CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00245/5**

TITLE: **Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration**

AWARDEE: **Michigan Department of Community Health**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Michigan's Adult Benefits Waiver section 1115(a) Medicaid Demonstration (hereinafter referred to as "Demonstration"). The parties to this agreement are the Michigan Department of Community Health ("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 January 1, 2010, unless otherwise specified. This Demonstration is approved through September 30, 2014.

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

In January 2004, the Adult Benefits Waiver (ABW) was initially approved and implemented as a title XXI funded section 1115 Demonstration. The ABW provides a limited ambulatory benefit package to previously uninsured, low-income non-pregnant childless adults ages 19 through 64 years with incomes at or below 35 percent of the Federal poverty level (FPL) who are not eligible for Medicaid. The ABW services are provided to beneficiaries through a managed healthcare delivery system utilizing a network of county administered health plans (CHPs) and Public Mental Health and Substance Abuse provider network. The programmatic goals for the ABW Demonstration include:

- Improve access to healthcare;
- Improve the quality of healthcare services delivered;
- Reduce uncompensated care;
- Encourage individuals to seek preventive care and choose a healthy lifestyle; and
- Encourage quality, continuity, and appropriate medical care.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

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

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

    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

    b. If mandated changes in 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 for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the 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 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current Federal share "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

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

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

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

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

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

    b. Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas ((c) through (f) below), they

need not be documented a second time. Consistent with Federal law, CMS reserves the right to deny approval for a requested extension based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein.

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

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

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

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

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

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

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

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, when the State proposes any program changes to the Demonstration, including, but not limited to, those referenced in STC 6. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and/or renewal of this Demonstration. In the event that the State conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS.

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

17. **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 expenditures incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR section 438.6.

IV. ELIGIBILITY DETERMINATION, ENROLLMENT, AND DISENROLLMENT

18. **Eligibility.** Childless adults eligible for coverage under this Demonstration are defined as individuals ages 19 through 64 years with income that is at or below 35 percent of the FPL. They are individuals who are not pregnant, disabled, or qualified for any other Medicaid, Medicare or Children's Health Insurance Program (CHIP). A childless adult is an individual who does not have children or dependents living in his/her home.

    An applicant must meet the following eligibility requirements in order to enroll for coverage under this Demonstration:

    a. Must be at least 19 but no more than 64 years of age;

    b. Must not have any children or dependents living in his/her home;

    c. Must not be pregnant;

    d. Must not be eligible for Medicaid, CHIP, or Medicare;

    e. Must have gross family income at or below 35 percent of the FPL;

    f. Income test - An earned income disregard of $200 plus 20 percent of the remaining earned income is applied to the income of the Demonstration applicant prior to conducting the income test.

    g. Asset Limit - An asset limit of $3,000 will be applied to applicants who meet the above income requirement. Cash assets include, but are not limited to, checking accounts. Investments and retirement plans are also counted towards this $3000 asset limit.

    h. Must not have access to other creditable health insurance. The State defines "creditable health insurance" as coverage for medical care obtained by a participant as an individual, via group health plans (self-funded or fully-insured), a State high risk pool, Medicare, Medicaid, Federal Employee Health Benefit Program, military sponsored healthcare program (CHAMPUS or Tri Care), medical program of Indian Health Services or tribal organization public health plan or coverage under the Peace Corps;

    i. Must provide verification, including documentation, of U.S. citizenship and Social Security number (or proof of application for an SSN) in accordance with section 1903(x) of the Act;

    j. Must be a Michigan resident.

19. **Application Processing and Enrollment Procedures.** Enrollees under this Demonstration will use the same application and enrollment procedures required of other individuals applying for other Medicaid programs.

20. **Screening for Eligibility for Medicaid and/or CHIP.** All applicants must receive a pre-screening in order to determine possible eligibility for either Medicaid or CHIP programs before eligibility determination is performed for the Demonstration.

21. **Effective Date of Coverage - No Retroactive Eligibility.** Enrollees who qualify for coverage under this Demonstration will not receive retroactive coverage. The beginning effective date of coverage under the Demonstration will be the first day of the month in which the application was received. After the application is processed, the enrollee will be enrolled in a county health plan (CHP) on the first day of the next month available for enrollment in the 72 counties that operate this type of delivery system. If the enrollee resides in a county that does not have CHP, that enrollee will continue to obtain services through Medicaid Fee for Service (FFS).

22. **Redetermination of Eligibility.** Enrollees who are eligible for coverage under this Demonstration will have eligibility redetermined at least every 12 months. The State will send eligibility renewal notification to the enrollee prior to the end of the enrollee's current eligibility period.

