

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

Tom Moss
Interim Assistant Commissioner, Health Care Administration
State of Minnesota, Department of Human Services
540 Cedar Street
P.O. Box 64983
St. Paul, MN 55167-0983

NOV 26 2019

Dear Mr. Moss:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a temporary extension of state's section 1115 demonstration, entitled "Minnesota Reform 2020" (Project Number 11-W-00286/5) in order to allow the state and CMS to continue working together on approval of the extension of this demonstration. This demonstration is now to expire on January 31, 2020.

CMS' approval is conditioned upon the state's continued compliance with the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs and expenditure authorities will continue to apply during the temporary extension of this demonstration until January 31, 2020.

Your CMS project officer for this demonstration is Mr. Thomas Long. He is available to answer any questions concerning your section 1115 demonstration. Mr. Long can be reached at Thomas.Long@cms.hhs.gov.

If you have questions regarding this communication, please contact me at (410) 786-9686.

Sincerely, 



Judith Cash
Director

cc: James Scott, Director, Division of Medicaid Field Operations North

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

Jodi Harpstead
Commissioner, Health Care Administration
State of Minnesota, Department of Human Services
540 Cedar Street
P.O. Box 64983
St. Paul, MN 55167-0983

SEP 26 2019

Dear Ms. Harpstead:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a temporary extension of state's section 1115 demonstration, entitled "Minnesota Reform 2020" (Project Number 11-W-00286/5) in order to allow the state and CMS to continue working together on approval of the extension of this demonstration. This demonstration is now to expire on November 29, 2019.

CMS' approval is conditioned upon the state's continued compliance with the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs and expenditure authorities will continue to apply during the temporary extension of this demonstration until November 29, 2019.

Your CMS project officer for this demonstration is Mr. Thomas Long. He is available to answer any questions concerning your section 1115 demonstration. Mr. Long can be reached at Thomas.Long@cms.hhs.gov.

If you have questions regarding this communication, please contact me at (410) 786-9686.

Sincerely,

A large black rectangular box redacts the signature of Judith Cash.

Judith Cash
Director

cc: James Scott, Director, Division of Medicaid Field Operations North

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

Marie Zimmerman
Assistant Commissioner, Health Care Administration
State of Minnesota, Department of Human Services
540 Cedar Street
P.O. Box 64983
St. Paul, MN 55167-0983

AUG 28 2019

Dear Ms. Zimmerman:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a temporary extension of state's section 1115 demonstration, entitled "Minnesota Reform 2020" (Project Number 11-W-00286/5) in order to allow the state and CMS to continue working together on approval of the extension of this demonstration. This demonstration is now to expire on September 30, 2019.

CMS' approval is conditioned upon the state's continued compliance with the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs and expenditure authorities will continue to apply during the temporary extension of this demonstration until September 30, 2019.

Your CMS project officer for this demonstration is Mr. Thomas Long. He is available to answer any questions concerning your section 1115 demonstration. Mr. Long can be reached at Thomas.Long@cms.hhs.gov.

If you have questions regarding this communication, please contact me at (410) 786-9686.

Sincerely,

A black rectangular redaction box covering the signature of Judith Cash.

Judith Cash
Director

cc: James Scott, Director, Division of Medicaid Field Operations North

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

Marie Zimmerman
Assistant Commissioner, Health Care Administration
State of Minnesota, Department of Human Services
540 Cedar Street
P.O. Box 64983
St. Paul, MN 55167-0983

JUN 28 2019

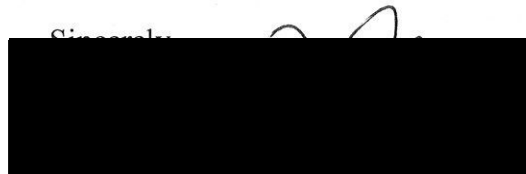
Dear Ms. Zimmerman:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a two-month temporary extension of state's section 1115 demonstration, entitled "Minnesota Reform 2020" (Project Number 11-W-00286/5) in order to allow the state and CMS to continue working together on approval of the extension of this demonstration. This demonstration is now to expire on August 31, 2019.

CMS' approval is conditioned upon the state's continued compliance with the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs and expenditure authorities will continue to apply during the temporary extension of this demonstration until August 31, 2019.

Your CMS project officer for this demonstration is Mr. Thomas Long. He is available to answer any questions concerning your section 1115 demonstration. Mr. Long can be reached at Thomas.Long@cms.hhs.gov.

If you have questions regarding this communication, please contact me at (410) 786-9686.

Sincerely,


Judith Cash
Director

cc: James Scott, Director, Division of Medicaid Field Operations North

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

Marie Zimmerman
Assistant Commissioner, Health Care Administration
State of 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 granting a temporary extension of Minnesota's Reform 2020 section 1115 demonstration (Project Number 11-W-00286/5), which is due to expire on April 30, 2019. This temporary extension will allow the state and CMS to continue working together on approval of the extension of this demonstration. This demonstration is now to expire on June 30, 2019.

CMS' approval is conditioned upon the state's continued compliance with the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs and expenditure authorities will continue to apply during the temporary extension of this demonstration until June 30, 2019.

Your CMS project officer for this demonstration is Mr. Thomas Long. He is available to answer any questions concerning your section 1115 demonstration. Mr. Long's contact information is as follows:

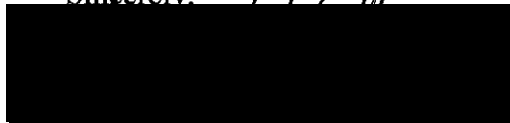
Mr. Thomas Long
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Thomas.Long@cms.hhs.gov

Official communications regarding demonstration program matters should be sent simultaneously to Mr. Thomas Long and to Mr. James Scott, Director, Division of Medicaid Field Operations North. Mr. Scott's contact information is as follows:

Mr. James Scott
Division of Medicaid Field Operations North
Regional Operations Group
Centers for Medicare & Medicaid Services
Richard Boling Federal Building
601 E. 12th St, Room 355
Kansas City, MO 64106-2808
Email: James.Scott1@cms.hhs.gov.

If you have any additional questions, please contact me at (410) 786-9686.

Sincerely, 



 Judith Cash
Director

cc: James Scott, Director, Division of Medicaid Field Operations North

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

MAR 29 2019

Marie Zimmerman
Assistant Commissioner, Health Care Administration
State of 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 granting a temporary extension of Minnesota's Reform 2020 section 1115 demonstration (Project Number 11-W-00286/5), which is due to expire on March 31, 2019. This temporary extension will allow the state and CMS to continue working together on approval of the extension of this demonstration. This demonstration is now to expire on April 30, 2019.

CMS' approval is conditioned upon the state's continued compliance with the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs and expenditure authorities will continue to apply during the temporary extension of this demonstration until April 30, 2019.

Your CMS project officer for this demonstration is Mr. Thomas Long. He is available to answer any questions concerning your section 1115 demonstration. Mr. Long's contact information is as follows:


Mr. Thomas Long
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Thomas.Long@cms.hhs.gov

Official communications regarding demonstration program matters should be sent simultaneously to Mr. Thomas Long and to Mr. James Scott, Director, Division of Medicaid Field Operations North. Mr. Scott's contact information is as follows:

Mr. James Scott
Division of Medicaid Field Operations North
Regional Operations Group
Centers for Medicare & Medicaid Services
Richard Boling Federal Building
601 E. 12th St, Room 355
Kansas City, MO 64106-2808
Email: James.Scott1@cms.hhs.gov.

If you have any additional questions, please contact me at (410) 786-9686.

Sincerely,

A black rectangular redaction box covering the signature of Judith Cash.

Judith Cash
Director

cc: James Scott, Director, Division of Medicaid Field Operations North

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

NOV 30 2018

Ann Berg
Deputy Medicaid Director| Health Care Administration
Minnesota Department of Human Services
540 Cedar Street
P.O. Box 64983
St. Paul, MN 55167-0983

Dear Ms. Berg:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a temporary extension of the Minnesota Reform 2020 section 1115 demonstration (Project Number 11-W-00286/5) to allow the state and CMS to continue working together on approval of the extension of this demonstration. This demonstration is now to expire on March 31, 2019.

CMS' approval is conditioned upon the state's continued compliance with the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The current STCs and expenditure authorities will continue to apply during the temporary extension of this demonstration until March 31, 2019.

