

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



Children and Adults Health Programs Group

MAR 06 2014

Julie Hamos
Director
Illinois Department of Healthcare and Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Dear Ms. Hamos:

Thank you for the state's communication regarding the temporary extension of the state's section 1115 Medicaid demonstration, entitled "Illinois/Cook County Care" (Project No. 11-W-00281/5). The state requested that the current program, which is due to expire on March 31, 2014, be extended to June 30, 2014.

With this letter, the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of your program until June 30, 2014. The demonstration will continue to operate under the authority of section 1115(a) of the Social Security Act. Additionally, the current list of expenditure authorities and Special Terms and Conditions will continue to apply to the Cook County Care demonstration until June 30, 2014.

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

Sincerely,



Anne Marie Costello
Deputy Director for Policy

cc: Verlon Johnson, Associate Regional Administrator, CMS Region V
Catherine Song, Chicago Regional Office

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



December 30, 2013

Julie Hamos
Director
Illinois Department of Healthcare and Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Dear Ms. Hamos:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a temporary extension of Illinois' section 1115 demonstration, entitled "Illinois/Cook County Care" (Project No. 11-W-00281/5), only to the extent necessary to permit Illinois to continue using the payment methodology it has been using under the demonstration for services furnished through the Cook County Health and Hospital System (CCHHS) to individuals eligible in the new adult population who reside in Cook County and elect to receive services only through CCHHS. The demonstration is now set to expire on March 31, 2014. CMS may consider an additional three-month temporary extension if needed.

CMS approval of the demonstration extension is conditioned upon continued compliance with the enclosed revised set of Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The prior STCs remain in effect to the extent that they detail reporting, evaluation, and payment reconciliation responsibilities that extend beyond December 31, 2013, except as expressly specified in these STCs. This demonstration project is subject to the limitations specified in the enclosed list of waiver authorities. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been specifically waived. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. A copy of the new STCs and expenditure authorities is enclosed.

Written acceptance should be sent to your project officer for this demonstration, Ms. Shanna Wiley. She is also available to answer any questions concerning your section 1115 demonstration and this extension. Ms. Wiley's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-1370
E-mail: Shanna.Wiley@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Wiley and to Ms. Verlon Johnson, Associate Regional Administrator for the Division of Medicaid & Children's Health in the Chicago Regional Office. Ms. Johnson's contact information is as follows:

Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health Operations
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601
Email: Verlon.Johnson@cms.hhs.gov

I appreciate your efforts working with us to reach this agreement. If you have additional questions, please contact Ms. Julia Hinckley, Senior Policy Advisor, Children and Adults Health Programs Group (CAHPG), Center for Medicaid & CHIP Services (CMCS) at (410)786-5647.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Verlon Johnson, Associate Regional Administrator, Region V
Catherine Song, CMS Chicago Regional Office

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

NUMBER: 11-W-00281/5

TITLE: Illinois/Cook County Care

AWARDEE: Illinois Department of Healthcare and Family Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Illinois for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this demonstration beginning January 1, 2014 through March 31, 2014, shall be regarded as expenditures under the state's title XIX plan.

The following expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the state to operate its Illinois/Cook County Care (County Care) section 1115 demonstration. This expenditure authority expires March 31, 2014.

Demonstration Expenditures. Expenditures for payments to Cook County Health and Hospital System for care and services covered under the state plan, in lieu of payments authorized under the state plan.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the demonstration beginning as of January 1, 2014 through March 31, 2014.

Title XIX Requirements Not Applicable to the Demonstration:

1. Payment Rates

Section 1902(a)(30)(A)

To the extent necessary to permit payment rates that may not be consistent with efficiency, economy, or quality of care.

2. Direct Payment

Section 1902(a)(32)

To the extent necessary to permit payments to Cook County Health and Hospital Systems for services rather than payment directly to the provider that may provide the service.

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

NUMBER: 11-W-00281/5

TITLE: Illinois/Cook County Care

AWARDEE: Illinois Department of Healthcare and Family Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the extension period for Illinois’s section 1115(a) Medicaid Illinois/Cook County Care (County Care) demonstration (hereinafter “demonstration”). The STCs applicable to the prior period remain in effect to the extent that they detail reporting, evaluation, and payment reconciliation responsibilities that extend beyond December 31, 2013, except as expressly specified. The parties to this agreement to extend the demonstration are the Illinois Department of Healthcare and Family Services (“state”) and the Centers for Medicare & Medicaid Services (CMS). These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration extension period and the state’s obligations to CMS during the demonstration extension period. The STCs are effective January 1, 2014 through March 31, 2014, unless otherwise specified.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility
- V. Benefits
- VI. Cost Sharing
- VII. Delivery Systems
- VIII. General Reporting Requirements
- IX. General Financial Requirements
- X. Monitoring Budget Neutrality
- XI. Evaluation of the Demonstration
- XII. Schedule of State Deliverables During the Demonstration Extension Period
- Attachment A. Quarterly Report Content and Format
- Attachment B. Administrative Cost Claiming Rules and Protocol
- Attachment C. Interim and Final Cost Settlement Protocol

II. PROGRAM DESCRIPTION AND OBJECTIVES

Until December 31, 2013, the Illinois Department of Healthcare and Family Services section 1115 demonstration provides comprehensive health care benefits to adults, ages 19 through 64 years, who do not have a Medicaid-eligible dependent child living in the household, who had family income at or below 133 percent of the Federal poverty level (FPL), who were not otherwise eligible for coverage under the Medicaid state plan, the Children’s Health Insurance program (CHIP), or Medicare and who reside in Cook County.

The demonstration population received health care benefits only through the Cook County Health and Hospital System (CCHHS) and community partners that CCHHS includes in the provider network for the demonstration. Payment for such benefits was made to CCHHS on a cost basis.

After January 1, 2014, the demonstration extension period provides for a temporary continuation of the demonstration payment methodology for CCHHS for individuals eligible under the state plan in the new adult eligibility population who elect (or are deemed to elect) to receive services only through CCHHS and its community partners.

The demonstration extension goal is to provide stability in payment for CCHHS while Illinois reviews whether the demonstration payment methodology is desirable and consistent with section 1902(a) requirements

Demonstration Extension Hypotheses:

This demonstration extension will enable the state to study the extent to which the demonstration payment methodology will promote high quality cost-effective care for the new adult population, comparing costs, quality of care, and satisfaction rates for individuals who elect to receive care through CCHHS with individuals who otherwise obtain care through enrolled Medicaid providers.

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 time frames specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy statement affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly 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 as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget

neutrality agreement will be effective upon the implementation of the change.

- b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPAs) 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 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, enrollee rights, delivery systems, cost sharing, evaluation design, 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 STC 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 STC 13, to reach a decision regarding the requested amendment.
 - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX state plan amendment, if necessary; and
 - d. If applicable, a description of how the evaluations design will be modified to incorporate the amendment provisions.

8. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STCs 27 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 1.
9. **CMS's Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
10. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.
11. **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's 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.
12. **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; complying with cost sharing requirements; and reporting on financial and other demonstration components.
13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in

accordance with the consultation process outlined in the July 17, 2001, letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. section 431.408(b)(2)).

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 demonstration proposal, and/or renewal of this demonstration (42 C.F.R. section 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

14. **FFP.** No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ENSURING BENEFICIARY FREEDOM OF CHOICE OF PROVIDER FOR THE DEMONSTRATION EXTENSION PERIOD

15. **Ensuring Beneficiary Freedom of Choice.** Individuals who reside in Cook County, and are determined eligible in the new adult eligibility group, will be given the option to obtain all services through CCHHS and its community partners. Such individuals will be required to sign a form stating they understand that they have the option to receive all of their services through CCHHS or may opt-out and receive care through any of the state's enrolled Medicaid providers. Beneficiaries will be deemed to have elected the CCHHS option unless they affirmatively opt-out. A beneficiary who elects the CCHHS option (or is deemed to have elected the CCHHS option) may rescind that election on any business day and receive services through any of the state's enrolled Medicaid providers.

V. DELIVERY SYSTEMS FOR THE DEMONSTRATION EXTENSION PERIOD

16. **Patient Centered Medical Homes.** Individuals who elect the CCHHS option will be encouraged to elect a CCHHS network PCMH at the initial date of enrollment. The individual has the option, at any time, to elect a different PCMH or a different primary care provider within a different PCMH. Individuals that do not have a relationship with a primary care provider or who have not elected a PCMH will be contacted three times by CCHHS by phone to confirm a primary care provider or PCMH. If the individual cannot be reached, a primary care provider and PCMH will be assigned to that individual based on their location or historical use of a provider. Individuals who are assigned to a primary care provider and PCMH will continue to have the option to elect another primary care provider, in the network, at any time. The PCMH is charged with assisting individuals in coordinating care and assisting the participant in obtaining care that will improve health outcomes.
17. **Role of CCHHS and its Community Partners.** The CCHHS and its community partners are charged with assisting individuals in coordinating care, improving health outcomes, and assisting enrollees in selecting a PCMH. The CCHHS manages the primary care provider network and is required to contract with community partners to ensure adequate access to

PCMHs and covered benefits. In addition to managing a network of primary care providers, CCHHS must establish a network of specialists and ancillary providers.

