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

Children and Adults Health Programs Group

March 25, 2015

Marie Zimmerman
Director
Minnesota Department of Human Services
540 Cedar Street
P.O. Box 64983
St. Paul, MN 55167-0983

Dear Ms. Zimmerman:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your requested technical corrections to the Minnesota section 1115 demonstration, entitled, "Prepaid Medical Assistance Project Plus" (PMAP+), (Project Number: 11-W-00039/5), which was approved on December 30, 2014.

The technical corrections requested by your staff include a revision of expenditure authority number 3, for population 2, to match the language referencing income and definition of the population to the language approved in Special Term and Condition (STC) 18. Other technical changes include small grammatical/typographical edits in STC pages 2, 9, 10, 14, and 15.

If you have any questions, please do not hesitate to contact your project officer, Ms. Heather Hostetler. Ms. Hostetler can be reached at (410) 786-4515 or by e-mail at heather.hostetler@cms.hhs.gov.

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

Sincerely,

/s/

Manning Pellanda
Director
Division of State Demonstrations and Waivers

Enclosures

cc: Verlon Johnson, Associate Regional Administrator, Region V

CENTERS FOR MEDICARE AND MEDICAID SERVICES
WAIVER AND EXPENDITURE AUTHORITIES

NUMBER: **11-W-00039/5**

TITLE: **Minnesota Prepaid Medical Assistance Project Plus (PMAP+)**

AWARDEE: **Minnesota Department of Human Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project from January 1, 2015 through December 31, 2015.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are in effect to enable Minnesota to carry out the PMAP+ demonstration:

Title XIX Waivers

1. Statewideness/Uniformity — **Section 1902(a)(1) as implemented by 42 CFR 431.50**

To the extent necessary to enable the state to provide managed care plans or certain types of managed care plans, including provider-sponsored networks, only in certain geographical areas of the state.

2. Freedom of Choice — **Section 1902(a)(23)(A) as implemented by 42 CFR 431.51**

To the extent necessary to enable the state to require enrollment in managed care in order to receive benefits, with the exception of family planning benefits.

3. Amount, Duration, and Scope — **Section 1902(a)(10)(B) of the Act as implemented by 42 CFR 440.240(b)**

To the extent necessary to enable the state to vary the services offered to individuals, within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or in the absence of managed care arrangements.

4. Coverage /Benefits for Pregnant Women — **Section 1902(a)(47), as implemented by 42 CFR §§ 435.1103 and 435.1110**

To the extent necessary to exempt the state from the requirement that it limit medical assistance to certain pregnant women to ambulatory prenatal care during a hospital presumptive eligibility period described in section 1920(d).

Expenditure Authorities

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

The following expenditure authorities shall enable Minnesota to operate its section 1115 demonstration.

1. Population 1: Expenditures for Medicaid coverage for children from age 12 months through 23 months, who would not otherwise be eligible for Medicaid, above 275% and at or below 283% of the Federal poverty line.

2. Expenditures for Medicaid coverage for pregnant women described in section 1902(a)(47) of the Act, to the extent that services are provided during a hospital presumptive eligibility period, that are in addition to ambulatory prenatal care services.

3. Population 2: Expenditures for coverage for caretaker adults, eligible for Medical Assistance, with incomes at or below 133 percent of the FPL who assume responsibility for and live with a child age 18 who is not a full time student in secondary school.

4. Expenditures for payments made directly to medical education institutions or medical providers and restricted for use to fund graduate medical education (GME) of the recipient institution or entity through the Medical Education and Research Costs (MERC) Trust Fund. In each demonstration year, payments made under this provision are limited to the amount claimed for FFP under this demonstration as MERC expenditures for SFY 2009. Except as specifically authorized in the STCs, the state may not include GME as a component of capitation rates or as the basis for other direct payment under the State plan. This expenditure authority will be subject to changes in federal law or regulation that may restrict the availability of federal financial participation for GME expenditures.

Requirements Not Applicable to the Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the list below, shall apply to the expenditure authorities beginning as of January 1, 2015 through December 31, 2015.

1. Managed Care Payment **Section 1903(m)(2)(A)(ii)**
Section 1902(a)(4)

To the extent necessary to allow the state to make payments directly to providers, outside of the capitation rate, for graduate medical education and other medical education through the Medical Education and Research Costs (MERC) Trust Fund.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00039/5**

TITLE: **Minnesota Prepaid Medical Assistance Project Plus (PMAP+)**

AWARDEE: **Minnesota Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Minnesota' s Prepaid Medical Assistance Project Plus section 1115(a) Medicaid demonstration extension (hereinafter "demonstration"). The parties to this agreement are the Minnesota Department of Human Services (DHS) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, extent of Federal involvement in the demonstration, and the state's obligations to CMS during the life of the demonstration. The STCs are effective on the date of the approval letter unless otherwise specified. All previously approved STCs, Waivers, Expenditure Authorities and Not Applicables are superseded by the STCs set forth below. This demonstration extension is approved through December 31, 2015.

The STCs have been arranged into the following subject areas:

I. Preface;
II. Program Description and Objectives;
III. General Program Requirements;
IV. Eligibility and Demonstration Scope;
V. Benefits;
VI. Cost Sharing;
VII. Delivery System;
VIII. Medical Education and Research Costs (MERC);
IX. General Reporting Requirements;
X. General Financial Requirements Under Title XIX;
XI. Monitoring Budget Neutrality;
XII. Evaluation of the Demonstration;
XIII. Measurement of Quality of Care and Access to Care Improvement; and,
XIV. Schedule of State Deliverables for the Demonstration Extension Period.
Attachment A Quarterly Report Content and Format
Attachment B. Evaluation Plan (future)
Attachment C. Comprehensive Quality Strategy (future)
Attachment D Historical PMPM for the PMAP+ Demonstration

II. PROGRAM DESCRIPTION AND OBJECTIVES

Minnesota's section 1115 PMAP+ demonstration was initially approved and implemented in July 1995. Its original purpose was to enable the state to establish a prepaid, capitated managed care delivery model that operates statewide, and to provide federal support for the extension of health care coverage to additional populations through the MinnesotaCare program. The demonstration also has been used to test waivers and expenditure authorities that allow simplification and streamlining of Medicaid program administration, and for alternative funding and payment approaches to support graduate medical education (GME) through the Medical Education and Research Costs (MERC) fund.

In December 2013, Minnesota was granted a one-year temporary extension for PMAP+, with amendments to reflect new health care coverage options introduced in 2014 under the Affordable Care Act. The extended demonstration continued MinnesotaCare coverage only for 19 and 20 year olds, caretakers adults, and adults without children with incomes above 133 and at or below 200 percent of the FPL, with the expectation that MinnesotaCare would eventually be transitioned to a Basic Health Plan (BHP) option for these groups in 2015. Other populations that participated in MinnesotaCare – pregnant women, children, foster care age outs, juvenile residential correctional facility post-release, and adults with incomes at or below 133 percent of the FPL – began receiving Medicaid coverage in 2014 under Minnesota's state plan, and MinnesotaCare adults with incomes above 200 percent of FPL were transitioned to subsidized qualified health plan coverage through Minnesota's new state-based Marketplace. Waiver and expenditure authorities allowing streamlining benefit sets for pregnant women, GME funding through MERC, medical assistance for children ages 12 through 23 months with incomes at or below 283 percent of FPL, and mandatory managed care for population groups were continued in the extended demonstration. New authority was granted to provide medical assistance for caretaker adults who live with and are responsible for children age 18 who are not full time secondary school students.

In December 2014, a further one-year extension was granted for PMAP+, for the period of January 1 through December 31, 2015. The PMAP+ demonstration in 2015 consists of the following:

- Medical assistance for groups not included in Minnesota's Medicaid state plan; specifically, children ages 12 through 23 months with incomes above 275 percent FPL and at or below 283 percent of the FPL, and parents and caretaker adults with incomes at or below 133 percent of the FPL who assume responsibility for and live with an 18 year old who is not a full time secondary school student;
- Full Medical assistance benefits for pregnant women during their hospital presumptive eligibility period;
- Mandatory enrollment into prepaid managed care of certain groups that are excluded from such under section 1932 of the Act and;
- GME payments through the MERC fund.

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, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

3. **Changes in Medicaid and CHIP 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. In addition, CMS reserves the right to amend the STCs as needed to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STCs 6 and 7. CMS will notify the state within 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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 implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b) If mandated changes in the federal law, regulation, or policy requires 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 a Title XIX state plan amendment for changes to any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state plan is required, except as otherwise noted in these STCs. In all such instances, the Medicaid state plan governs.

6. **Changes Subject to the Demonstration Amendment Process.** Changes related to program design, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, federal financial participation (FFP), sources of non-federal share of funding, budget neutrality, and other comparable program and budget elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. In certain instances, amendments to the Medicaid state plan may or may not require an amendment to the demonstration as well. Amendments to the demonstration are not retroactive and federal financial participation (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 the STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in STC 7, required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must be accompanied by information that includes but is not limited to the following:

    a) Demonstration of Public Notice 42 CFR §431.408 and tribal consultation: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in STC 15 have been met.

    b) Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including; what the state intends to demonstrate via the amendment as well as impact on beneficiaries with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI state plan amendment, if necessary.

    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 for the amendment.

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

e) An up-to-date CHIP allotment neutrality worksheet, if necessary; and

f) Updates to existing demonstration reporting, quality and evaluation plans: A description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the 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 6 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 9. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in paragraph 15.

9. **Demonstration Transition and Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements;

a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

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

c) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

d) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and

hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category in accordance with 42 CFR §413.916.

e) Exemption from the Public Notice Procedures of 42 CFR §431.416(g): CMS may expedite federal and state public notice requirements in the event it determines that the objectives of Titles XIX and XXI would be served or under circumstances described in 42 CFR §431.416(g).

f) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **Expiring Demonstration Authority.** For demonstration authority that expires prior to the overall demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a) Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b) Expiration Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

c) Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d) Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

11. **CMS Right to Amend, Terminate or Suspend.** CMS may amend, 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 or Expenditure 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. 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 comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, the state public notice process for Section 1115 demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

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

    b) In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the

solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 30, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 31.

17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The state shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information on T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

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IV. ELIGIBILTY AND DEMONSTRATION SCOPE

18. **Eligibility.** Demonstration eligibles are described in the charts below:

Table 1. State Plan Eligible Populations Affected by the Demonstration	
Medicaid State Plan Populations required to enroll in managed care in order to receive benefits	i. Medicare and Medicaid Dual eligibles under 65 years who have not elected to be made eligible based on disability; ii. American Indians, as defined in 25 U.S.C. 1603(c), who would not otherwise be mandatorily enrolled in managed care; iii. Disabled children under age 19 who are eligible for SSI under Title XVI and who have not elected to be made eligible on the basis of disability; iv. Children under age 19 who are in state-subsidized foster care or other out of home placement; v. Children under age 19 who are receiving Foster Care under Title IV-E; vi. Children under age 19 who are receiving adoption assistance under Title IV-E; vii. Children under 19 with special health care needs but who have not elected to be made eligible on the basis of disability who are receiving services through family-centered, community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V.

Population Number	**Population Description**	**Funding Stream**	**CMS-64 Eligibility Group Reporting**
Population 1	Infants age 12 months through 23 months (MA One Year Olds) with incomes above 275% FPL and at or below 283 % FPL	Title XIX	MA Children Age 1
Population 2	Medicaid Caretaker Adults with income at or below 133% of the FPL living with child(ren) age 18 who are not full time secondary school students	Title XIX	MA Caretaker 18 Yr Old

a) **Medicaid Caretaker Adult.** The term “caretaker adult” used in paragraph 18 includes parents and other caretaker relatives. Caretaker adults have incomes at or below 133 percent of the FPL The demonstration provides expenditure authority for Medicaid Caretaker adults who meet the income standards for Medical Assistance and live with and assume primary responsibility for child(ren) age 18 who are not enrolled full time in secondary school.

b.) **Pregnant Women in a Hospital Presumptive Eligibility Period.** The demonstration provides Medicaid coverage for pregnant women described in section 1902(a)(47) of the Act, to the extent that services are provided during a hospital presumptive eligibility period, that are in addition to ambulatory prenatal care services.

V. BENEFITS

19. **Benefits Package: MA One Year Olds.** The benefit offered to MA One Year Olds is identical to the benefit offered to categorically eligible individuals under Minnesota’s Medicaid state plan, including all services that meet the definition of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) found in section 1905(r) of the Act.

20. **Benefits Package: Pregnant Women.** The benefit for pregnant women during a hospital presumptive eligibility period (as defined in section 1902(a)(47)(B)) will be the full medical assistance benefit that is available to qualified pregnant women (in accordance with section 1902(a)(10)(A)(i)(III) of the Act).

21. **Benefits Package: Medicaid Caretaker Adults With an 18 Year Old.** Medical Assistance Caretaker Adults with effective incomes at or below 133 percent of the FPL who live with and have primary responsibility for a youngest or only child who is 18 and is not enrolled full time in secondary school receive full Medicaid state plan benefits.

VI. COST SHARING.

22. **Cost Sharing in Medicaid.**

    a) The cost sharing requirements for Medicaid eligibles under the Medicaid state plan must conform to the requirements set forth in the state plan.

    b) The cost sharing requirements for MA One Year Olds must be identical to the requirements specified for Medicaid eligible infants, as specified in the Medicaid state plan.

    c) The cost sharing requirements for pregnant women described in section 1902(a)(47) and MA Caretaker Adults with an 18 year old conform to the requirements set forth under the state plan for those populations, respectively.

d) **Co-Payments and Indians.** Items or services furnished to an Indian directly by Indian Health Services, an Indian Tribe or Tribal Organization or an Indian Urban Organization (I/T/U), or through referral under contract health services are exempt from copayments, coinsurance, deductibles, or similar charge.

VII. DELIVERY SYSTEM

23. **Pre-Paid Managed Care Delivery Systems.** All categories of individuals described in paragraph 18 may be required to participate in the PMAP pre-paid managed care delivery system, on the same basis as other Medicaid eligibles whose participation in managed care was mandated under section 1932 of the Act. All Medicaid managed care arrangements are subject to the Federal regulations found at 42 CFR 438.