Your CMS project officer for this demonstration is Ms. Linda Macdonald. She is available to answer any questions concerning your section 1115 demonstration. Ms. Macdonald's contact information is as follows:

Ms. Linda Macdonald
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2872
Email: Linda.Macdonald@cms.hhs.gov

Official communications regarding demonstration program matters should be sent simultaneously to Ms. Linda Macdonald and to Ms. Ruth Hughes, Associate Regional Administrator (ARA) for the Division of Medicaid and Children's Health in our Chicago Regional Office. Ms. Hughes' contact information is as follows:

Ms. Ruth Hughes
Division of Medicaid and Children Health Operations Program
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519
Email: Ruth.Hughes@cms.hhs.gov

If you have any additional questions, please contact me at (410) 786- 9686.

Sincerely,

A large black rectangular redaction box covering the signature area.

Judith Cash
Director

cc: Ruth Hughes, ARA, CMS Chicago Regional Office

October 18, 2013

Ms. Lucinda E. Jesson
Commissioner
Minnesota Department of Human Services
540 Cedar St.
St. Paul, MN 55101

Dear Ms. Jesson:

The Centers for Medicare & Medicaid Services (CMS) is pleased to inform you that it has approved Minnesota's proposed section 1115 demonstration project, entitled Reform 2020 (11W 00286/5). The demonstration is effective as of the date of this letter through June 30, 2018.

The demonstration provides authority for two programs – the Alternative Care program and Community First Services and Supports (CFSS). The Alternative Care program provides a package of home and community-provider based services to higher income people age 65 and older in order to prevent premature entry into nursing facilities and prevent or delay people from spending-down to Medicaid state plan eligibility.

The CFSS program provides personal care assistance services to people who would not be eligible to receive such services under a 1915(i) or 1915(k) state plan amendment (SPA). The CFSS program expands self-directed options for people to maintain and increase independence. Individuals under the demonstration will be eligible for CFSS services once the state's 1915(i) and 1915(k) SPAs are approved.

CMS approval of this section 1115 demonstration is subject to the limitations specified in the approved expenditure authorities. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been identified or described as waived or not applicable to the expenditure authorities. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not identified or described as waived or as not applicable shall apply to Minnesota's Reform 2020 program. This approval is also conditioned upon compliance with the enclosed special terms and conditions (STCs) defining the nature, character, and extent of federal involvement in this project.

These approvals are conditioned upon written acceptance from the state that it agrees with the expenditure authorities, and STCs. This written acceptance is needed for our records within 30 days of the date of this letter.

Your project officer is Ms. Heather Hostetler. She is available to answer any questions concerning your section 1115 demonstration. Ms. Hostetler's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard
Mailstop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-4515
E-mail: Heather.Hostetler@cms.hhs.gov

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

Ms. Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children Health Operations Program
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

If you have questions regarding this approval, please contact Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services at (410)786-5647.

Congratulations on the approval of your section 1115 demonstration.

Sincerely,

/s/

Marilyn Tavenner
Administrator

Enclosures

cc: Carol Backstrom, State Medicaid Director
Verlon Johnson, Associate Regional Administrator, Region V

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITIES**

NUMBER: 11W 00286/5

TITLE: Minnesota Reform 2020: Pathways to Independence

AWARDEE: Minnesota Department of Human Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not identified as not applicable in this document, shall apply to the demonstration project beginning with the date of the approval letter through June 30, 2018.

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 Alternative Care program services for individuals age 65 or older who have income and/or assets exceeding the state plan standards for the aged, blind and disabled for any group covered in the state plan. Combined adjusted income, as defined in STC 23, and assets do not exceed projected nursing facility (NF) cost for 135 days of NF care, based on the statewide average NF rate. The beneficiary must not be within an asset penalty period and home equity must be within the Home Equity Limit. This authority is intended to include expenditures for the state to operate the Alternative Care program as it did under the state-only program.
2. Expenditures for the alternate eligibility and benefit operations for the Alternative Care program to allow the state to operate the Alternative Care program consistent with how it was operated as a state-only funded program. This includes, but is not limited to, alternate methods for determining eligibility, limited benefit package, and alternate treatment of resources and annuities. These alternate operations and methods are described in Attachment D of the Special Terms and Conditions. The state must provide fair hearings consistent with requirements at 42 CFR 431.200.
3. Population 2: Expenditures for Community First Services and Supports Program (CFSS) coverage for the 1915(k)-like population which includes individuals who meet non-financial requirements for Medical Assistance. Individuals do not meet financial eligibility factors under a Medicaid state plan group, but do meet income and asset criteria for Medical Assistance as if qualifying using the rules of the special home and community-based waiver group described in 42 CFR §435.217 and meet one of the financial eligibility factors for payment of Medicaid long-term care services described in

STC 18(c)(i). These individuals meet the institutional level of care on January 1, 2014 and Personal Care Assistance targeting criteria, but are not currently receiving an HCBS service through a 1915(c) waiver. This authority is contingent upon the state submitting and receiving CMS approval of a 1915(k) state plan amendment to authorize the CFSS program.

Population 3: Expenditures for Community First Services and Supports Program coverage for the 1915(i)-like population which includes state plan eligible individuals with incomes above 150 percent of the FPL and at or below the relevant state plan limit (includes pregnant women and children). These individuals must meet the Personal Care Assistance criteria but do not meet the new adult nursing facility level of care on January 1, 2014. This authority is contingent upon the state submitting and receiving CMS approval of a 1915(i) state plan amendment to authorize the CFSS program.

4. Population 4: Expenditures for children under 21 who are state plan eligible but will not meet the institutional level of care as of January 1, 2014 and would therefore lose Medicaid eligibility without the demonstration..

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

NUMBER: 11W 00286/5

TITLE: Minnesota Reform 2020

AWARDEE: Minnesota Department of Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Minnesota's "Reform 2020" section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable Minnesota (the state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the award letter unless otherwise specified. This demonstration is approved from the date of the approval letter through June 30, 2018.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility
- V. Eligibility Process
- VI. Benefits
- VII. Cost Sharing
- VIII. Enrollment
- IX. Delivery System
- X. General Reporting Requirements
- XI. General Financial Requirements
- XII. Monitoring Budget Neutrality
- XIII. Evaluation of the Demonstration
- XIV. Measurement of Quality of Care and Access to Care Improvement
- XV. Schedule of State Deliverables
- Attachment A. Quarterly Report Content and Format
- Attachment B. Evaluation Plan (future)
- Attachment C. Comprehensive Quality Strategy (future)
- Attachment D. Operational Protocol for the Alternative Care Program (future)

II. PROGRAM DESCRIPTION AND OBJECTIVES

On February 13, 2012 and November 21, 2012, the state of Minnesota submitted two Medicaid section 1115 demonstration proposals, entitled Long Term Care Realignment and Reform 2020; Pathways to Independence. This demonstration combines components of both new section 1115 demonstration proposals into one demonstration to allow people to access the home and community-based services they need to support independence, increase community integration and reduce reliance on institutional care.

This five year demonstration will:

- Provide federal support for a state based program called “Alternative Care,” which provides a package of home and community based services to higher income people in order to prevent premature entry into nursing facilities and prevent or delay people from spending-down to Medicaid state plan eligibility.
- Provide access to the state’s redesigned Personal Care Assistance Services state plan benefit, now called “Community First Services and Supports” (CFSS). The CFSS program will expand self-directed options for HCBS to people with disabilities who are currently state plan eligible. The CFSS program will be implemented contingent upon approval of corresponding 1915(i) and 1915(k) state plan amendments submitted by the state.
- Provide expenditure authority for children under 21 who are state plan eligible, who meet the March 23, 2010 institutional level of care standard, but will not meet the institutional level of care as of January 1, 2014, and would therefore lose Medicaid eligibility or home and community-based services eligibility.

The Reform 2020 demonstration will assist the state in its goals to:

- Achieve better health outcomes;
- Increase and support independence and recovery;
- Increase community integration;
- Reduce reliance on institutional care;
- Simplify the administration of the program and access to the program; and
- Create a program that is more fiscally sustainable.

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 and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP expressed in law, regulation, and policy statement, not expressly identified as not applicable in the

expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

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 or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly 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 as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - 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.** Except as expressly provided in the STCs or Expenditure Authorities, the state will not be required to submit Title XIX or Title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.
6. **Changes Subject to the Amendment Process.** Changes related to demonstration features, such as eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement 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 STC 7 below.