23. **Intermittent Periods of Open Enrollment to the Demonstration.** The State is responsible to determine and maintain the appropriate enrollment levels in order to remain under the annual budget neutrality limit/ceiling established for the Demonstration. Therefore, the State will determine the timeframe for opening enrollment for the Demonstration based upon the capacity and amount of available budgetary resources. The State will provide written notification to CMS at least 15 days before closing or re-opening enrollment to the Demonstration. The State should report to CMS via the quarterly and annual reports the status of enrollment and provide a description of the enrollment management process. In addition, the State will provide CMS with Monthly Enrollment Reports as described in paragraph 31.

24. **Disenrollment.** An enrollee in the Adult Benefits Waiver may be disenrolled if he/she:

    a. Exceeds the income limit of 35 percent of the FPL;

    b. Becomes eligible for Medicare, Medicaid, or CHIP coverage;

    c. No longer resides in the State of Michigan;

    d. Obtains health insurance coverage;

    e. Attains age 65; or

    f. Voluntarily requests closure of his/her case.

V. BENEFITS AND COST SHARING

25. **Limited Benefit Package.** Enrollees under the Demonstration will continue to receive a limited benefit package that includes outpatient hospital services, physician services, diagnostic services, pharmacy, mental health and substance abuse services. The enrollees may be required to receive prior authorization (PA) from the State or their CHP assigned provider before accessing certain ambulatory services. The chart below describes the specific benefit coverage.

Health Benefit Plan for Adult Benefits Waivers

Service Type	Description of Coverage	Co-Payments
Ambulance	Limited to emergency ground transportation to the hospital Emergency Department (ED).	
Case Management	Not covered.	
Chiropractor	Not covered.	
Dental	Not covered, except for services of oral surgeons as covered under the current Medicaid physician benefit for the relief of pain or infection.	
Emergency Department	Covered per current Medicaid policy. For CHPs, prior authorization may be required for nonemergency services provided in the emergency department.	
Eyeglasses	Not covered.	
Family Planning	Covered. Services may be provided through referral to local Title X designated Family Planning Program.	
Hearing Aids	Not covered.	
Home Health	Not covered.	
Home Help (personal care)	Not covered.	
Hospice	Not covered.	
Inpatient Hospital	Not covered.	
Laboratory and Radiology	Covered if ordered by MD, DO, or NP for diagnostic and treatment purposes. Prior authorization may be required by the CHP.	
Medical Supplies / Durable Medical Equipment (DME)	Limited Coverage: • Medical supplies are covered except for the following non-covered categories: gradient surgical garments, formula and feeding supplies, and supplies related to any uncovered DME item. • DME items are non-covered except for glucose monitors	

Mental Health	Covered: Services must be provided through the Prepaid Inpatient Health Plans (PIHP)/Community Mental Health Services Programs (CMHSP).	
Outpatient Hospital (Nonemergency Department)	Covered: Diagnostic and treatment services and diabetes education services. Prior authorization may be required for some services by the CHPs. Noncovered: Therapies, labor room, and partial hospitalization.	Maximum $3 co-payment for professional services
Pharmacy	Covered: • Products included on the Michigan Pharmaceutical Product List (except enteral formulas) that are ordered by an MD, DO, NP or type 10–enrolled oral surgeon. Prior authorization may be required by the CHPs. • Psychotropic medications are provided under the FFS benefit. Refer to Michigan Dept. of Community Health (MDCH) Pharmacy Benefit Manager (PBM) website for current list. Noncovered: injectable drugs used in clinics or physician offices.	Maximum $1 co-payment per prescription
Physician Services	Covered per Medicaid policy.	Maximum $3 co-payment for office visits
Nurse Practitioner	Covered per Medicaid policy.	Maximum $3 co-payment for office visits
Oral Surgeon	Covered per Medicaid policy.	Maximum $3 co-payment for office visits
Medical Clinic	Covered per Medicaid policy.	Maximum $3 co-payment for office visits
Podiatrist	Not covered.	
Prosthetics/Orthotics	Not covered.	
Private Duty Nursing	Not covered.	
Substance Abuse	Covered through the Substance Abuse Coordinating Agencies (CAs).	