24. **American Indians**. CMS acknowledges that, in consultation with tribal governments, DHS has developed an approach to Medicaid purchasing for American Indian recipients that is different from the remainder of the Medicaid program. These approaches address issues related to tribal sovereignty, the application of Federal provisions that prevent Indian Health Services (IHS) facilities from entering into contract with managed care organizations (MCOs), and other issues that have posed obstacles to enrolling American Indian/Alaska Native Medicaid recipients into PMAP. Minnesota will continue to abide by the terms of these agreements, as stipulated below.

    a. American Indian Medicaid recipients, whether residing on or off a reservation, will have direct access to out-of-network services at IHS, 93-638 (IHS/638) facilities, or Urban Indian Organizations. DHS will reimburse IHS and 93-638 out-of-network services at the State plan rate. Physicians at IHS and 93-638 facilities will be able to refer recipients to specialists within the MCO network. Enrollees may not be required to see their MCO primary care provider prior to accessing the referral specialist.

    b. The state will consult with tribal governments before approving marketing materials that target American Indians recipients. Certificates of Coverage (COC) will include a description of how American Indian enrollees may direct access IHS/638 providers and how they may obtain referral services. The state will consult with tribal government prior to approving the COC. MCOs will provide trainings and orientation material s to tribal governments upon request, and will make training and orientation available to interested tribal governments. Tribal governments may assist the state in presenting or developing materials describing various MCO options to their members. If a tribal government revises any MCO materials, the MCO may review them. No MCO materials will be distributed until there is agreement between the MCO and Tribal government on any revisions.

    c. MCOs may not require any prior approval or impose any condition for an American Indian to access services at IHS/638 facilities. A physician in an IHS/638 facility may refer an American Indian recipient to an MCO participating provider for services covered by Medicaid and the MCO may not require the recipient to see a primary care

provider within the MCO's network prior to referral. The participating provider may determine that services are not medically necessary.

VIII. MEDICAL EDUCATION AND RESEARCH COSTS (MERC)

The following STCs reflect amendments to the MERC trust fund payments that are effective January 1, 2015.

26. **Medical Education and Research Costs (MERC) Trust Fund.** Through expenditure authority granted under this demonstration, total computable payments that are paid directly to medical education institutions (or to medical care providers) through the MERC Trust Fund are eligible for FFP to the extent consistent with the following limitations:

    a) Each demonstration year, payments made under this provision are limited to the amount claimed for FFP under this demonstration as MERC expenditures for SFY 2009, and the distribution set forth in (c) below. This aggregate limit applies to all MERC payments authorized under this demonstration.

    b) The state may not include GME as a component of capitation rates or as a direct payment under the state plan for managed care enrollees while this expenditure authority exists, with the exception of GME paid outside of MERC based on hospital services furnished to managed care enrollees through managed care products for which no carve-out existed in calendar year 2008, which includes the MinnesotaCare Program, the Minnesota Disability Health Options Program, and those capitation payments for dual eligibles enrolled in the Minnesota Senior Health Options Program. The state may also continue to make a GME adjustment to capitation rates paid to a health plan or a demonstration provider serving MA and MinnesotaCare enrollees residing in Hennepin County in order to recognize higher than average GME costs associated with enrollees utilizing Hennepin County Medical Center, not to exceed $6,800,000 in annual total computable payments. The GME authorized to be paid outside of MERC and the adjustment to the health plan or demonstration provider rates is in addition to the MERC adjustment and is not subject to the MERC limit. Nothing in this provision exempts Minnesota from any of the requirements of 42 CFR 438.6(c) with respect to Medicaid managed care rate setting and actuarial soundness.

    c) The amounts described in (a) may be distributed as follows:

        i. Up to $2,157,000 may be paid to the University of Minnesota Board of Regents, to be used for the education and training of primary care physicians in rural areas, and efforts to increase the number of medical school graduates choosing careers in primary care;

        ii. Up to $1,035,360 may be paid to Hennepin County Medical Center for graduate clinical medical education;

iii. Up to $1,121,640 may be used to fund payments to teaching institutions and clinical training sites for projects that increase dental access for under-served populations and promote innovative clinical training of dental professionals;

iv. Up to $17,400,000 may be paid to the University of Minnesota Academic Health Center for purposes of clinical GME;

v. Amounts in excess of those distributed under (i) through (iv) above, up to the prescribed limit, may be paid to eligible training sites, based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

vi. Public program revenue for the distribution formula includes revenue from medical assistance and prepaid medical assistance. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. Training sites whose training site level grant is less than $5,000, based on the formula described in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the formula described in this paragraph. For the period January 1, 2015 through June 30, 2015, the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be equal to ten percent of each training sites grant. The grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For state fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described above.

d) FFP is available for total computable amounts paid from the MERC Trust Fund to recipient entities, within the limits described in this paragraph and the expenditure authorities. The Minnesota Department of Health, which operates the MERC Trust Fund, must certify the total computable payments made from the MERC Trust fund to eligible entities in order for the state to receive FFP.

e) The state shall provide information to CMS regarding any modifications to the existing source of non-Federal share for any MERC or GME expenditures claimed under PMAP+. This information shall be provided to CMS, and is subject to CMS approval, prior to CMS providing FFP at the applicable Federal matching rate for any valid PMAP+ expenditures.

f) As part of the Annual Report required under paragraph 31, the state must include a report on MERC and GME activities in the most recently completed DY, that must include (at a minimum):

   i. A list of the sponsoring institutions and training sites receiving payments from the MERC Trust Fund under these provisions, the amount paid to each sponsoring institution/training site, the subparagraph of (c) above under which each payment was made, and the source of the non-Federal share for each payment (i.e., each payment from the MERC Trust Fund must be identified with a corresponding transfer into the fund to account for the non-Federal share). A blanket statement can be used if the source of the non-Federal share is the same for all or most of the payments. Sponsoring institutions are the entities that receive payments from the MERC Trust Fund under (c)(i) through (c)(iv) above. The amounts paid to sponsoring institutions, and by training sites under (c)(v), are the basis for Minnesota's claim of FFP.

   ii. A description of the process used by the University of Minnesota Board of Regents to allocate funds they received from the MERC Trust Fund, a list of sub-grantees receiving these funds, and the amount each sub-grantee received;

   iii. With respect to payments made under (c)(iii) above: (A) a description of the public process used to determine which potential sponsoring institutions will receive grants and the amount of each grant, and (B) if any of the sponsoring institutions made sub-grants, a list of the sub-grantees and the amount each received; and

   iv. With respect to payments made under (c)(v) above: a description of the public process used to determine which potential training site will receive grants and the amount of each grant.

IX. GENERAL REPORTING REQUIREMENTS

27. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX of the Social Security Act in section X of the STCs.

28. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as outlined in Section 42. The state must submit any corrected budget neutrality data upon request.

29. **Monitoring Calls.** The state must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to: updates on population transitions to other programs, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, MCO financial performance that is relevant to the demonstration, enrollment of all waiver and

expenditure authority populations in the demonstration, progress on evaluations, state legislative developments, changes in the MinnesotaCare application, and any demonstration amendments, concept papers, or state plan amendments. CMS will 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 will jointly develop the agenda for the calls.

30. **Quarterly Progress Reports.** The state must submit progress reports no later than 60 days following the end of each calendar 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:

    a) An updated budget neutrality monitoring spreadsheet;

    b) Events occurring during the quarter, or anticipated to occur in the near future, that will effect health care delivery, including but not limited to: benefits; enrollment of all populations covered by waiver or expenditure authorities in the demonstration; grievances; quality of care; access;; pertinent legislative activity; and other operational issues relevant to the demonstration.

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

    d) Quarterly enrollment reports that include the member months for each demonstration population; and,

    e) Evaluation activities and any interim findings.

31. **Annual Report.** The state must submit a draft annual report documenting annual enrollment, benefits, grievances, quality of care and any access issues for all populations granted included in waiver or expenditure authority under the demonstration. The report must also document accomplishments, project status, quantitative and case study findings, any interim evaluation findings, utilization data, progress on implementing cost containment initiatives 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 each DY. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

    a) As an attachment to the annual report, the state must submit the following information regarding the managed care plans the state contracts with to provide PMAP+ services.
       i. A description of the managed care contract bidding process;
       ii. The number of contract submissions, the names of the plans, and a summary of the financial information, including detailed information on administrative expenses, premium revenues, provider payments and reimbursement rates, contributions to reserves, service costs and utilization, and capitation rate-setting and risk adjustment methods submitted by each bidder;
       iii. Annual managed care plan financial audit report summary;
       iv. A description of any corrective action plans required of the managed care plans; and

v. A summary of any complaints received by the state from the public regarding the managed care contracting and oversight process.

32. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 90 days after receipt of CMS comments.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

This project is approved for Title XIX and Title XXI expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

33. **Quarterly Expenditure Reports: CMS 64.** The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. The state must reconcile expenditures for incarcerated beneficiaries on a quarterly basis, and make any necessary adjustments on the CMS-64 to ensure that no FFP was inadvertently claimed for incarcerated beneficiaries during the reporting quarter. 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 XI.

34. **Reporting Expenditures Under the Demonstration: CMS-64.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

    a) **Tracking Expenditures.** In order to track expenditures under this demonstration, Minnesota must report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the state Medicaid Manual (SMM). All demonstration expenditures subject to the budget neutrality expenditure limit will be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). DY 1 is defined as the year beginning July 1, 1995, and ending June 30, 1996, and DY 2 and subsequent DYs are defined accordingly. All other Medical Assistance payments that are not subject to the budget neutrality expenditure limit for PMAP+, and are not part of any other title XIX waiver program, should be reported on Forms CMS-64.9 Base and/or 64.9P Base as instructed in the SMM.

    b) For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the

State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 43.

c) For each DY, beginning in waiver year 8, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted reporting expenditures for the demonstration populations, by eligibility group. Payments made to provide health care services to the eligibility groups listed below are the expenditures subject to the budget neutrality expenditure limit. The state must complete separate pages for the following eligibility groups:

   i. **MA Children Age One.** Population 1, waiver name: "MA CHILDREN AGE 1";

   ii. **Medicaid Caretaker Adults with 18 Year Olds**. Population 2, waiver name: "MA CARETAKER 18 YR OLD."

d) The allocated expenditures for Caretaker Adults with 18 year olds (population 10) described in waiver form "MA CARETAKER 18 YR OLD" are estimates of the allocated costs. This method will result in a corresponding reduction in line 18A of the corresponding pages. The state will use the following formula to estimate allocated costs for this group: 0.83% * expenditures for MA Caretaker Adults = estimated allocated expenditures. Percentage is based on the percentage of MA Caretaker Adults with youngest or only child age 18 as compared to all MA Caretaker Adults.

e) For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in Section IV, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

f) **Premiums and Pharmacy Rebates.** Premiums that are collected by the state from enrollees whose expenditures are subject to budget neutrality must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. Pharmacy rebates are reported on Form CMS-64.9 base, Service Category Line 7. Neither premium collections nor pharmacy rebates figure into the calculation of net expenditures subject to the budget neutrality test.

g) **Payments for Health Plan Performance.** The state makes annual payments to recognize health plan performance of contractual targets during the previous calendar year. Such payments should be allocated on the CMS-64 waiver pages to reflect the amounts attributable to waiver group and waiver year in the following manner. First, determine the percentage distribution of each calendar year's payment amount by waiver year and waiver group. Then apply those same proportions to the payment totals for the same calendar year.

h) **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are

directly attributable to the demonstration using Forms CMS-64.10 Waiver and/or 64.10P Waiver with waiver name "ADM".

i) **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 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.

35. **Reporting Member-Months:** Quarterly Progress Report. For the purpose of calculating the budget neutrality expenditure limit, the state will provide to CMS on a quarterly basis the actual number of eligible member/months for each of the four eligibility groups (EGs) defined in (b) below. The enrollment data will be submitted to the CMS Project Officer 60 days after the end of each quarter as part of the quarterly progress report. To permit full recognition of "in-process" eligibility, reported counts of member months shall be subject to minor revisions as needed.

a) 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 three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

b) Member months must be provided for the following categories of enrollees, which correspond to categories that appear in the eligibility table in paragraph 18 (Eligibility):

i. **MA Children Age One** (waiver name: "MA CHILDREN AGE 1");

ii. **Medicaid Caretaker Adults with 18 Year Olds** (Effective January 1, includes Population 2, Medicaid Caretaker Adults with 18 Yr Old) (waiver name "MA CARETAKER 18 YR OLD").

36. **Standard Medicaid Funding Process: CMS-37.** The standard Medicaid funding process will be used during the demonstration. The state must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). The CMS will make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter

just ended. The CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

37. **Medical Education and Research Costs (MERC).** Claims eligible for FFP, based on payments from the MERC Trust Fund as described in paragraph 26, must be reported on separate Forms CMS-64.9 Waiver and 64.9 Waiver, on line 18E, using waiver name, "MERC 1115." These expenditures are not subject to the budget neutrality expenditure limit.

38. **Extent of Federal Financial Participation for the demonstration.** CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Section IX.

    a) Administrative cost, including those associated with the administration of the PMAP+ demonstration;

    b) Net expenditures of the Medicaid program that are paid in accordance with the approved state plan and waivers granted for the purpose of implementing PMAP+ ; and

    c) Net expenditures that are paid in accordance with the approved expenditure authorities granted for the purpose of implementing PMAP+.

39. **Sources of Non-Federal Share.** The state certifies that the source of the 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 Social Security 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 amendments that impact the financial status of the program.

    c) Additionally, the state shall provide information to CMS regarding any modifications to the existing source of non-Federal share for expenditures claimed under PMAP+. This information shall be provided to CMS, and is subject to CMS approval, prior to CMS providing FFP at the applicable Federal matching rate for any valid PMAP+ expenditures.

    d) 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 or demonstration payments) are not considered returning and/or redirecting a Medicaid or demonstration payment.

40. **State Certification of Funding Conditions.** The state certifies 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 used as the non-Federal share of Title XIX payments.

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 must certify to the state the total computable amount of demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for Federal match.

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state in accordance with Title XIX of the Social Security Act and implementing regulations. 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. Additionally, all transfers must occur prior to the specific payments under the demonstration which the transfers are designated to fund. 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 or demonstration 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 or the demonstration and in which there is no connection to Medicaid or demonstration payments, are not considered returning and/or redirecting a Medicaid or demonstration 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 time frame.

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

XI. MONITORING BUDGET NEUTRALITY

43. **Limit on Title XlX Funding.** The state will be subject to a limit on the amount of Federal Title XIX funding that the state may receive on expenditures for the eligibility groups listed in paragraph 34(c) during the demonstration period. This limit will be determined using a per capita cost method. In this way, the state will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the state at risk for changing economic conditions. However, by placing the state at risk for the per capita costs of Medicaid eligibles, CMS assures that the state demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. All eligibility groups listed in paragraph 18(a) are hypothetical groups, meaning that they are groups of individuals that could have been covered under the Medicaid state plan, but instead are covered solely through the demonstration. CMS policy prohibits the use of any savings from hypothetical groups (i.e., any variance between the projected and actual coverage costs) to offset costs arising from other demonstration expenditure authorities (other than the costs of the hypothetical groups themselves). Costs for Medicaid state plan populations affected by the demonstration and MERC are not subject to a budget neutrality test.