VI. PAYMENT METHODOLOGY FOR THE DEMONSTRATION EXTENSION PERIOD

18. **CCHHS Payment.** During the demonstration extension period, the state shall pay CCHHS which will be paid an interim per member per month (PMPM), for each individual in the new adult eligibility group who elects (or is deemed to elect) to receive services only through CCHHS and its community partners. Such payment will be prorated if such an individual elects at any time in the month to receive services through Medicaid FFS. The interim PMPM payment to CCHHS will begin as of the month an individual makes such an election. Within 6 months following the end of the demonstration extension period, CCHHS must submit “Cook County Care Section 1115 Demonstration” preliminary cost reports to the state detailing the actual cost of furnishing covered services to such individuals during the demonstration extension period, consistent with OMB and Medicare cost reporting principles. Within 150 days after the submission of such preliminary cost reports, the state must reconcile the interim PMPM to the preliminary actual CCHHS cost. As detailed in Attachment C, the state must submit the findings of the cost analysis to CMS within 150 days of the submission of the cost reports and no later than November 30, 2014.
19. **Allowable service costs for CCHHS.** Allowable service costs for CCHHS include only costs for services covered under the state plan that are furnished to individuals in the new adult eligibility group who have elected (or are deemed to elect) the CCHHS option that are provided either directly by CCHHS itself or by primary care providers, specialists, and ancillary providers that have contracted to be a network provider within the CCHHS network. Allowable costs shall also include payments for services out of the CCHHS network in two instances: 1) services associated with an emergency condition; and 2) prior-approved medically necessary services. Prior approval for medically necessary services will be granted whenever the individual cannot obtain timely access to the services within the CCHHS network because of network capacity limitations, need for specialized expertise, or to ensure continuity of care for ongoing treatment.
20. **Reconciliation of CCHHS Interim Payments to Allowable Service Costs.** If the interim PMPM, or other expenditures claimed by CCHHS exceed actual expenditures, the state anticipates that it will collect the amount in excess of actual expenditures from CCHHS within 150 days. The state must properly credit the federal share of any such excess payments to the federal government upon receipt of repayment but no later than December 31, 2014, regardless of receipt of repayment. If expenditures claimed by CCHHS were understated and there are no budget neutrality restrictions, the state may make additional payment to CCHHS in the amount of such understatement. The state may draw down the federal share of any such payments from the Federal government at the time of the additional payment. Additional detail regarding the interim and final reconciliations can be found in Attachment C: “Interim and Final Cost Settlement Protocol.”

Provider Reimbursement. CCHHS will be responsible for paying all providers for covered services under the state plan for individuals in the new adult eligibility group who

have elected (or are deemed to elect) the CCHHS option. Provider rates paid by CCHHS will not exceed, in the aggregate, the rates that would be otherwise payable under the state plan for the covered services furnished to the enrolled population.

To the extent that CCHHS includes FQHCs in its network, payment to FQHCs will not be less than the level and amount of payment which CCHHS would make if the service were furnished by a non-FQHC provider.

21. **CCHHS Network Requirements.** The state must ensure the service delivery system is sufficient to provide individuals who elect the CCHHS option access to all covered benefits. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. Services must be delivered in a culturally competent manner and consistent with all requirements under the Americans with Disabilities Act, and all requirements related to serving individuals with limited English proficiency. If an individual needs a service that is not available through the CCHHS network, the provider must educate the individual on where s/he may receive the service. Providers must refer the individual to other providers to assure benefits can be received.

At minimum, reasonably prompt access to care must include:

- a. Routine, preventive care appointments available within 5 weeks;
 - b. Urgent, non-emergency appointments are triaged and provided within 24 hours ;
 - c. Appointments for individual problems or complaints available within 3 weeks from the date of request for such care;
 - d. Upon notification of hospitalization or of an ER visit, any follow-up appointment available within the earlier of 7 days after discharge or a date specified in the hospital discharge plan; and
 - e. Individuals have access to a provider through an answering service, paging mechanism or other arrangement for coverage 24 hours a day, 7 days a week (24/7).
22. **Demonstrating Network Adequacy.** The state must provide updates on the CCHHS network including community partners in each quarterly report, consistent with the requirements of STC 27. Every six months, each CCHHS network provider must provide adequate assurances that it has sufficient capacity to serve the expected enrollment. For primary care providers, the provider to patient ratio will be the same as the state's Primary Care Case Management Program, Illinois Health Connect, standards. In addition, the CCHHS network must have urgent care clinics open at 3 regional campuses 365 days per year.
23. **Delivery System and Access to Care Monitoring.** The state and CCHHS must monitor and evaluate the sufficiency of the CCHHS delivery system for demonstration enrollees including the need for and access to comprehensive health care services at both the CCHHS facilities and their community partners. Monitoring activities must be reported quarterly

(within 45 days of the ending of the calendar quarter) and must include:

- a. A tracking of CCHHS Option patient volumes at all CCHHS and community partner facilities including a comparison to historical volumes; and,
- b. A reporting of clinic wait times for primary care, physician specialty care, and outpatient services.

VII. GENERAL REPORTING REQUIREMENTS

24. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX set forth in Section IX of these STCs.
25. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section X of these STCs.
26. **Quarterly Calls.** The state must participate in monitoring calls with CMS. 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, CCHHS operations (such as network adequacy, assignment of a PCMH, contract amendments, and rate certifications), health care delivery, enrollment, proposed or implemented changes to the enrollment limit and/or state-specified income eligibility standard, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes in payment rates, CCHHS and community partner financial performance that is relevant to the demonstration, role of the evaluators progress, state legislative developments, any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.
27. **Quarterly Reports.** The state must submit progress reports in the format specified 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. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, CCHHS and community partner operations (such as network adequacy, assignment of a PCMH, contract amendments and rate certifications); health care delivery; grievances; quality of care; access; proposed changes to payment rates; pertinent legislative activity; and other operational issues;
 - c. Action plans for addressing any policy and administrative issues identified;

- d. Quarterly reports that include the CCHHS option member months, in addition to end of quarter and other statistical reports listed in Attachment A;
 - e. Comparison of the actual PMPM costs with the projected PMPM costs of the approved proposal.
 - f. Updates on improvements to the CCHHS provider network and community partners as stipulated in STC 172;
 - g. Updates on the number of CCHHS Option patients who have been enrolled into a PCMH;
 - h. Evaluation activities and interim findings.
28. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS's comments.

VIII. GENERAL FINANCIAL REQUIREMENTS

29. **Quarterly Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX of the STCs.
30. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
- a. Tracking Expenditures. In order to track expenditures under this demonstration, Illinois must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).
 - b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C.

For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

- c. Premium and Cost Sharing Contributions. Applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64Narr by demonstration year.
 - d. Pharmacy Rebates. Providers under this demonstration are participants in the 340B program, therefore pharmacy rebates will not apply to the demonstration. If there is a change from this position, rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.
 - e. Use of Waiver Forms. For the demonstration extension period, a separate Form CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name "Adults" to report expenditures. The waiver name "Adults" must be used to identify these separate forms CMS-64.9 Waiver and/or 64.9P Waiver expenditures should be allocated to these forms based on the guidance found below.
31. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures related to the demonstration benefit package described in Section V of the STCs provided to individuals who are enrolled in this demonstration as described in Section IV of the STCs. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on forms CMS-64.9 Waiver and /or 64.9P Waiver.
32. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 Waiver and/or 64.10P Waiver.
33. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver form in order to properly account for these expenditures in determining budget neutrality.
34. **Reporting Member Months.** The following describes the reporting of member months for CCHHS Option:
- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under

STC 27, the actual number of individuals who have elected (or are deemed to have elected) the CCHHS option for the month or a prorated part of the month. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of “in-process” eligibility, reported counts of CCHHS member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

35. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. Illinois must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.
36. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section X of the STCs:
 - a. Administrative costs, including those associated with the administration of the demonstration;
 - b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
 - c. Net medical assistance expenditures made under section 1115 demonstration authority.
37. **Sources of Non-Federal Share.** The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.
 - a. CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
 - b. Any amendments that impact the financial status of the program must require the state

to provide information to CMS regarding all sources of the non-federal share of funding.

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

38. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

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

39. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

40. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION EXTENSION PERIOD

41. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS’s assessment of the state’s compliance with these annual limits will be done using the Schedule C report from the CMS-64.
42. **Risk.** Illinois shall be at risk for the per capita cost (as determined by the method described below) for individuals in the new adult population who elect the CCHHS option.
43. **Demonstration Population Used to Calculating the Budget Neutrality Expenditure Cap.** The following describes the method for calculating the budget neutrality expenditure cap for the demonstration extension period:
- i. PMPM amounts for individuals in the new adult eligibility group who have elected (or are deemed to have elected) to receive all services through CCHHS. The state may not derive savings from this population.

PMPM Group	Growth Rate	DY 1 Date of approval letter through 12/31/2012 PMPM	DY 2 01/01/2013 through 12/31/2013 PMPM	DY 3 01/01/2014 through 3/30/2014 PMPM
CCHHS Option	.56%	\$625.45	\$628.96	\$632.48

44. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.
45. **Exceeding Budget Neutrality.** If, at the end of this demonstration period, the cumulative budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

X. EVALUATION OF THE DEMONSTRATION EXTENSION PERIOD

46. **Submission of Draft Evaluation Design.** The state shall submit to CMS for approval within 120 calendar days from the award of the demonstration extension a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the demonstration. The draft design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall 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.

- a. Domain of Focus. The Evaluation Design must, at a minimum, address the research questions/topics listed below and the goals of the demonstration as outlined in Section II of the STCs. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.
- i. The number of individuals who have elected the CCHHS option in comparison to the total number of individuals eligible in the new adult population in Cook County;
 - ii. The state must address the following evaluation questions and topics in the draft evaluation plan:
 1. How has the demonstration addressed unmet healthcare needs and provided a regular source of coordinated care for enrollees;
 2. How effective have the PCMHs been in providing high-quality, coordinated care? (The state must propose quality measures that would be used to evaluate the effectiveness of the PCMHs);
 3. How has the demonstration informed the state's payment methodology as it prepares establish capitated rates for its entire Medicaid population?

47. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design described in STC 46 within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation report within 120 days after 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's comments.

48. **Cooperation with CMS Evaluators.** Should CMS conduct 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 the contractor or CMS.

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date - Specific	Deliverable	STC Reference
60 days from date of award letter	Submit Draft Evaluation Plan	STC 46
90 days of receipt of CMS comments	Submit Final Evaluation Plan	STC 47
Each Quarter	Deliverable	STC Reference
60 days after the close of the quarter	Quarterly Operational Reports	STC 29
	CMS-64 Reports	STC 30

ATTACHMENT A

Quarterly Report Content and Format

Under STC 27, 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. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Illinois/Cook County Care Demonstration Extension Period

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 1 (Date of approval letter through 12/31/2012)

Federal Fiscal Quarter: 1 (01/01/2013 through 12/31/2013)

I. Introduction

Information describing the goals of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

II. 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”.

A. CCHHS Option Counts

Note: CCHHS Option counts should be person counts, not member months

CCHHS Option Patients (as hard coded in the CMS 64)	Current Numbers (to date)	Non-CCHHS Option (to date)
<u>CCHHS Option</u>		

B. Collection and Verification of Encounter Data and and CCHHS Option Patient Data

Summarize any issues, activities or findings related to the collection and verification of

ATTACHMENT A

Quarterly Report Content and Format

encounter and enrollment data.

III. Assignment of a Primary Care Medical Home

Summarize CCHHS activities related to assignment of new enrollees to a PCMH and complete the following chart:

Demonstration Populations	New Electees for the Quarter	Electees Who Choose a PCMH	New Electees Assigned to a PCMH
<u>CCHHS Option Population</u>			

IV. Updates on Additional Community Partners

Provide a list of any additional Community Partners that have joined the demonstration delivery system.

V. Outreach/Innovative Activities

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

VI. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, CCHHS operations (such as network adequacy, assignment of a PCMH, contract amendments and rate certifications); approval and contracting with new plans; health care delivery; benefits; grievances; quality of care; access; proposed changes to payment rates; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; and other operational issues.

Summarize the development, implementation, and administration of any action plans for addressing issues related to the demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

VII. Expenditure Containment Initiatives

Identify all current activities. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

VIII. Budget Neutrality

A. Financial/Budget Neutrality Development/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.

ATTACHMENT A

Quarterly Report Content and Format

B. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

i. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
County Care				

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures (Member months multiplied by PMPM)
County Care			

IX. 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. Also discuss feedback received from enrollees and consumer groups.

X. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

XI. Demonstration Evaluation

Discuss progress of evaluation design and planning.

XII. Transition Plan

Pursuant to STC 15 provide updates on the state’s work related to the transition plan consistent with the provisions of the Affordable Care Act, for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of enrolled individuals to a coverage option.

XIII. Additional Information

A. Enclosures/Attachments

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

B. State Contact(s)

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

C. Date Submitted to CMS

ATTACHMENT B

Administrative Cost Claiming Rules and Protocol

Administrative Cost Claiming Rules and Protocol for Cook County Health and Hospital Systems Bridge and the Illinois Department of Healthcare and Family Services

I. Preface

As part of the total amount payable under the demonstration authority granted under section 1115(a)(2) of the Social Security Act (the Act) by the Centers for Medicare & Medicaid Services (CMS) to the Illinois Department of Healthcare and Family Services (the single state agency) and their partner Cook County Health and Hospital System (CCHHS), Federal Financial Participation (FFP) as authorized by 42 Code of Federal Regulations (CFR) 433.15 is available to CCHHS at the 50 percent rate for expenditures required for “proper and efficient” administration of the demonstration, subject to the limitations outlined below.

The following guidance and protocols are based on and in response to information submitted in writing or otherwise communicated to CMS and are provided to inform the state and assist the state in its efforts to comply with the rules and protocols regarding claiming of FFP for administrative expenditures incurred by the state and/or its contractors under this demonstration.

a. General Requirements

The state must comply with all federal statute, regulations and guidance for all claims for FFP.

In order for the costs of administrative activities to be claimed as Medicaid administrative expenditures at the 50 percent FFP rate, the following requirements must be met:

- Costs must be “necessary for the proper and efficient administration of the Medicaid state Plan” (Section 1903(a)(7) of the Social Security Act).
- If applicable, costs must be allocated in accordance with the relative benefits received by all programs, not just Medicaid.
- Claims for costs must not duplicate costs that have been, or should have been, paid through another source.
- State or local governmental agency costs must be supported by an allocation methodology under the applicable approved public assistance Cost Allocation Plan (42 CFR 433.34).
- Costs must not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- Costs must not include the overhead costs of operating a provider facility or otherwise include costs of a direct service to beneficiaries (these should be claimed as service costs, not plan administration).
- Costs must not duplicate activities that are already being offered or should be provided by other entities, or through other programs.
- Costs must be supported by adequate source documentation.
- Costs must not be federally-funded or used for any other federal matching purposes.

ATTACHMENT B

Administrative Cost Claiming Rules and Protocol

b. Memorandum of Understanding (MOU Agreement)/Contract

Because only the single state Medicaid agency (Illinois Department of Healthcare and Family Services) may submit a claim to CMS to receive FFP for allowable and properly allocated Medicaid costs, every participating entity that is performing administrative activities on behalf of the Medicaid program must be covered, through an MOU/contract. These MOUs/contracts must be in effect before the state Medicaid agency may claim federal matching funds for any and all administrative activities conducted on the Medicaid agency's behalf by the CCHHS. CCHHS will be entering into multiple contracts, including one with a Third Party Administrator (TPA) contractor and another with an Application Assistance contractor. As the single state Medicaid agency, Illinois Department of Healthcare and Family Services will maintain ultimate responsibility for assuring compliance with all federal requirements in the administration of this demonstration and will have access to all information needed to insure oversight and compliance with the demonstration and all federal regulations.

In order to provide a basis for FFP to be claimed, these contracts and agreements must describe and define the relationships between the state Medicaid agency, CCHHS and the contractors (TPA and Application Assistance) and must define the details regarding the scope of the activities being performed once the contractors have been selected. The contracts must include:

- Mutual objectives of the agreement;
- Responsibilities of all the parties to the agreement;
- Activities or services each party to the agreement offers and under what circumstances;
- Cooperative and collaborative relationships at the state and local levels;
- Specific methodology to be approved by CMS for computation of the claim, by reference or inclusion;
- Methods for reimbursement, exchange of reports and documentation, and liaison between the parties, including designation of state and local liaison staff.

These contracts must identify the scope of activities and services to be provided to the state Medicaid agency and CCHHS including any related reimbursement and funding mechanisms, and define the responsibilities of all parties, including the Medicaid agency's oversight and monitoring activities. All participation requirements should be detailed in the contractual agreements. Maintenance of records, participation in audits, designation of local project coordinators, training timetables and criteria, and submission of fiscal information are all important elements are examples of the required elements of this agreement. Also, the specific methodologies to be employed, the mechanism for filing the claim, and the allocation methodology to identify Medicaid costs and other sources of funding should be identified.

This agreement also requires the governmental agency that performs the administrative activities on behalf of the Medicaid agency to provide funding for the state matching funds required for Medicaid administrative claiming. As always, the non-federal share of the Medicaid payments must be derived from permissible sources as indicated in the STCs and must comply with federal

ATTACHMENT B

Administrative Cost Claiming Rules and Protocol

regulations and policy. (Illinois has indicated that the source of funding is an intergovernmental transfer.)

c. Identification, Documentation and Allocation of Costs

All administrative costs (direct and indirect) are normally charged to federal grant awards such as Medicaid through the state's public assistance Cost Allocation Plan (CAP). Federal regulations (42 CFR 433.34) require that under the Medicaid state plan, the single state agency have an approved public assistance CAP on file with the Division of Cost Allocation in the U.S. Department of Health and Human Services that meets regulatory requirements specified at Subpart E of 45 CFR part 95 and referenced in OMB Circular A-87.

The public assistance CAP, which a state Medicaid agency must submit and update to ensure that costs are properly allocated between Medicaid and non-Medicaid before claiming FFP for administrative expenditures, must detail the methodologies, claiming mechanisms, contractual arrangements and/or interagency agreements, and other relevant issues pertinent to the allocation of costs and submission of claims by the participating entities.

Documentation for administrative activities must clearly demonstrate that the activities directly support the administration of the state Medicaid program. In accordance with the statute, the regulations, and the Medicaid state plan, the state is required to maintain/retain adequate source documentation to support Medicaid payments. The basis for this requirement can be found in statute and regulations. See section 1902(a)(4) of the Act and 42 CFR 431.17; see also 45 CFR 92.20(b) and 42 CFR 433.32(a) (requiring source documentation to support accounting records) and 45 CFR 92.42 and 42 CFR 433.32(b and c) (retention period for records). The records must be made available for review by state and federal staff upon request during normal working hours (section 1902(a) (4) of the Act, implemented at 42 CFR 431.17).

When states submit claims for FFP for Medicaid administration, only costs directly related to Medicaid administration are allowable and these costs must be allocated according to accepted cost principles. Since most administrative activities are provided both to Medicaid and non-Medicaid eligible individuals, the costs applicable to these activities must be appropriately allocated to each group.

d. Administrative FFP for Skilled Professional Medical Personnel

In addition to the 50 percent federal Medicaid administrative matching rate, Section 1903(a)(2) of the Act provides for FFP at 75 percent for expenditures attributable to the compensation and training of skilled professional medical personnel (SPMP) of the state agency (See also 42 CFR 432.2, 432.45, 432.50 and 433.15.)

The state has not identified to CMS any activities under this section 1115 demonstration that are reimbursable at the enhanced 75 percent SPMP matching rate.

ATTACHMENT B

Administrative Cost Claiming Rules and Protocol

Note: Administrative costs incurred that are an integral part of, or an extension of, the provision of services by medical providers, may only be reimbursed as a component of the rate paid by the state or its fiscal agent for the medical service. There is no additional FFP available.

II. General Conditions

The state Medicaid agency for Illinois and CCHHS must:

1. Submit the TPA and application assistance contracts to CMS for review once vendors are selected to identify all administrative costs to be included under the section 1115 demonstration.
2. Identify all costs reflected in the administrative cost claiming budget (including the interim administrative support services, facility, management support costs) to be included as administrative expenditures in this demonstration, provide a detailed narrative description of all administrative costs for CMS review, and provide details of other sources of funding or other program costs.
3. Obtain prior approval from CMS for changes to the methodology used to capture or claim FFP for administrative costs associated with the demonstration.
4. Describe how they will offset other revenue sources for administrative expenditures associated with the demonstration, if applicable.
5. Obtain prior approval for any new categories for administrative expenditures to be claimed under the demonstration.
6. Agree to permit CMS to review any forms and/or contract modifications that are subsequently developed for use by this program, prior to modification or execution.
7. Submit all necessary changes for administrative expenditures to CMS for review and approval prior to implementation.
8. Submit copies of signed contracts with all parties for administrative expenditures to CMS including detailed budget and budget narratives.

ATTACHMENT C

Interim and Final Cost Settlement Protocol

Interim Reconciliation to As-Filed Cost Report

CCHHS' interim PMPM cost payments must be reconciled to actual cost of the demonstration based on the "Cook County Care Section 1115 Demonstration" cost reports established from the individual CCHHS as-filed CMS-2552 reports for the expenditure year. If, at the end of the interim reconciliation process, it is determined that expenditures claimed were overstated, the overpayment must be properly credited to the Federal government. If, at the end of the interim reconciliation process, it is determined that expenditures claimed were understated and there are no budget neutrality restrictions, the underpayment must be properly debited to the Federal government.

The interim reconciliation is based on the "Cook County Care Section 1115 Demonstration" cost report which is established from the as-filed cost reports (filed to the Medicare contractor) for the expenditure period. The supplemental as-filed system cost report will include all costs associated with providing care under the demonstration.

The state will perform this interim reconciliation within 5 months from the filing of the "Cook County Care section 1115 demonstration" cost reports for the expenditure period.

Final Reconciliation to Finalized Cost Report

CCHHS' interim PMPM cost payments will be reconciled to actual cost based on its "Cook County Care Section 1115 Demonstration" cost reports and will be updated to include data based on the individual CCHHS finalized CMS-2552 reports for the expenditure year. If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The final reconciliation will be established from the consolidated CCHHS' allowable cost on its "Cook County Care Section 1115 Demonstration" cost report which is based on the finalized cost reports (finalized/settled by the Medicare contractor with the issuance of a Notice of Provider Reimbursement or a revised Notice of Provider Reimbursement) for the expenditure period. The "Cook County Section 1115 Demonstration" finalized system cost report will include all costs associated with providing care under the demonstration.

For the final reconciliation, the demonstration days and charges must be tied to State Paid Claims Listing (SPCL) paid claims reports, with no further claim lag adjustments. The state will perform this final reconciliation within six months from the finalization of the individual cost reports for the expenditure period (issuance of notice of program reimbursement of the applicable Medicare costs for CCHHS).

If at the end of the final reconciliation process, the state determines that expenditures claimed were overstated, the federal share of the overpayment must be properly credited

ATTACHMENT C

Interim and Final Cost Settlement Protocol

to the Federal government. If, at the end of the final reconciliation process, the state determines that expenditures claimed were understated and there are no budget neutrality restrictions, the state shall make payment to CCHHS and may draw down the federal share of the payment from the federal government.



Administrator
Washington, DC 20201

OCT 26 2012

Julie Hamos
Director
Illinois Department of Healthcare and Family Services
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Dear Ms. Hamos:

We are pleased to inform you that Illinois' request for a new Medicaid section 1115(a) demonstration, entitled "Illinois/ Cook County Care" (Project Number 11-W-00281/5), has been approved for the period starting as of the date of this approval letter through December 31, 2013.

Illinois' new section 1115 demonstration is a safety-net institution based coverage expansion. The demonstration provides coverage to adults without dependent children, who have family income at or below 133 percent of the Federal poverty line (FPL), who reside in Cook County, and who are not otherwise eligible for Medicaid. These adults will receive benefits through the Cook County Health and Hospital System (CCHHS) and its community partner network providers. CCHHS will coordinate care through Patient Centered Medical Homes.

The demonstration will support efforts to develop a provider network in Cook County that will increase capacity to serve the demonstration population, increase the number of services available to the population, and improve the quality of care of services provided.

Our approval of this demonstration project is subject to the limitations specified in the attached expenditure authorities, the specification of title XIX requirements not applicable to the expenditure authorities, and the attached special terms and conditions (STCs) applicable to the demonstration. The state may deviate from Medicaid state plan requirements only to the extent that those requirements have been specified as not applicable to the expenditure authorities. The demonstration is authorized through December 31, 2013, upon which date, all authorities granted to operate this demonstration will expire.

The award is subject to our receipt of your written acknowledgement of the award, and acceptance of the STCs and expenditure authorities within 30 days from the date of this letter.

Your project officer for this demonstration is Ms. Cathy Song. She is available to answer any questions concerning your section 1115 demonstration, and may be contacted as follows:

Ms. Cathy Song
Centers for Medicare & Medicaid Services

233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601
Telephone: (312) 353-5184
Facsimile: (443) 380-6748
Email: Catherine.Song1@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Song and Ms. Verlon Johnson, Associate Regional Administrator in our Chicago Regional Office. Ms. Johnson's address is:

Ms. Verlon Johnson
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health Operations
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601

We extend our congratulations to you on this award, and we appreciate your collaboration through the review process. If you have any questions regarding this correspondence, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, (410) 786-5647.

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

Sincerely,



Marilyn Tavenner
Acting Administrator

Enclosures

cc: Verlon Johnson, Associate Regional Administrator, Chicago Regional Office
Cathy Song, Project Officer
Victoria Wachino, CAHPG Director, CMCS

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

NUMBER: 11-W-00281/5

TITLE: Illinois/Cook County Care

AWARDEE: Illinois Department of Healthcare and Family Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Illinois for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this demonstration beginning the date of the approval letter through December 31, 2013, shall be regarded as expenditures under the state's title XIX plan.

The following expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the state to operate its Illinois/Cook County Care (County Care) section 1115 Demonstration.

Demonstration Population Expenditures. Expenditures to provide health coverage to the following Demonstration population:

County Care Demonstration Population. Expenditures for health care-related costs for uninsured adults, ages 19 through 64 years, who do not have a Medicaid-eligible dependent child living in the household, who are not otherwise eligible under the Medicaid state plan, CHIP, or Medicare, who reside in Cook County, and who have family income at or below 133 percent of the Federal poverty line (FPL), or an equivalent standard using a modified adjusted gross income-based (MAGI-based) income determination methodology.

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

Title XIX Requirements Not Applicable to the Demonstration Population:

1. Statewideness

Section 1902(a)(1)

To the extent necessary to enable the state to limit the service area served by the demonstration to Cook County.

2. Amount, Duration and Scope

Section 1902(a)(10)(B)

To the extent necessary to enable the state to limit the amount, duration and scope of services available to Demonstration-eligible individuals.

3. Freedom of Choice

Section 1902(a)(23)(A)

To the extent necessary to enable the state to restrict freedom of choice of provider by using a limited delivery system consisting of the Cook County Health and Hospital System and community partners network providers.

4. Annual Redeterminations

Section 1902(a)(17) and 1902(a)(19)

To the extent necessary to enable the state to not conduct a 12 month redetermination during the demonstration period that is not related to a specific change in the individuals' circumstances.

5. Comparability

Section 1902(a)(17)

To the extent necessary to enable the state to use MAGI-based eligibility determination methods as described in Section 1902(e)(14) to the extent the methodology does not disadvantage an individual and to the extent that such methodologies and standards are not otherwise used under the Medicaid state plan.

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

NUMBER: 11-W-00281/5

TITLE: Illinois/Cook County Care

AWARDEE: Illinois Department of Healthcare and Family Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Illinois's section 1115(a) Medicaid Illinois/Cook County Care (County Care) demonstration (hereinafter "Demonstration"). The parties to this agreement are the Illinois Department of Healthcare and Family Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, through December 31, 2013, unless otherwise specified.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility
- V. Benefits
- VI. Cost Sharing
- VII. Delivery Systems
- VIII. General Reporting Requirements
- IX. General Financial Requirements
- X. Monitoring Budget Neutrality
- XI. Evaluation of the Demonstration
- XII. Schedule of State Deliverables During the Demonstration Extension Period
- Attachment A. Quarterly Report Content and Format
- Attachment B. Administrative Cost Claiming Rules and Protocol
- Attachment C. Interim and Final Cost Settlement Protocol

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Illinois Department of Healthcare and Family Services section 1115 demonstration provides comprehensive health care benefits to adults, ages 19 through 64 years, who do not have a Medicaid-eligible dependent child living in the household, who have family income at or below 133 percent of the Federal poverty line (FPL), who are not otherwise eligible for coverage under the Medicaid state plan, the Children's Health Insurance program (CHIP), or Medicare and who reside in Cook County. The state share of demonstration expenditures will be primarily funded through an intergovernmental transfer (IGT) from Cook County of funds derived from state or local tax revenues, and certified public expenditures for administrative costs.

The demonstration population will receive health care benefits through the Cook County Health and Hospital System (CCHHS) and community partners that CCHHS includes in the provider network for the demonstration. Individuals who apply for Medicaid and are found ineligible under the state plan will be assessed for eligibility under the demonstration, with the help of eligibility staff and application assistants who will help facilitate enrollment into the demonstration. As part of the demonstration, clients will be encouraged to elect a CCHHS network Patient Centered Medical Home (PCMH) from the initial date of enrollment or they will be assigned to a PCMH.

Demonstration Goals:

The demonstration will help the state and CCHHS build both capacity and experience to support the transition to expanded Medicaid coverage under the Affordable Care Act in 2014. The state's goals under the demonstration are to:

- Provide health care coverage, over the course of the demonstration, to approximately 125,000 currently uninsured Cook County residents;
- Provide previously uninsured individuals with the additional benefit of mental health, substance use disorder services, and prescription services;
- Ensure that services are provided in an effective and coordinated fashion through PCMHs that will ensure that appropriate services are provided in a cost-effective manner for this population;
- Provide comprehensive coverage for individuals not eligible for Medicaid or CHIP
- Expand the network of providers within the CCHHS network to ensure access to services for the demonstration population and build collaborations as the state prepares for expanded coverage in 2014.

This demonstration will enable the state to study and evaluate trends in beneficiary needs, provider capacity, care delivery, and payment rates to assist in preparations for the implementation of provisions of the Affordable Care Act in 2014, including the coverage and payment for the group described in section 1902(a)(10)(A)(i)(VIII) for individuals under age 65, regardless of disability status, with income at or below 133 percent of the FPL.

Demonstration Hypotheses:

The state will test the following hypotheses in its evaluation of the demonstration:

- Expanding Medicaid services to the low-income adult population will improve the quality, coordination, and cost effectiveness of care at CCHHS.
- Expanding eligibility to the currently uninsured low-income adult population will jump-start the enrollment process for the sub-group of individuals who will be newly eligible for Medicaid state plan benefits in 2014.
- Building partnership with community providers such as area FQHCs, mental health, and substance use providers will prepare the safety net for the substantial changes that will take place starting in 2014.

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 time frames specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy statement affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly 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 as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPAs) 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 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, enrollee rights, delivery systems, cost sharing, evaluation design, 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 STC 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 STC 16, to reach a decision regarding the requested amendment.
- b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX state plan amendment, if necessary; and
- d. If applicable, a description of how the evaluations design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration.

- a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 6 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.
- b. Compliance with Transparency Requirements 42 CFR Section 431.412:

Effective April 27, 2012, as part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 16, as well as include the following supporting documentation:

- i. Historical Narrative Summary of the Demonstration Project: 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 the change and desired outcomes must be included.

- ii. **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.
 - iii. **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.
 - iv. **Quality:** The state must provide summaries of External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; state quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.
 - v. **Financial Data:** 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 as well as cumulatively over the lifetime of the demonstration. 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 doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. 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.
 - vi. **Evaluation Report:** 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.
 - vii. **Documentation of Public Notice 42 CFR section 431.408:** The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.
9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a. **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the

demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

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

- b. **Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- c. **Phase-out Procedures:** The state must comply with all notice requirements found in 42 CFR sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- d. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraphs 35 and 36 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 37.

11. **CMS's 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's 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; complying with cost sharing requirements; and reporting on financial and other demonstration components.
15. **Submission of State Plan and Demonstration Amendments, and Transition Plan, Related to Implementation of the Affordable Care Act (ACA).**

Upon implementation of the Affordable Care Act (ACA) in January 2014, expenditure authority for the demonstration Expansion population will end. To the extent that the state seeks authority for the eligibility, benefits and cost sharing for these populations under the Medicaid state plan, the state will, by April 1, 2013, submit proposed state plan amendments for any such populations. In addition, the state will submit by July 1, 2013, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs outlined below. In addition, the Plan will include a schedule of implementation activities that the state will use to operationalize the Transition Plan and meet the requirements of regulations and other CMS guidance related to ACA implementation.

 - a. Transition plan must assure seamless transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the state will obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage

option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the state must:

- i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in section 1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
 - ii. Identify demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
 - iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014, eligibility groups for new applicants for Medicaid eligibility.
- b. Transition Plan Implementation:
- i. By October 1, 2013, the state must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the state plan, the state will not require these individuals to submit a new application.
 - ii. On or before December 31, 2013, the state must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

16. Public Notice, Tribal Consultation, and Consultation with Interested Parties.

The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001, letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. section 431.408(b)(2)).

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 demonstration proposal, and/or renewal of this demonstration (42 C.F.R. section 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in

statewide methods and standards for setting payment rates.

17. **FFP.** No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

18. **Eligibility Criteria.** Individuals eligible for the Demonstration eligibles are:
 - a. Adults age 19 through 64 years who are not pregnant and do not have a Medicaid-dependent child living in the household;
 - b. Screened and found not eligible for Medicaid under the state plan, Medicare, or CHIP;
 - i. Do not qualify under the Aged, Blind, and Disabled category
 - ii. Are not pregnant; and
 - iii. Are not a parent living with his or her children
 - c. Have family income at or below 133 percent of the FPL, or an equivalent standard using a modified adjusted gross income-based (MAGI-based) income determination methodology;
 - d. Reside in Cook County;
 - e. U.S. citizens, nationals, or qualified non-citizens; and
 - f. Not subject to any asset test.
19. **Eligibility Determinations.** Eligibility determinations for the demonstration-eligible population are determined based on an application to the demonstration eligibility staff. Demonstration-eligible individuals may apply for the demonstration by phone, online, mail or at any of the CCHHS sites. Individuals may apply at primary care community partner sites (for example, FQHCs and other primary care providers who have contracted with CCHHS to provide services to demonstration recipients as part of the demonstration provider network). The CCHHS will employ and/or contract with out-stationed eligibility intake staff to screen applicants for Medicaid or CHIP eligibility prior to enrollment into the demonstration. The out-stationed eligibility staff will assist individuals with completing an application for the appropriate program (including Medicaid, CHIP, and County Care) and, with respect to demonstration eligibility, collecting any necessary supplemental information to verify income, residency, citizenship or immigration status for eligibility determinations.

In addition to CCHHS sites or community partner sites, individuals can reach out-stationed eligibility intake staff by phone to obtain assistance in enrolling into the demonstration. Designated DHS eligibility staff will process applications for enrollment in the demonstration. While individuals may apply for the demonstration at CCHHS sites or primary care community partner sites, all eligibility determinations for the demonstration will be made by state of Illinois staff authorized to determine eligibility for Medicaid. If eligible, the individual will be enrolled into the demonstration and offered coverage as outlined below in Sections V and VII of the STCs. Eligible individuals will be sent an approval notice and information about coverage, including notice that that non-emergency coverage is limited to services provided by the CCHHS provider network unless given prior authorization.

The state must first screen demonstration applicants to determine if they may be eligible under the Medicaid or CHIP state plans. If so, the state must treat the demonstration application as an application for Medicaid or CHIP, and use information submitted on the demonstration application for that purpose.

Individuals who present at DHS offices located in Cook County will be screened for demonstration eligibility and will be provided assistance in applying for the demonstration.

20. **Notice to CMS for Eligibility Determination Process Changes.** The income counting methodologies used in the demonstration, including income disregards, will be the income counting methodologies used for parent coverage under the Medicaid state plan. In the future, the state may use different income counting methods for purposes of the demonstration relative to other Medicaid populations covered in the state such as using the modified adjusted gross income-based (MAGI-based) eligibility determination methods as described in section 1902(e)(14) for the demonstration population, to the extent the methodology does not disadvantage an individual. As the state develops its eligibility systems to make MAGI-based income eligibility determinations, the state must notify CMS how eligibility determinations for the demonstration will be revised to use MAGI-based income methodologies and when changes will be implemented.
21. **Eligibility Period.** An individual who meets program eligibility criteria can be determined eligible through December 31, 2013.
22. **Retroactive Eligibility.** Retroactive eligibility for services provided at CCHHS facilities prior to the month of application as provided for under the approved Medicaid state plan applies to demonstration-eligible individuals. During the three month retroactive eligibility period, CCHHS will be paid based on the fee-for-service reimbursement rates applicable under the Medicaid state plan, which will be reconciled to actual cost when the interim rates otherwise paid are reconciled to actual cost.
23. **Eligibility Redeterminations.** Individuals enrolled in the demonstration are expected to move into the newly eligible Medicaid low-income adult group beginning January 1, 2014.
 - a. A demonstration enrollee may apply for eligibility under the Medicaid or CHIP state plan at any time for any reason. The state must determine eligibility for Medicaid and CHIP and enroll individuals in programs for which they are found eligible.
 - b. As the state develops its eligibility systems to make determinations based on MAGI, redeterminations will be updated to allow for eligibility determinations using MAGI and enrollment to other Medicaid programs.
 - c. Redeterminations for demonstration enrollees (who are found eligible in 2012) may take place after a period of greater than 12 months.
 - d. For those individuals who are found eligible in 2012, eligibility must be redetermined prior to January 1, 2014, to ensure that individuals are properly enrolled in either Medicaid or Exchange coverage beginning in January 2014. Therefore, redeterminations for demonstration enrollees (who are found eligible in 2012) may take place after a period of greater than 12 months. An individual would not need to be redetermined if the period is less than 12 months.

24. **Disenrollment.** Demonstration enrollees will be disenrolled when circumstances change in accordance with Medicaid law and policy. Prior to disenrollment from the demonstration, the state must determine if an individual is eligible under any other basis/existing Medicaid category.

V. BENEFITS

25. **Benefits.** Demonstration enrollees must receive all approved demonstration services, listed below. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose.

