports)
Other	**Deliverable**
In compliance with paragraph VI.3(h)(ii)	Submit a plan for making premium assistance payments directly to individuals.
1 year before expiration of the demonstration, per paragraph III.8 or III.9.	Submit a request for extension or a phase-out plan
120 days after expiration of the demonstration, per paragraph X.4.	Submit Draft Final Evaluation Report
Within 60 days after receipt of CMS comments, per paragraph X.4.	Submit Final Evaluation Report

ATTACHMENT A

QUARTERLY REPORT FORMAT AND CONTENT

Under Section IX.4, 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 – Idaho Adult Access Card Demonstration
Title Line Two - Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 1 (January 1, 2010 – December 31, 2010)
Federal Fiscal Quarter: 01/01/2010 – 03/31/2010

Introduction

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 Count

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

Demonstration Populations (as hard coded in the CMS 64)	**Current Enrollment** (last day of quarter)	**Newly Enrolled in Current Quarter**	**Disenrolled in Current Quarter**
Childless Adults			

Member Month Reporting

Enter the member months for the quarter.

Eligibility Group	**Month 1**	**Month 2**	**Month 3**	**Total for Quarter Ending XX/XX**
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 State's actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

Consumer Issues:
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.

Status of Benefits and Cost Sharing:
Provide update regarding any changes to benefits or cost sharing during the quarter.

Demonstration Evaluation:
Discuss progress of evaluation design and planning.

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

RECORD OF BUDGET NEUTRALITY EXPENDITURE LIMIT

Effective Date: December 9, 2009
A blank preceding a percent sign (%) or following a dollar sign ($) or "Effective:" indicates that a value is to be entered there some time in the future.

	Initial Preliminary Estimates		Revised Preliminary Estimates		Final Amounts	
	Trend Factor	**Amount**	**Trend Factor**	**Amount**	**Trend Factor**	**Amount**
Base Year Expenditure (Paragraphs XI.3(c) and (d))	N/A	$76,703 Effective: DOIA	N/A	N/A	N/A	$ Effective:
FFY 2010 Expenditure Projection (Paragraph XI.3(e))	3.7% Effective: DOIA	$79,541 Effective: DOIA	N/A	$ Effective:	3.7% Effective: DOIA	$ Effective:
Annual Limit, DY 1 (Paragraph XI.3(f))	N/A	$59,656 Effective: DOIA	N/A	$ Effective:	N/A	$ Effective:
Annual Limit, DY 2 (Paragraphs XI.3(g) and (i))	4.6% Effective: DOIA	$83,200 Effective: DOIA	% Effective:	$ Effective:	% Effective:	$ Effective:

Annual Limit, DY 3 (Paragraphs XI.3(h) and (i))	4.9% Effective: DOIA	$87,277 Effective: DOIA	% Effective:	$ Effective:	% Effective:	$ Effective:
Annual Limit, DY 4 (Paragraphs XI.3(h) and (i))	5.2% Effective: DOIA	$91,815 Effective: DOIA	% Effective:	$ Effective:	% Effective:	$ Effective:
Annual Limit, DY 5 (Paragraphs XI.3(h) and (i))	5.6% Effective: DOIA	$96,957 Effective: DOIA	% Effective:	$ Effective:	% Effective:	$ Effective: