

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

NUMBER: 11-W-0000-5/4

TITLE: Kentucky Health Care Partnership

AWARDEE: Kentucky Cabinet for Health and Family Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Kentucky Health Care Partnership section 1115(a) Medicaid Demonstration (hereinafter “Demonstration”). The parties to this agreement are the Kentucky Cabinet for Health 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. This Demonstration renewal is approved through October 31, 2011.

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Kentucky Health Care Partnership Demonstration was implemented on November 1, 1997. The Demonstration provides services for Medicaid beneficiaries in the city of Louisville, Jefferson County, and the 15 surrounding counties. Most non-institutionalized Medicaid beneficiaries are enrolled in the Demonstration.

Beneficiaries receive a comprehensive benefit package that is comparable to benefits and services available under the Medicaid State plan. Services are delivered through a single managed care plan known as the Passport Health Plan (PHP). Any willing provider may participate in the PHP. The primary objective of the Demonstration is to improve access to health care and needed services for the beneficiaries, and to test the feasibility of providing services through a single managed care entity.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The State agrees that it must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil

Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

- 2. Compliance with Medicaid and State Children’s Health Insurance Program (SCHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and SCHIP programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part, must apply to the Demonstration.
- 3. Changes in Medicaid and SCHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or SCHIP programs that occur during this Demonstration approval period, unless the provision being changed is explicitly waived under the STCs herein governing the Demonstration.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement and allotment neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreements would 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 earlier of: the day such State legislation becomes effective, or the first day such legislation was required to be in effect under Federal law.
- 5. State Plan Amendments (SPAs).** The State will not be required to submit title XIX or title XXI SPAs for changes to any populations made eligible solely through the Demonstration. If a population covered through the Medicaid or SCHIP State plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State plan is required, except as otherwise noted in these STCs.
- 6. Changes Subject to the Amendment Process.** Demonstration provisions related to eligibility, enrollment, benefits, delivery systems, cost sharing, family planning services covered under this Demonstration, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7.

- 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. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:
- a) An explanation of the public process used by the State consistent with the requirements of paragraph 15 to reach a decision regarding the requested amendment;
 - b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
 - c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI SPA; and
 - d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.
- 8. Extension of the Demonstration.** States that intend to request Demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension proposal or a phase-out plan consistent with the requirements of paragraph 9. The State must also provide an interim evaluation report for the current approval period along with the extension proposal, pursuant to Section IX, paragraph 50.
- 9. Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

- 10. Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the waiver will not be renewed.
- 11. CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS shall 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 CMS' finding that the State materially failed to comply.
- 13. Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or XXI. CMS must promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.
- 14. Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.
- 15. Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration, including, but not limited to those referenced in paragraph 6, are proposed by the State.
- 16. Compliance with Managed Care Regulations.** The State must comply with the managed care regulations at 42 CFR section 438 *et. seq.*, except as expressly waived or identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR section 438.6.
- 17. Federal Funds Participation.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY, BENEFITS AND COST SHARING

The Partnership Demonstration provides coverage for most non-institutionalized Medicaid beneficiaries in the City of Louisville, Jefferson County, and the surrounding 15 counties (demonstration area). Beneficiaries receive a comprehensive benefit package that corresponds to the Medicaid State plan. Partnership participants are subject to the same cost-sharing requirements as the Medicaid State plan.

18. Partnership Demonstration Participants. Mandatory and Optional State plan groups described below, who are eligible under the current approved State plan reside in the demonstration area, participate in the demonstration. All applicable Medicaid laws and regulations apply with respect to such participants, except as expressly waived through the waiver authorities for this Demonstration. Each new participant shall have an initial 6 months guaranteed eligibility to receive Partnership services regardless of loss of eligibility for Medicaid during the 6-month period, provided the participant continues to reside in the Partnership region, is not incarcerated or deceased, and is not disenrolled from the Partnership by the State.

Mandatory State Plan Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Demonstration Population
Infants under age 1	Up to 133 % of the Federal Poverty Level (FPL)	2
Children 1-5	Up to 133% of the FPL	2
Children 6-18	Up to 100% of the FPL	2
Children under the age of 21 and in a psychiatric residential treatment facility.	Up to 300% of the SSI benefit limit	2
Children under the age of 18, placed in foster care as defined in State eligibility regulations.	Up to 100% of the FPL	2
Children under the age of 18, adopted and having special needs.	Up to 100% of the FPL	2
Blind/Disabled Children	Up to the Medically Needy scale	3
Pregnant women	Up to 133% of the FPL	1
Section 1931 adults	Up to AFDC Income Level	1
Kentucky Transitional Assistance Program (K-Tap)	Up to AFDC Income Level - Adults	1
	Up to AFDC Income Level - Children	2
Blind/Disabled Adults Without SSI	Up to State Supplementation Standards, SSI limit, or Medically Needy scale	3
Aged and Related Populations	Up to State Supplementation Standards, SSI limit, or Medically Needy scale	3
Medicare Dual Eligibles (QMB Plus, SLMB Plus, and Medicaid Only)	100% of the FPL, 120% of the FPL, or up to 300% of the SSI benefit amount	3
Optional State Plan Groups		
Infants under age 1	Up to 185% of the FPL	2
Pregnant Woman	Up to 185% of the FPL	1

The following individuals are excluded from participation in the demonstration:

Individuals who must spend down to meet eligibility income criteria
Individuals currently Medicaid eligible who have been in a nursing facility for more than thirty-one (31) days.
Individuals determined eligible for Medicaid due to a nursing facility admission, including those individuals eligible for institutionalized hospice.
Individuals served under the alternate intermediate services, mental retardation or developmental disabilities (AIS-MR-DD), home and community-based, or other Medicaid waivers.
Qualified MEDICARE beneficiaries (QMBs), specified low income Medicare beneficiaries (SLMBs), or qualified disabled working individuals (QDWIs).
Individuals in an intermediate care facility for mentally retarded (ICF-MR)
Individuals who are inpatients in a psychiatric facility, excluding a PRTEF.
Individuals who are eligible for the Breast or Cervical Cancer Treatment Program

19. Eligibility Determination. To reflect a policy of family responsibility, the State considers the income of each member of the family unit (including any Medicaid eligible members) for purposes of determining countable income for Partnership demonstration participants. The family unit includes the applicant, any individual who has financial responsibility for the applicant, and any other individual residing with the applicant for whom an individual in the family unit has responsibility. Countable income therefore includes the income of the applicant as well as that of the following family members who reside in the household:

- a) Individuals for whom the applicant has financial responsibility;
- b) Individuals who have financial responsibility for the applicant; and
- c) Any other individual for whom such individual in the second bullet above has financial responsibility. Note: the income of a step-parent who has financial responsibility is also included when determining eligibility for an applicant child.

20. Benefit Package. Partnership demonstration participants receive a comprehensive benefit package which includes all benefits under either the Global Choices Benefit Plan (for adults, foster children, and disabled and elderly), or the Family Choices Benefit Plan (for the majority of children) as provided under the Medicaid State plan. The Partnership benefit package also includes wellness, preventive services, and disease management services not available under the traditional State plan.

21. Enrollment Process. The State agrees to notify Partnership demonstration participants regarding eligibility changes. The notification to participants must meet the provisions of 42 CFR section 431.210.

22. Cost Sharing. The premium and co-payment amounts may not exceed those premium and co-payment limits for all populations in the Global Choices Benefit Plan and the Family Choices Benefit Plan as approved in the State plan. The State shall submit an amendment pursuant to items 6 and 7 under Section II, General Program Requirements,

should the State decide to implement different co-payments or premiums. Children under the age of 19 and pregnant women are not subject to co-payments or premiums.

V. DELIVERY SYSTEM

23. Limitation of Freedom of Choice. Partnership demonstration participants may be restricted to a choice of only one managed care organization (MCO).

24. Geographic Limitation. The State must not expand the Partnership Plan Demonstration beyond the geographic boundaries served by the Plan operating in the city of Louisville, Jefferson County, and the 15 surrounding counties.

25. Provider Access. The State must provide that MCOs under the Partnership Plan Demonstration allow participants to obtain services from any willing provider that will accept the standard MCO payment rate. Providers must meet licensure and regulatory requirements as established by the State.

26. Contracts. All contracts and modifications of existing contracts between the State and MCO must be approved by CMS prior to the effective date of the contract or modification of an existing contract. The State will provide CMS with a minimum of 30 days to review and approve changes. The Kentucky Cabinet for Health and Family Services will be responsible for ensuring MCO compliance with State and Federal statutes, regulations, Special Terms and Conditions, and waiver and expenditure authorities.