Services	
Advanced Practice Nurse services	Laboratory and x-ray services
Targeted Case Management	Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies
Emergency Services (includes post-stabilization services)	Mental Health Services (including rehabilitation and clinic option)
EPSDT (for 19-21 year olds)	Nursing Facility Services (30 days) (covers post-hospitalization nursing home stays)
Family planning services and supplies	Podiatric Services (for diabetics)
FQHCs, RHCs and other Encounter rate clinic visits	Prescription Drugs
Home health agency visits	Physical, Occupational, Hearing and Speech Therapy Services
Hospice (and palliative)	Physician services
Hospital emergency room visits	Sub-acute alcoholism and substance use disorder services
Hospital inpatient services	Transportation - to secure Covered Services
Hospital ambulatory services	

VI. COST SHARING

26. **Cost Sharing.** All demonstration enrollees will be subject to cost-sharing up to cost-sharing levels applied under the Medicaid state plan. The state ensures that any cost-sharing will be nominal, as stipulated in 42 C.F.R 447.54. Standard Medicaid exemptions from cost-sharing, such as family planning services, as stipulated in 42 C.F.R. 447(b) apply to the demonstration.

VII. DELIVERY SYSTEMS

27. **Patient Centered Medical Homes.** The CCHHS will establish Patient Centered Medical Homes to provide high-quality, coordinated care and case-management to demonstration enrollees. Individuals will be encouraged to elect a CCHHS network PCMH at the initial date of enrollment. The participant has the option, at any time, to elect a different PCMH or a different primary care provider within a different PCMH. Individuals that do not have

a relationship with a primary care provider or who have not elected a PCMH will be contacted three times by phone to confirm a primary care provider or PCMH. If the individual cannot be reached, a primary care provider and PCMH will be assigned to that individual based on their location or historical use of a provider. Individuals who are assigned to a primary care provider and PCMH will continue to have the option to elect another primary care provider, in the network, at any time. The PCMH is charged with assisting individuals in coordinating care and assisting the participant in obtaining care that will improve health outcomes.

28. **Role of CCHHS and its Community Partners.** The CCHHS and its community partners are charged with assisting individuals in coordinating care, improving health outcomes, and assisting enrollees in selecting a PCMH. The CCHHS manages the primary care provider network and is required to contract with community partners to ensure adequate access to PCMHs and covered benefits. In addition to managing a network of primary care providers, CCHHS must establish a network of specialists and ancillary providers.
29. **Provider Reimbursement.** The state is responsible for making payments to CCHHS which will be paid an interim per member per month (PMPM). CCHHS will be responsible for paying all providers for covered services under the demonstration. Provider rates paid by CCHHS will not exceed, in the aggregate, the rates that would be otherwise payable under the state plan for the covered services furnished to the enrolled population. The PMPM payment to CCHHS will begin as of the month of application for individuals determined eligible for the demonstration. Within 6 months following the end of calendar year 2013, CCHHS must submit "Cook County Care Section 1115 Demonstration" preliminary cost reports to the state detailing the actual cost of furnishing covered services, consistent with OMB and Medicare cost reporting principles. Within 150 days after the submission of such preliminary cost reports, the state must reconcile the interim PMPM to the preliminary actual CCHHS cost. As detailed in Attachment C, the state must submit the findings of the cost analysis to CMS within 150 days of the submission of the cost reports and no later than November 30, 2014.

Allowable service costs for CCHHS include only costs for demonstration benefits furnished to demonstration-eligible individuals that are provided either directly by CCHHS itself or by primary care providers, specialists, and ancillary providers that have contracted to be a network provider within the CCHHS network. Out of network services are covered in two instances: 1) Services associated with an emergency condition; and 2) Prior-approved medically necessary services. Prior approval for medically necessary services will be granted whenever the individual cannot obtain timely access to the services within the network because of network capacity limitations, need for specialized expertise, or to ensure continuity of care for ongoing treatment.

To the extent that CCHHS includes FQHCs in its network, payment to FQHCs will not be less than the level and amount of payment which CCHHS would make if the service were furnished by a non-FQHC provider, and the state is responsible to make supplemental payments to Federally Qualified Health Centers which they would be entitled to if CCHHS were a managed care provider, consistent with section 1902(bb)(5) of the Social Security

Act. CCHHS may also include the costs it incurs for outstation eligibility staff and these costs must be claimed at the administrative services matching rate of 50 percent.

If the interim PMPM, or other expenditures claimed by CCHHS exceed actual expenditures, the state anticipates that it will collect the amount in excess of actual expenditures from CCHHS within 150 days. The state must properly credit the federal share of any such excess payments to the federal government upon receipt of repayment but no later than December 31, 2014, regardless of receipt of repayment.

If expenditures claimed by CCHHS were understated and there are no budget neutrality restrictions, the state may make additional payment to CCHHS in the amount of such understatement. The state may draw down the federal share of any such payments from the Federal government at the time of the additional payment. Additional detail regarding the interim and final reconciliations can be found in Attachment C: "Interim and Final Cost Settlement Protocol."

A description of the timeframes appears below:

Deadline	Deliverable
12/31/2013	Expiration of demonstration
06/30/2014 (6 months after the expiration of the demonstration)	CCHHS must submit the demonstration cost reports to the state
150 days after submission of the interim cost reports and no later than 11/30/2014	State must reconcile the interim PMPM to actual CCHHS cost based interim cost report
150 days after submission of the interim cost reports and no later than 11/30/2014	State submits findings of interim reconciliation cost analysis to CMS
No later than 11/30/2014	State should recover any overpayments from CCHHS based on the interim reconciliation
No later than 12/31/2014	State must provide any overpayments back to the federal government based on the interim reconciliation
No later than 12/31/2014 (12 months after the expiration of the demonstration).	CCHHS must submit the clean, finalized demonstration cost reports to the state
150 days after submission of the clean, final cost reports and no later than 05/31/2015	State must perform the final cost reconciliation
150 days after the submission of the final cost reports and no later than 05/31/2015	State submits findings of the final cost reconciliation to CMS
No later than 05/31/2015	State should recover any overpayments from CCHHS based on the final cost reconciliation
No later than 06/30/2015	State must provide any overpayments back to the federal government based on the final cost reconciliation

30. **Network Requirements.** The state must ensure the service delivery system is sufficient to provide enrollees with access to all covered benefits. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. Services must be delivered in a culturally competent manner and consistent with all requirements under the Americans with Disabilities Act, and all requirements related to serving individuals with limited English proficiency. If a demonstration participant needs a service that is outside the demonstration benefit package, the provider must educate the demonstration participant on where s/he may receive the service. Providers must refer the demonstration enrollee to other providers to assure benefits can be received.

At minimum, reasonably prompt access to care must include:

- a. Routine, preventive care appointments available within 5 weeks
 - b. Urgent, non-emergency appointments are triaged and provided within 24 hours ;
 - c. Appointments for enrollee problems or complaints available within 3 weeks from the date of request for such care;
 - d. Upon notification of enrollee hospitalization or of an ER visit, any follow-up appointment available within the earlier of 7 days after discharge or a date specified in the hospital discharge plan; and,
 - e. Enrollees have access to a provider through an answering service, paging mechanism or other arrangement for coverage 24 hours a day, 7 days a week (24/7).
31. **Demonstrating Network Adequacy.** The state must provide updates on the CCHHS network including community partners in each quarterly report, consistent with the requirements of STC 37. Every six months, each CCHHS network provider must provide adequate assurances that it has sufficient capacity to serve the expected enrollment. For primary care providers, the provider to patient ratio will be the same as the state's Primary Care Case Management Program, Illinois Health Connect, standards. In addition, the CCHHS network must have urgent care clinics open at 3 regional campuses 365 days per year.
32. **Delivery System and Access to Care Monitoring.** The state and CCHHS must monitor and evaluate the sufficiency of the CCHHS delivery system for demonstration enrollees including the need for and access to comprehensive health care services at both the CCHHS facilities and their community partners. Monitoring activities must be reported quarterly (within 45 days of the ending of the calendar quarter) and must include:
- a. A tracking of demonstration enrollee volumes at all CCHHS and community partner facilities including a comparison to historical volumes; and,
 - b. A reporting of clinic wait times for primary care, physician specialty care, and outpatient services.

VIII. GENERAL REPORTING REQUIREMENTS

33. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX set forth in Section IX of these STCs.

34. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section X of these STCs.
35. **Quarterly Calls.** The state must participate in monitoring calls with CMS. 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, CCHHS operations (such as network adequacy, assignment of a PCMH, contract amendments, and rate certifications), health care delivery, enrollment, proposed or implemented changes to the enrollment limit and/or state-specified income eligibility standard, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes in payment rates, CCHHS and community partner financial performance that is relevant to the demonstration, role of the evaluators progress, state legislative developments, any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.
36. **Quarterly Reports.** The state must submit progress reports in the format specified 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. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, CCHHS and community partner operations (such as network adequacy, assignment of a PCMH, contract amendments and rate certifications); health care delivery; benefits; enrollment; grievances; quality of care; access; proposed changes to payment rates; proposed or implemented changes to the enrollment limit and/or state-specified income eligibility standard; pertinent legislative activity; and other operational issues;
 - c. Action plans for addressing any policy and administrative issues identified;
 - d. Quarterly enrollment reports that include the member months, in addition to end of quarter and point-in-time enrollment for each demonstration population and other statistical reports listed in Attachment A;
 - e. Comparison of the demonstration enrollees actual PMPM costs with the projected PMPM costs of the approved proposal.
 - f. Updates on improvements to the CCHHS provider network and community partners as

stipulated in STC 29;

- g. Updates on the number of demonstration enrollees who have been enrolled into a PCMH;
- h. Progress updates to the Transition Plan as specified in STC 15, including how the state will reduce the time that the Expansion Population must wait before receiving benefits; and
- i. Evaluation activities and interim findings.

37. **Annual Report.** The annual report must include, at a minimum, the requirements outlined below. The state must submit the draft annual report no later than 120 days after the close of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

- a. All items included in the quarterly report pursuant to STC 39 must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and
- c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement.

38. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS's comments.