44. **Projecting Service Expenditures.** Each DY estimate of Medicaid service expenditures will be calculated as the product of the projected per member/per month (PMPM) cost times the actual number of eligible member months for the eligibility groups listed in paragraph 34(c) as reported to CMS by the state under the guidelines set forth in Section X, paragraph 34. The budget neutrality expenditure limit for the eligibility groups listed in paragraph 34(c) is the sum of these annual limits for all DYs.

45. **Calculation of the Budget Neutrality Expenditure Limit.** The following are the PMPM costs for the calculation of the budget neutrality expenditure limit for the demonstration enrollees in the eligibility groups listed in paragraph 34(c) under this extension period. *The demonstration year for purposes of budget neutrality is July 1 through June 30.*

Eligibility Group	Trend Rate	DY 20 SFY 2015 PMPM	DY 21 SFY 2016 PMPM
MA Children Age One	3.9 %	$374.49	$389.10

Eligibility Group	Trend Rate	DY 20 SFY 2015 PMPM	DY 21 SFY 2016 PMPM
Medicaid Caretaker adults living with 18 yr old	4.9%	$512.81	$537.94

* Historical PMPM limits for DY 1 (1996) through DY 19 (2014) are provided in Attachment A.

46. **Application of the Budget Neutrality Test.** The budget neutrality limit for the eligibility groups listed in paragraph 34(c) shall consist of a comparison between the Federal share of the budget neutrality expenditure limit for the demonstration and the amount of FFP that the state has received for expenditures subject to that limit.

    a) The federal share of the budget neutrality expenditure limit for the eligibility groups listed in paragraph 34(c) is equal to the budget neutrality limit for the demonstration multiplied by the Composite Federal Share.

    b) The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C, by total computable expenditures as reported for the same period on the same schedule. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative method based on mutual agreement.

47. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's cumulative expenditures exceed the calculated budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan for CMS for approval

Demonstration Year	Cumulative Expenditure Limit Definition	Percentage
Year 1 through 21	Combined budget neutrality expenditure caps plus	0 percent

48. **Exceeding Budget Neutrality.** If, at the end of this demonstration period, the budget neutrality expenditure limit for the demonstration 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.

XII. EVALUATION OF THE DEMONSTRATION

49. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval a draft evaluation design for a revisedevaluation of the demonstration incorporating changes for 2015, within 120 days after CMS' approval of the demonstration extension. The design submitted under this paragraph may be in the form of an addendum to the draft evaluation plan already submitted by Minnesota to CMS for the 2014 approval period. 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, including those indicators that focus specifically on the target populations and all expenditure authorities as well as the public health outcomes, any administrative savings generated from the use of demonstration funds and the effectiveness of the demonstration on all populations and graduate medical education funds affected by 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. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state.

50. **Further Extension of Demonstration.** In the event the state requests to extend the demonstration beyond the current approval period, the state must submit with its application a draft evaluation design for an overall evaluation of the demonstration. The draft design must cover every element of the demonstration that the state proposes to continue past December 31, 2015. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation. (CMS prefers that an outside contractor be used, to the extent feasible.)

    The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. Among the characteristics of rigor that will be met are the use of best available data, investigation design, discussion on comparison groups for each testable hypothesis, reporting of the limitations of data and their effects on results; and the generalizability of results to the waiver population. Information from the EQRO may be considered for the purposes of evaluation, as appropriate. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

    The design must include a proposed budget that is adequate to support the scale and rigor consistent with the expectations discussed herein.

The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including a description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable), the measure steward, the baseline value for each measure, and the sampling methodology for assessing these outcomes. CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

The evaluation design must also discuss the data sources used, including, but not limited to, the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. 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 evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

51. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design described in paragraph 49 within 60 days of receipt, and the state must 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. The state must submit to CMS a draft of the final evaluation report within 120 days after the expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments. The final evaluation report must include the following: an executive summary; a description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions; a summary of the evaluation design employed, including research questions, hypotheses, study design (qualitative versus quanitative or both), performance measures, data sources, and analyses; a description of the population included in the evaluation (by age, gender, race/ethnicity, etc.); and final evaluation findings, including a discussion of the findings (interpretation and policy context); successes, challenges, lessons learned, and policy implications.

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

53. **Public Access.** The state shall post the final approved Evaluation Design on the state Medicaid website within 30 days of approval by CMS.

54. **Electronic Submission of Reports.** The state shall submit all required plans and reports using the process stipulated by CMS, if applicable**.**

XIII. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

55. **Comprehensive State Quality Strategy.** The state will revise the state's Comprehensive Quality Strategy (combined for PMAP+ and Reform 2020) to incorporate all waiver expenditure authority populations as well as the MERC trust fund, included in the PMAP+ demonstration extension, as required by these terms and conditions and the terms and conditions of Reform 2020. The revised strategy must be submitted to CMS within 120 days of approval of the extension.