27. Contracting with Federally Qualified Health Centers (FQHCs). The State shall require health plans to contract with FQHCs. If an MCO can demonstrate to CMS and to the Kentucky Cabinet for Health and Family Services that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in all service areas without contracting with FQHCs, the plan may, with CMS approval, be relieved of this requirement. If the Partnership requests an exemption from the requirement that an MCO contract with FQHCs, the State must submit to CMS a report with the following information at least 60 days prior to submission of the final managed care contract for CMS approval.

- a.) The FQHCs in the affected service area, and a description of the Demonstration populations served and the services provided by the FQHCs prior to the Demonstration.
- b.) An analysis that the MCO has sufficient provider capacity to serve the participant populations currently receiving services at the FQHC. The analysis must include, but not be limited to, a listing of providers signed with the Partnership, capacity of each provider to take on additional Medicaid patients, geographic location of providers and description of accessibility for Medicaid patients to these providers. The MCO must inform the State if any of this information or data changes over the course of the Demonstration.

- c.) An analysis that the MCO will provide a comparable level of Medicaid services as the FQHC (as covered in the approved State Medicaid plan), including covered outreach, social support services, and the availability of culturally sensitive services, such as translators and training for medical and administrative staff. The analysis should describe the proximity of providers, and range of services as it relates to FQHC patients, to the extent these services are currently available through FQHCs in the service area.
- d.) To the extent that an MCO covers FQHC services, it must pay the FQHC(s) on either a capitated (risk) basis (with appropriate adjustments for risk factors) or on a cost-related basis. A description of the payment methodology used by each MCO shall be provided by the State. If during the Demonstration, the MCO changes its payment methodology to an FQHC, the changes must be submitted by the State to CMS for review and approval.

VI. GENERAL REPORTING REQUIREMENTS

- 28. General Financial Requirements.** The State shall comply with all General Financial Requirements under title XIX set forth in Section VII, General Financial Requirements Under Title XIX.
- 29. Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 *et. seq.* except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.
- 30. Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for Monitoring Budget Neutrality set forth in Section VIII.
- 31. Bi-Monthly Call.** CMS shall schedule bi-monthly conference calls with the State. The purpose of these calls is to discuss any significant actual, or anticipated developments, affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or SPAs 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.

32. Quarterly Operational 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 data along with an analysis of the various operational areas under the Demonstration. These quarterly reports must include, but are not limited to:

- a) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery including benefits, enrollment, grievances, quality of care, access, health plan financial performance that is relevant to the Demonstration, pertinent legislative activity, and other operational issues;
- b) Action plans for addressing any policy and administrative issues identified;
- c) Enrollment data, member month data, and budget neutrality monitoring tables; and
- d) Evaluation activities and interim findings.

33. Annual Report. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the operational reports required under paragraph 32. The State must submit the draft annual report no later than 120 days after the end of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

VII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

34. Quarterly Expenditure Reports. The State shall provide quarterly expenditure reports using the form CMS-64 to 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 VIII.

35. Reporting Expenditures Under the Demonstration. In order to track expenditures under this Demonstration, Kentucky must report Demonstration expenditures through the Medicaid and SCHIP Budget and Expenditure System (MBES/CBES), following routine Form CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension which indicates the Demonstration year in which services were rendered or for which capitation payments were paid).

- a) For each Demonstration year, starting November 1, 2008, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted reporting expenditures subject to the budget neutrality cap for the following Participant populations and services. The State must complete separate forms for the following Participant populations as described in paragraph 18:
 - i. Participant Population 1: Adults Eligibility Group (EG);
 - ii. Participant Population 2: Children EG; and
 - iii. Participant Population 3: Aged, Blind, and Disabled EG.
- b) The sum of the quarterly expenditures for all Demonstration years will represent the expenditures subject to the budget neutrality limit as defined in paragraph 46.
- c) For purposes of this section, the term “expenditures subject to the budget neutrality limit” must include all Medicaid expenditures on behalf of the individuals who are enrolled in the Demonstration. 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.
- d) 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.
- e) All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

- f) Premiums and other applicable cost-sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, both the total computable and Federal share amounts that are attributable to the Demonstration must be separately reported on the CMS-64 Narrative.

36. Reporting Member Months. The following describes the reporting of member months for the Participant populations:

- a) For the purpose of calculating the budget neutrality expenditure agreement and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 32, the actual number of eligible member months for the EGs defined in paragraph 35. 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 shall be subject to minor revisions for an additional 180 days after the end of each quarter; and
- 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.

37. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the Demonstration. Kentucky must estimate matchable Demonstration expenditures (total computable and Federal Share) subject to the budget neutrality expenditure agreement and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAPs) and State and Local Administrative Costs (ADM)s. 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.

38. 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 VIII:

- 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 State plan; and
- c) Net medical assistance expenditures made under section 1115 Demonstration authority, with dates of service during the Demonstration extension period.

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

- a) CMS may review the sources of the non-Federal share of funding for the Demonstration at any time. Kentucky agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

40. 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; and
- d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of

government within the State. Any transfers from governmentally-operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

- e) Nothing in these STCs concerning certification of public expenditures relieves the State of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

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

VIII. MONITORING BUDGET NEUTRALITY

42. Limit on Title XIX Funding. Kentucky 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. The budget neutrality expenditure targets 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' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

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

44. Participant Populations Subject to the Budget Neutrality Agreement. The following Participant populations are subject to the budget neutrality agreement and are incorporated into the Demonstration EGs used to calculate budget neutrality.

- a) **EG 1: Adults** – Population 1
- b) **EG 2: Children** – Population 2

c) **EG 3: Aged, Blind, and Disabled** – Population 3

45. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit for the Demonstration.

- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for the EG described in paragraph 44 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 paragraph 36, for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below;
 - ii. The PMPM costs in subparagraph (iii) below are net of premiums paid by Demonstration eligibles; and
 - iii. The PMPM costs for the EG used to calculate the annual budget neutrality expenditure limit for this Demonstration are specified below.

Category	2009 PMPM	Trend Rate	2010 PMPM	Trend Rate	2011 PMPM	Trend Rate
Eligibility Group 1	\$634.08	6.6%	\$675.93	6.6%	\$720.54	6.6%
Eligibility Group 2	\$295.52	6.6%	\$315.02	6.6%	\$335.82	6.6%
Eligibility Group 3	\$883.76	6.6%	\$942.09	6.6%	\$1,004.27	6.6%

- b) The overall budget neutrality expenditure limit for the 3-year Demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a) (iii) above for each of the 3 years. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of Participant populations and expenditures described in paragraph 35 during the Demonstration period.

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

<u>Year</u>	<u>Cumulative Target</u>	<u>Percentage</u>
Year 12	Year 12 budget neutrality cap plus	1%
Year 13	Years 12 and 13 combined budget neutrality cap plus	.05%
Year 14	Years 12 through 14 combined budget neutrality cap plus	0%

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

IX. EVALUATION OF THE DEMONSTRATION

48. Submission of Draft Evaluation Design. The State must submit to CMS for approval within 120 days from the award of the Demonstration 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 population for the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from 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.

49. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 48, within 60 days of receipt of CMS comments. The State must implement the evaluation design and report its progress in the quarterly reports. The State must submit to CMS a draft evaluation report 120 days after the expiration of the current Demonstration period. CMS shall provide comments within 60 days of receipt of the report. The State shall submit the final report no later than 60 days after receipt of the comments from CMS.

50. Cooperation with Federal Evaluators. Should CMS conduct an 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.

X. SCHEDULE OF STATE MANDATORY DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

	Deliverable	STC Reference
Annual	By January 31st - Draft Annual Report	Section VI, paragraph 33
Quarterly		
	Quarterly Operational Reports	Section VI, paragraph 32
	CMS-64 Reports	Section VII, paragraph 35
	Eligible Member Months	Section VII, paragraph 36

ATTACHMENT A

Under Section VI paragraph 32 of these Special Terms and Conditions (STCs), 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 update on budget neutrality monitoring.

NARRATIVE REPORT FORMAT

Title Line One – Kentucky Partnership Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 12 (11/1/2008 – 10/31/2009)

Federal Fiscal Quarter: 1/2008 (10/08 - 12/08)

Introduction

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

Enrollment Information

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

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

Participant Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	No. Voluntary Disenrolled in current Quarter	No. Involuntary Disenrolled in current Quarter
Population 1			
Population 2			
Population 3			

Outreach/Innovative Activities

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

Operational/Policy Developments/Issues

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

Financial/Budget Neutrality 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.

Member Month Reporting

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

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

Consumer Issues

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

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

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

State Contact(s)

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

Date Submitted to CMS