IX. GENERAL FINANCIAL REQUIREMENTS

39. **Quarterly Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX of the STCs.

40. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Illinois must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine

CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).

- b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
 - c. Premium and Cost Sharing Contributions. Applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64Narr by demonstration year.
 - d. Pharmacy Rebates. Providers under this demonstration are participants in the 340B program, therefore pharmacy rebates will not apply to the demonstration. If there is a change from this position, rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.
 - e. Use of Waiver Forms. For each demonstration year, a separate Form CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name "Adults" to report expenditures for the demonstration population. The waiver name "Adults" must be used to identify these separate forms CMS-64.9 Waiver and/or 64.9P Waiver expenditures should be allocated to these forms based on the guidance found below.
41. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures related to the demonstration benefit package described in Section V of the STCs provided to individuals who are enrolled in this demonstration as described in Section IV of the STCs. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on forms CMS-64.9 Waiver and /or 64.9P Waiver.
42. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 Waiver and/or 64.10P Waiver.
43. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in

which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver form in order to properly account for these expenditures in determining budget neutrality.

44. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:

- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 39, the actual number of eligible member months for the demonstration population. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

- b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

45. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. Illinois must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

46. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section X of the STCs:

- a. Administrative costs, including those associated with the administration of the demonstration;

- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Net medical assistance expenditures made under section 1115 demonstration authority.

47. **Sources of Non-Federal Share.** The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

48. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

- e. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.
- 49. **Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.
- 50. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

X. MONITORING BUDGET NEUTRALITY

- 51. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS's assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
- 52. **Risk.** Illinois shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not for the number of demonstration eligibles. Because CMS provides FFP for all demonstration eligibles, Illinois shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Illinois at risk for the per capita costs for current, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.
- 53. **Demonstration Population Used to Calculate the Budget Neutrality Expenditure Cap.** The following describes the method for calculating the budget neutrality expenditure cap for the demonstration:
 - a. For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group (EG) described as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under STC 44 for the demonstration

population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (ii) below.

- ii. The PMPM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility group subject to the budget neutrality agreement under this demonstration are specified below. A PMPM was constructed based on state historical expenditure data. The trend rate and PMPM amounts for the demonstration population are shown below. The demonstration population is a “pass-through” or “hypothetical” population. Therefore, the state may not derive savings from this population.

Eligibility Group	Growth Rate	DY 1 Date of approval letter through 12/31/2012 PMPM	DY 2 01/01/2013 through 12/31/2013 PMPM
County Care	.56%	\$625.45	\$628.96

- iii. The annual budget neutrality expenditure cap for the demonstration as a whole is the sum of the projected annual expenditure cap for the demonstration population calculated in subparagraph (i) above.
- b. Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the extension approval period, as reported on the forms listed in STC 40(e) above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.
 - c. The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a)(iii). The federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration population described in STC 40(e) during the demonstration period reported in accordance with STC 40.
54. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.
55. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of

the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

<u>Demonstration Year</u>	<u>Cumulative Expenditure Cap Definition</u>	<u>Percentage</u>
Year 1	Budget neutrality expenditure cap plus	1 percent
Years 1 and 2	Combined budget neutrality expenditure caps plus	0 percent

56. **Exceeding Budget Neutrality.** If, at the end of this demonstration period, the cumulative budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XI. EVALUATION OF THE DEMONSTRATION

57. **Submission of Draft Evaluation Design.** The state shall submit to CMS for approval within 120 calendar days from the award of the demonstration extension a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the demonstration. The draft design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall 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.

- a. Domain of Focus. The Evaluation Design must, at a minimum, address the research questions/topics listed below and the goals of the demonstration as outlined in Section II of the STCs. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.
 - i. The impact of the demonstration in covering the uninsured in the County, including the estimated numbers of eligible uninsured individuals who did and did not enroll in the demonstration;
 - ii. The number of demonstration-enrolled individuals accessing health care services in comparison to the number of demonstration-eligible individuals in need of services;
 - iii. The state must address the following evaluation questions and topics in the draft evaluation plan:
 1. How has the demonstration bridged the gap in moving toward Medicaid coverage required under the Affordable Care Act;
 2. How has the demonstration addressed unmet healthcare needs and provided a regular source of coordinated care for enrollees;

3. How has the demonstration influenced health seeking behavior in a manner that could help manage costs in 2014;
 4. How has the demonstration informed the state's progress in understanding the service utilization and costs to prepare for 2014;
 5. How effective have the PCMHs been in providing high-quality, coordinated care? (The state must propose quality measures that would be used to evaluate the effectiveness of the PCMHs);
 6. How has the demonstration informed the state's payment methodology as it prepares establish capitated rates for its entire Medicaid population?
- iv. The limitations, challenges, opportunities and best practices in provider capacity and care delivery for the demonstration population to aid in preparation for coverage expansions pursuant to the Affordable Care Act.
 - v. An analysis of service utilization and trends identified over time;
 - vi. The decrease in uncompensated care provided by hospitals and federally qualified health centers (FQHCs) serving individuals who would have received discounted medical services through the CCHHS in the absence of the demonstration;
 - vii. The number of demonstration-enrolled individuals who would have received discounted medical services through CCHHS participating hospitals and FQHCs in the absence of the demonstration;
 - viii. The cost-effectiveness and efficiency of the demonstration program in ensuring that appropriate health care services are provided in a cost-effective and coordinated fashion;
 - ix. Provider network capacity to serve the health care needs of the demonstration population; and
 - x. Trends in beneficiary needs for the demonstration population to aid in preparation for coverage expansions pursuant to the Affordable Care Act.

58. 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 its request for each subsequent renewal.

59. Final Evaluation Design and Implementation. CMS shall provide comments on the draft evaluation design described in STC 59 within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation report within 120 days after 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's comments.

60. Cooperation with CMS Evaluators. Should CMS conduct 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 the contractor or CMS.

XII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date - Specific	Deliverable	STC Reference
120 days from date of award letter	Submit Draft Evaluation Plan	STC 57
60 days of receipt of CMS comments	Submit Final Evaluation Plan	STC 59
07/13/2013	Submit Draft Transition Plan	STC 15
Annually	Deliverable	STC Reference
120 days after the close of the DY	Draft Annual Report	STC 37
30 days following receipt of CMS comments	Final Annual Report	STC 38
Each Quarter	Deliverable	STC Reference
60 days after the close of the quarter	Quarterly Operational Reports	STC 36
	CMS-64 Reports	STC 39

ATTACHMENT A

Quarterly Report Content and Format

Under STC 36, 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. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Illinois/Cook County Care

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 1 (Date of approval letter through 12/31/2012)

Federal Fiscal Quarter: 1 (01/01/2013 through 12/31/2013)

I. Introduction

Information describing the goals of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

II. 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”.

A. Enrollment Counts

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

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	Disenrolled in Current Quarter
<u>County Care</u>		

B. Enrollment

Summarize what the current enrollment within the demonstration.

C. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities or findings related to the collection and verification of

ATTACHMENT A

Quarterly Report Content and Format

encounter and enrollment data.

III. Benefits Information

Discuss any changes or anticipated changes in populations served and benefits, including any implemented or proposed changes to the state plan benefits or covered mental health diagnosis for eligible individuals to receive behavioral health services.

IV. Assignment of a Primary Care Medical Home

Summarize CCHHS activities related to assignment of new enrollees to a PCMH and complete the following chart:

Demonstration Populations	New Enrollees for the Quarter	New Enrollees Who Choose a PCMH	New Enrollees Assigned to a PCMH
<u>County Care</u>			

V. Updates on Additional Community Partners

Provide a list of any additional Community Partners that have joined the demonstration delivery system.

VI. Outreach/Innovative Activities

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

VII. Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, CCHHS operations (such as network adequacy, assignment of a PCMH, contract amendments and rate certifications); approval and contracting with new plans; health care delivery; benefits; enrollment; grievances; quality of care; access; proposed changes to payment rates; proposed or implemented changes to the enrollment limit and/or state-specified income eligibility standard; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; and other operational issues.

Summarize the development, implementation, and administration of any action plans for addressing issues related to the demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

VIII. Expenditure Containment Initiatives

Identify all current activities, by program and or demonstration population. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

ATTACHMENT A

Quarterly Report Content and Format

IX. Budget Neutrality

A. Financial/Budget Neutrality Development/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.

B. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

i. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
County Care				

Eligibility Group	Total Member Months for the Quarter	PMPM	Total Expenditures (Member months multiplied by PMPM)
County Care			

X. 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. Also discuss feedback received from enrollees and consumer groups.

XI. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

XII. Demonstration Evaluation

Discuss progress of evaluation design and planning.

XIII. Transition Plan

Pursuant to STC 15 provide updates on the state’s work related to the transition plan consistent with the provisions of the Affordable Care Act, for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of enrolled individuals to a coverage option.

XIV. Additional Information

A. Enclosures/Attachments

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

ATTACHMENT A

Quarterly Report Content and Format

B. State Contact(s)

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

C. Date Submitted to CMS

ATTACHMENT B

Administrative Cost Claiming Rules and Protocol

Administrative Cost Claiming Rules and Protocol for Cook County Health and Hospital Systems Bridge and the Illinois Department of Healthcare and Family Services

I. Preface

As part of the total amount payable under the demonstration authority granted under section 1115(a)(2) of the Social Security Act (the Act) by the Centers for Medicare & Medicaid Services (CMS) to the Illinois Department of Healthcare and Family Services (the single state agency) and their partner Cook County Health and Hospital System (CCHHS), Federal Financial Participation (FFP) as authorized by 42 Code of Federal Regulations (CFR) 433.15 is available to CCHHS at the 50 percent rate for expenditures required for “proper and efficient” administration of the demonstration, subject to the limitations outlined below.