PT,OT, SP Therapy Evaluation	Occupational, physical and speech therapy evaluations are covered when provided by physicians or in the outpatient hospital setting. Therapy services are not covered in any setting.	Maximum $3 co-payment for office visits
Transportation (non-ambulance)	Not covered.	
Urgent Care Clinic	Professional services provided in a freestanding facility are covered. CHPs may require authorization by the primary care physician or plan administrator.	Maximum $3 Co-payment per visit

26. **Cost Sharing.** Enrollees under the Demonstration are required to pay co-payments in order to receive certain ambulatory benefits as follows:

Service Type	Co-Payment Required
Outpatient Hospital	Maximum $3 co-pay for professional services
Nurse Practitioner	Maximum $3 co-pay for office visits
Physician	Maximum $3 co-pay for office visits
Prescribed Drugs	Maximum $1 co-pay per prescribed drug *

***There are no co-pays for family planning or pregnancy related drug products.**

VI. DELIVERY SYSTEMS

27. **County Health Plans (CHP**) - The CHPs are capitated health plans that provide the primary and preventive care services in an ambulatory/outpatient setting. The CHPs have been a long-standing delivery system created to serve the childless adults enrolled in the ABW. Demonstration enrollees will be required to continue to enroll in the CHPs in 72 of the 83 counties in the State. The Demonstration enrollees will have the choice of provider within the CHPs. In counties where CHPs do not currently operate, the State must provide a Medicaid card or other means to access the Medicaid qualified providers under Fee-for-Service (FFS). Tribal members are exempt from mandatory enrollment into CHPs, but may choose to participate in CHPs on a voluntary basis.

28. **Mental Health and Substance Abuse Provider Network.** The State will continue to provide mental health and substance abuse services using a capitated managed care provider network through the State's Public Mental Health System (PMHS). The mental health and substance abuse network consists of local agencies including Community Mental Health Services Programs (CMHSP) and Substance Abuse Coordinating Agencies. The mental health and substance abuse services will be provided based upon medical necessity and applicable benefit restrictions.

29. **Contracts.** All contracts and modifications of existing contracts between the State and the CHPs and Mental Health and Substance Providers must be approved by CMS prior to the effective date of the contract or modification of an existing contract. Upon the initial

implementation of the Demonstration the State will be provided a 90-day grace period to meet the above requirements. If the contract requirements are not met within the specified timeframe, CMS reserves the right as a corrective action to withhold FFP (either partial or full) for the Demonstration until the contract compliance requirement is met.

VII. GENERAL REPORTING REQUIREMENTS

30. **General Financial Requirements.** The State must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality set forth in section IX of these STCs. The State must submit any corrected budget and/or allotment neutrality data upon request.

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

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

32. **Bi-Monthly Calls.** CMS will schedule conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the State is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS will jointly develop the agenda for the calls.

33. **Quarterly Progress Reports.** The State must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval

and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;

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

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

e. Evaluation activities and interim findings.

34. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration. The State must submit the draft annual report no later than 120 days after the close of the Demonstration Year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

VIII. GENERAL FINANCIAL REQUIREMENTS

35. **Quarterly Expenditure Reports for Title XIX.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures that are subject to budget neutrality for services provided through this 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 these STCs.

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

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

    a. **Use of Waiver Forms.** In order to track expenditures under this Demonstration, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM). All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration Project Number (**11-W-00245/5**) assigned by CMS.

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

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

d. **Pharmacy Rebates.** The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the Demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the Demonstration and not on any other CMS 64.9 form to avoid double –counting. Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

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

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

39. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

40. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the Demonstration. The State must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality agreement must be separately reported by quarter for each FFY on the form CMS-37.12 for both the medical assistance program and administrative costs. CMS 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.

41. **Extent of Title XIX FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in section IX of these STCs:

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

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

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

    a. CMS 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 shall be addressed within the time frames set by CMS.

    b. The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendment that impacts the financial status of the program.

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

understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid or the Demonstration and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

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

IX. MONITORING BUDGET NEUTRALITY

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

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

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

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

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

        i. Projected expenditures and Annual Limits for each DY through the end of the approval period;

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

        iii. A proposed updated version of Attachment B.

The State may request technical assistance from CMS for the calculation of the Annual Limits and Trend Factors prior to its submission of the updated budget neutrality analysis. CMS will respond by either confirming the State's calculations or by working with the State to determine an accurate calculation of the Trend Factor and Annual Limit for the coming DY. CMS will ensure that the final Trend Factors for each DY are the same for all CHIPRA Medicaid childless adult waivers. The annual budget neutrality limit for each DY will be finalized by CMS by the following date, whichever is later: (1) 120 days prior to the start of the DY; or (2) two months following the date of the most recent publication of the National Health Expenditure projections occurring prior to the start of the DY.

c. **Base Year Expenditure.** The Base Year Expenditure will be equal to the total amount of FFP paid to the State for health care services or coverage provided to nonpregnant childless adults under the **Michigan Adult Benefits Waiver (21-W-00017/5)**, as reported on CMS-21 and CMS-21P Waiver forms submitted by the State in the four quarters of FFY 2009. A preliminary Base Year Expenditure total appears in Attachment B. A final Base Year Expenditure total will be determined by CMS following CMS receipt of the Budget Neutrality Update that the State must provide by April 1, 2010.