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE TERM OF THIS DEMONSTRATION EXTENSION

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

Date - Specific	Deliverable	STC Reference
Within six months of demonstration implementation and annually thereafter	Post Award Forum	Section III, STC 16
60 days following the end of the quarter	Quarterly Operational, Progress and Enrollment Reports	Section IX, STC 30
120 days following the end of the demonstration year	Annual Report	Section IX, STC 31
60 days following the end of the quarter	CMS-64 Reports	Section X, STC 33
60 days following the end of the quarter	Eligible Member Months	Section X, STC 35
30 days following the end of the quarter	Quarterly Financial Reports	Section X, STC 33
120 days following approval of the demonstration	Draft Evaluation Design	Section XII, STC 49
Within 60 days of	Final Evaluation Design	Section XII, STC 51

receipt of CMS comments		
120 days following approval/extensionof the demonstration	Draft Comprehensive Quality Strategy	Section XIII, STC 55
Within 45 days of CMS comments	Final Comprehensive Quality Strategy	Section XIII, STC 55
120 days following the end of the demonstration period	Draft Final Evaluation Report	Section XII, STC 51
120 days following the end of the demonstration	Draft Final Demonstration Report	Section XII, STC 51
90 days of receipt of CMS comments	Final Evaluation Report	Section XII, STC 51
Within 90 days of receipt of CMS comments	Final Demonstration Report	Section IX, STC 32

ATTACHMENT A

Quarterly Report Content and Format

Under Section IX, STC 30, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – PMAP+
Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 1 (date of approval letter – 12/31/2017)
Federal Fiscal Quarter: 2/2015(1/15 - 3/15)

Introduction
Information describing the goals of the demonstration, what it does, and key dates of approval and 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: Member months for Population 2 shall be derived consistently with the formula set out at STC 35 (d).

Demonstration Populations (as hard coded in the CMS 64)	**Enrollees at close of quarter** (date)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
Population 1: MA One Year Olds			
Population 2 Medicaid caretaker adults who assume responsibility for and live with a child age 18 who is not a full time student in secondary school.			

Outreach/Innovative Activities
Summarize marketing, outreach, or advocacy activities to current and potential enrollees and/or promising practices for the current quarter.

Operational Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, approval and contracting with new plans; benefits; enrollment; grievances; quality of care; changes in provider qualification standards; access; proposed changes to payment rates; health plan financial performance that is relevant to the demonstration; LTSS implementation and operation; pertinent legislative activity; and other operational issues.

Policy Developments/Issues
Identify all significant policy and legislative developments/issues/problems that have occurred in the current quarter. Include updates on any state health care reform activities to coordinate the transition of coverage through the Affordable Care Act.

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 any issues.

Member Month Reporting
Enter the member months for each of the EGs for the quarter, for use in budget neutrality calculations.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Population 1: MA One Year Olds				

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. The state must also report on the implementation and effectiveness of the Comprehensive Quality Strategy as it impacts the demonstration.

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

RESERVED FOR EVALUATION PLAN

ATTACHMENT C

RESERVED FOR COMPREHENSIVE QUALITY STRATEGY

ATTACHMENT D
HISTORICAL PMPM FOR THE PMAP + SECTION 1115 DEMONSTRATION

DY	SFY	Minnesota-Care Pregnant Women	Minnesota-Care Children	MA Children	Caretaker Adults	Minnesota-Care Adults without Children	Medicaid Caretaker adults living with 18 yr
1	1996	$532.85	$77.28	$480.34	$0		
2	1997	$550.96	$84.84	$516.00	$0		
3	1998	$780.63	$93.34	$534.46	$0		
4	1999	$808.73	$98.57	$563.86 - 1st 6 m $198.10 - 2nd 6 m	$135.46		
5	2000	$855.64	$105.82	$212.68	$143.32		
6	2001	$905.26	$113.61	$228.33	$151.63		
7	2002	$957.78	$121.97	$245.14	$160.42		
8	2003	$455.17	$152.97	$177.25	$294.62		
9	2004	$491.58	$164.23	$190.30	$318.19		
10	2005	$530.91	$176.32	$204.30	$343.64		
11	2006	$573.38	$189.30	$219.34	$371.13		
12	2007	$619.25	$203.23	$235.48	$400.82		
13	2008	$668.79	$218.19	$252.81	$432.89		
14	2009	$715.28	$233.35	$270.38	$462.98		
15	2010	$764.99	$249.56	$289.17	$495.16	499.06	
16	2011	$818.15	$266.91	$309.27	$529.57	530.00	
17	2012	$861.51	$280.00	$324.42	$557.64	562.86	
18	2013	$907.17	$293.72	$340.32	$587.19	597.76	
19	2014	$955.25	$308.11	$357.00	$618.31	$634.82	$487.00