The following guidance and protocols are based on and in response to information submitted in writing or otherwise communicated to CMS and are provided to inform the state and assist the state in its efforts to comply with the rules and protocols regarding claiming of FFP for administrative expenditures incurred by the state and/or its contractors under this demonstration.

a. General Requirements

The state must comply with all federal statute, regulations and guidance for all claims for FFP.

In order for the costs of administrative activities to be claimed as Medicaid administrative expenditures at the 50 percent FFP rate, the following requirements must be met:

- Costs must be “necessary for the proper and efficient administration of the Medicaid state Plan” (Section 1903(a)(7) of the Social Security Act).
- If applicable, costs must be allocated in accordance with the relative benefits received by all programs, not just Medicaid.
- Claims for costs must not duplicate costs that have been, or should have been, paid through another source.
- State or local governmental agency costs must be supported by an allocation methodology under the applicable approved public assistance Cost Allocation Plan (42 CFR 433.34).
- Costs must not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- Costs must not include the overhead costs of operating a provider facility or otherwise include costs of a direct service to beneficiaries (these should be claimed as service costs, not plan administration).
- Costs must not duplicate activities that are already being offered or should be provided by other entities, or through other programs.
- Costs must be supported by adequate source documentation.
- Costs must not be federally-funded or used for any other federal matching purposes.

ATTACHMENT B

Administrative Cost Claiming Rules and Protocol

b. Memorandum of Understanding (MOU Agreement)/Contract

Because only the single state Medicaid agency (Illinois Department of Healthcare and Family Services) may submit a claim to CMS to receive FFP for allowable and properly allocated Medicaid costs, every participating entity that is performing administrative activities on behalf of the Medicaid program must be covered, through an MOU/contract. These MOUs/contracts must be in effect before the state Medicaid agency may claim federal matching funds for any and all administrative activities conducted on the Medicaid agency's behalf by the CCHHS. CCHHS will be entering into multiple contracts, including one with a Third Party Administrator (TPA) contractor and another with an Application Assistance contractor. As the single state Medicaid agency, Illinois Department of Healthcare and Family Services will maintain ultimate responsibility for assuring compliance with all federal requirements in the administration of this demonstration and will have access to all information needed to insure oversight and compliance with the demonstration and all federal regulations.

In order to provide a basis for FFP to be claimed, these contracts and agreements must describe and define the relationships between the state Medicaid agency, CCHHS and the contractors (TPA and Application Assistance) and must define the details regarding the scope of the activities being performed once the contractors have been selected. The contracts must include:

- Mutual objectives of the agreement;
- Responsibilities of all the parties to the agreement;
- Activities or services each party to the agreement offers and under what circumstances;
- Cooperative and collaborative relationships at the state and local levels;
- Specific methodology to be approved by CMS for computation of the claim, by reference or inclusion;
- Methods for reimbursement, exchange of reports and documentation, and liaison between the parties, including designation of state and local liaison staff.

These contracts must identify the scope of activities and services to be provided to the state Medicaid agency and CCHHS including any related reimbursement and funding mechanisms, and define the responsibilities of all parties, including the Medicaid agency's oversight and monitoring activities. All participation requirements should be detailed in the contractual agreements. Maintenance of records, participation in audits, designation of local project coordinators, training timetables and criteria, and submission of fiscal information are all important elements are examples of the required elements of this agreement. Also, the specific methodologies to be employed, the mechanism for filing the claim, and the allocation methodology to identify Medicaid costs and other sources of funding should be identified.

This agreement also requires the governmental agency that performs the administrative activities on behalf of the Medicaid agency to provide funding for the state matching funds required for Medicaid administrative claiming. As always, the non-federal share of the Medicaid payments must be derived from permissible sources as indicated in the STCs and must comply with federal

ATTACHMENT B

Administrative Cost Claiming Rules and Protocol

regulations and policy. (Illinois has indicated that the source of funding is an intergovernmental transfer.)

c. Identification, Documentation and Allocation of Costs

All administrative costs (direct and indirect) are normally charged to federal grant awards such as Medicaid through the state's public assistance Cost Allocation Plan (CAP). Federal regulations (42 CFR 433.34) require that under the Medicaid state plan, the single state agency have an approved public assistance CAP on file with the Division of Cost Allocation in the U.S. Department of Health and Human Services that meets regulatory requirements specified at Subpart E of 45 CFR part 95 and referenced in OMB Circular A-87.

The public assistance CAP, which a state Medicaid agency must submit and update to ensure that costs are properly allocated between Medicaid and non-Medicaid before claiming FFP for administrative expenditures, must detail the methodologies, claiming mechanisms, contractual arrangements and/or interagency agreements, and other relevant issues pertinent to the allocation of costs and submission of claims by the participating entities.

Documentation for administrative activities must clearly demonstrate that the activities directly support the administration of the state Medicaid program. In accordance with the statute, the regulations, and the Medicaid state plan, the state is required to maintain/retain adequate source documentation to support Medicaid payments. The basis for this requirement can be found in statute and regulations. See section 1902(a)(4) of the Act and 42 CFR 431.17; see also 45 CFR 92.20(b) and 42 CFR 433.32(a) (requiring source documentation to support accounting records) and 45 CFR 92.42 and 42 CFR 433.32(b and c) (retention period for records). The records must be made available for review by state and federal staff upon request during normal working hours (section 1902(a) (4) of the Act, implemented at 42 CFR 431.17).

When states submit claims for FFP for Medicaid administration, only costs directly related to Medicaid administration are allowable and these costs must be allocated according to accepted cost principles. Since most administrative activities are provided both to Medicaid and non-Medicaid eligible individuals, the costs applicable to these activities must be appropriately allocated to each group.

d. Administrative FFP for Skilled Professional Medical Personnel

In addition to the 50 percent federal Medicaid administrative matching rate, Section 1903(a)(2) of the Act provides for FFP at 75 percent for expenditures attributable to the compensation and training of skilled professional medical personnel (SPMP) of the state agency (See also 42 CFR 432.2, 432.45, 432.50 and 433.15.)

The state has not identified to CMS any activities under this section 1115 demonstration that are reimbursable at the enhanced 75 percent SPMP matching rate.

ATTACHMENT B

Administrative Cost Claiming Rules and Protocol

Note: Administrative costs incurred that are an integral part of, or an extension of, the provision of services by medical providers, may only be reimbursed as a component of the rate paid by the state or its fiscal agent for the medical service. There is no additional FFP available.

II. General Conditions

The state Medicaid agency for Illinois and CCHHS must:

1. Submit the TPA and application assistance contracts to CMS for review once vendors are selected to identify all administrative costs to be included under the section 1115 demonstration.
2. Identify all costs reflected in the administrative cost claiming budget (including the interim administrative support services, facility, management support costs) to be included as administrative expenditures in this demonstration, provide a detailed narrative description of all administrative costs for CMS review, and provide details of other sources of funding or other program costs.
3. Obtain prior approval from CMS for changes to the methodology used to capture or claim FFP for administrative costs associated with the demonstration.
4. Describe how they will offset other revenue sources for administrative expenditures associated with the demonstration, if applicable.
5. Obtain prior approval for any new categories for administrative expenditures to be claimed under the demonstration.
6. Agree to permit CMS to review any forms and/or contract modifications that are subsequently developed for use by this program, prior to modification or execution.
7. Submit all necessary changes for administrative expenditures to CMS for review and approval prior to implementation.
8. Submit copies of signed contracts with all parties for administrative expenditures to CMS including detailed budget and budget narratives.

ATTACHMENT C

Interim and Final Cost Settlement Protocol

Interim Reconciliation to As-Filed Cost Report

CCHHS' interim PMPM cost payments must be reconciled to actual cost of the demonstration based on the "Cook County Care Section 1115 Demonstration" cost reports established from the individual CCHHS as-filed CMS-2552 reports for the expenditure year. If, at the end of the interim reconciliation process, it is determined that expenditures claimed were overstated, the overpayment must be properly credited to the Federal government. If, at the end of the interim reconciliation process, it is determined that expenditures claimed were understated and there are no budget neutrality restrictions, the underpayment must be properly debited to the Federal government.

The interim reconciliation is based on the "Cook County Care Section 1115 Demonstration" cost report which is established from the as-filed cost reports (filed to the Medicare contractor) for the expenditure period. The supplemental as-filed system cost report will include all costs associated with providing care under the demonstration.

The state will perform this interim reconciliation within 5 months from the filing of the "Cook County Care section 1115 demonstration" cost reports for the expenditure period.

Final Reconciliation to Finalized Cost Report

CCHHS' interim PMPM cost payments will be reconciled to actual cost based on its "Cook County Care Section 1115 Demonstration" cost reports and will be updated to include data based on the individual CCHHS finalized CMS-2552 reports for the expenditure year. If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The final reconciliation will be established from the consolidated CCHHS' allowable cost on its "Cook County Care Section 1115 Demonstration" cost report which is based on the finalized cost reports (finalized/settled by the Medicare contractor with the issuance of a Notice of Provider Reimbursement or a revised Notice of Provider Reimbursement) for the expenditure period. The "Cook County Section 1115 Demonstration" finalized system cost report will include all costs associated with providing care under the demonstration.

For the final reconciliation, the demonstration days and charges must be tied to State Paid Claims Listing (SPCL) paid claims reports, with no further claim lag adjustments. The state will perform this final reconciliation within six months from the finalization of the individual cost reports for the expenditure period (issuance of notice of program reimbursement of the applicable Medicare costs for CCHHS).

If at the end of the final reconciliation process, the state determines that expenditures claimed were overstated, the federal share of the overpayment must be properly credited to the Federal government. If, at the end of the final reconciliation process, the state determines that expenditures claimed were understated and there are no budget neutrality restrictions, the state shall make payment to CCHHS and may draw down the federal share of the payment from the federal government.