d. **Adjustments to the Base Year Expenditure.** CMS reserves the right to adjust the Base Year Expenditure in the event that any future audit or examination shows that any of the expenditures included in the Base Year Expenditure total were not expenditures for health care services, health insurance premiums, or premium assistance for nonpregnant childless adults participating in the **Michigan Adult Benefits Waiver (21-W-00017/5).**

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

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

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

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

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

i. **Calculation of the Trend Factor.** The percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of a DY (PERCAP2) over the preceding year(PERCAP1) to be referred to as the Trend Factor) will be calculated to one decimal place of precision (example: 3.7 percent) using computer spreadsheet rounding. (A sample formula for this calculation in Microsoft Excel reads as follows:

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

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

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

X. EVALUATION OF THE DEMONSTRATION

49. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after the effective date of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

50. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a),

(e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

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

52. **Final Evaluation Report**. 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' comments.

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

XI. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date	Deliverable
Within 30 days of the date of award	Confirmation Letter to CMS Accepting Demonstration STCs
Per paragraph 49	Submit Draft Evaluation Design
Per paragraph 8	Submit Demonstration Extension Application
Per paragraph 50	Submit Interim Evaluation Report
Monthly	**Deliverable**
Per paragraph 31	Monthly Enrollment Reports
Quarterly	**Deliverable**
Per paragraph 33	Quarterly Progress Reports
Per paragraph 33	Quarterly Enrollment Reports
Per paragraph 35	Quarterly Expenditure Reports
Annual	**Deliverable**
Per paragraph 34	Draft Annual Report
Per paragraph 46	National Health Expenditure Projection and Revised BN Analysis

ATTACHMENT A
QUARTERLY REPORT FORMAT AND CONTENT

Under section VII, paragraph 33, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

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

NARRATIVE REPORT FORMAT:

Title Line One – Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 1 (01/01/10-09/30/10)
Federal Fiscal Quarter: 2/2010 (01/01/10 – 03/31/10)

Introduction

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

Enrollment Information

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

Enrollment Count

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

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

Member Month Reporting

Enter the member months for the quarter.

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

Update on Enrollment Management

Provide an update of the current status of open versus closed enrollment under the Demonstration. This update should describe the status for each month included in the report period and any anticipated changes in the near future.

Outreach/Innovative Activities

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

Operational/Policy Developments/Issues

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

Financial/Budget Neutrality Developments/Issues

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

Consumer Issues

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

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Status of Benefits and Cost Sharing

Provide update regarding any changes to benefits or cost sharing during the quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

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

State Contact(s)

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

Date Submitted to CMS

ATTACHMENT B
RECORD OF BUDGET NEUTRALITY EXPENDITURE LIMIT

Effective Date: Date of Initial Award (DOIA)

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

	Initial Preliminary Estimates		**Revised Preliminary Estimates**		**Final Amounts**	
	Trend Factor	**Amount**	**Trend Factor**	**Amount**	**Trend Factor**	**Amount**
Base Year Expenditure (Paragraphs IX.46(c) and (d))	N/A	$132,072,780 Effective: DOIA	N/A	N/A	N/A	$ Effective:
FFY 2010 Expenditure Projection (Paragraph IX.46(e))	3.7% Effective: DOIA	$136,959,473 Effective: DOIA	N/A	$ Effective:	3.7% Effective: DOIA	$ Effective:
Annual Limit, DY 1 (Paragraph IX.46(f))	N/A	$102,719,605 Effective: DOIA	N/A	$ Effective:	N/A	$ Effective:
Annual Limit, DY 2 (Paragraphs IX.46(g) and (i))	4.6% Effective: DOIA	$143,259,609 Effective: DOIA	% Effective:	$ Effective:	% Effective:	$ Effective:
Annual Limit, DY 3 (Paragraphs IX.46(h) and (i))	4.9% Effective: DOIA	$150,279,330 Effective: DOIA	% Effective:	$ Effective:	% Effective:	$ Effective:
Annual Limit, DY 4 (Paragraphs IX.46(h) and (i))	5.2% Effective: DOIA	$158,093,855 Effective: DOIA	% Effective:	$ Effective:	% Effective:	$ Effective:

Annual Limit, DY 5 (Paragraphs IX.46(h) and (i))	5.6% Effective: DOIA	$166,947,111 Effective: DOIA	% Effective:	$ Effective:	% Effective:	$ Effective