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

- a. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in the statute for those sections. Otherwise, no later than 12 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 STC 9.
- b. Compliance with Transparency Requirements at 42 CFR §431.412: 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 STC 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 transition and 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 transition and phase-out plan to CMS, the state must publish on its website the draft transition and 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 (SPA). 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 transition and phase-out plan. Notification to any people currently on a wait list must be included in this 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 (including those on any wait lists), 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, whether currently enrolled or on a wait list, determined to be eligible individuals, 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 are 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 in accordance with 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 as discussed in October 1, 2010, State Health Official Letter #10-008. 42 CFR §431.416(g).
- e. **Exemption from Public Notice Procedures 42.CFR Section 431.416(g):** CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title 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 and Transition. 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, whether enrolled or on a wait list, 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 people, 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 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 or Title XXI if applicable. 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 in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) 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. Federal Financial Participation (FFP). No federal matching for administrative or service expenditures for this demonstration will take effect until the approval date identified in the demonstration approval letter.

IV. ELIGIBILITY

Standards for eligibility remain set forth under the state plan, and eligibility for the state's HCBS waiver programs is set forth in the concurrent approved 1915(c) waivers.

17. Demonstration Expansion Eligibility Groups. Those beneficiary eligibility groups described below who are made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration, the Alternative Care and 1915(k)- like and 1915(i)-like groups, are subject to Medicaid laws or regulations unless otherwise specified in the expenditure authorities for this demonstration.

18. Minnesota Reform 2020 Participating Groups.

- a. Participating Groups. The criteria for Reform 2020 participation are outlined below in a chart that summarizes each specific group of individuals; under what authority they are eligible for coverage, and the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed.

Demonstration Expansion Groups	Federal Poverty Level (FPL) and/or other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Alternative Care	Age 65 and older, Income and/or assets exceeding state plan standards for the aged, blind and disabled for any groups covered in the state plan [100 percent FPL for the aged, blind and disabled]; Combined adjusted income, as defined in STC 23, and assets do not exceed projected nursing facility (NF) cost for 135 days of NF care,	Title XIX	AltCare

	no asset penalty period, and home equity is within the Home Equity Limit.		
1915(i)-like	State plan eligible people with incomes above 150% of the FPL and at or below the relevant state plan limit (includes pregnant women and children). These individuals meet the programmatic criteria of 1915(i) including the Personal Care Assistance criteria but do not meet the Medicaid financial eligibility criteria to be eligible for the 1915(i) state plan benefit.	Title XIX Title XXI	1915(i)-like
1915(k)-like	People who meet non-financial requirements for Medical Assistance; do not meet financial eligibility factors under a Medicaid state plan group, but do meet income and asset criteria for Medical Assistance as if qualifying using the rules of the special home and community-based waiver group under 42 CFR §435.217 and meet one of the financial eligibility factors for payment of Medicaid long-term care services described in STC 18(c)(i). These people also meet the institutional LOC on January 1, 2014 and PCA targeting criteria, but are not currently receiving an HCBS service through a 1915(c) waiver and therefore, would not be eligible for the 1915(k) state plan benefit under a group covered in the state plan.	Title XIX	1915(k)-like
Children under 21 with Activities of Daily Living (ADL) Needs	Children under 21 who are state plan eligible, who meet the March 23, 2010 institutional level of care standard but will not meet the institutional level of care as of January 1, 2014 and would otherwise lose Medicaid eligibility or home and community-based services eligibility.	Title XIX Title XXI	ADL Children

b. Alternative Care Eligibility. Alternative Care (AC) is a program that provides limited home and community-based services to people who meet the following eligibility requirements. People enrolled in AC must:

- i. Be age 65 or older;
- ii. Meet the institutional level of care on January 1, 2014;
- iii. Have income and/or assets exceeding the state plan standards for aged, blind, and disabled categorical eligibility for any groups covered in the state plan;
- iv. Have combined adjusted income, as defined in STC 23, and assets that are not more

- than projected nursing facility cost for 135 days of NF care, based on the statewide average NF-rate. The beneficiary must not be within an asset penalty period, and home equity must be within the Home Equity limit;
- v. The monthly cost of AC services must be less than 75 percent of the funding limits for Elderly Waiver (a 1915(c) home and community-based waiver) participants with a comparable case mix classification;
 - vi. Choose to receive home and community-based services instead of NF services
 - vii. Pay the assessed monthly fee; and,
 - viii. Either have no other funding source available for the home and community based services (such as long term care insurance), or have long term care (LTC) insurance that pays for only a portion of the beneficiary's assessed needs. Alternative Care is a payor of last resort and long term care insurance is primary. If LTC insurance paid for all the beneficiary's assessed needs, the beneficiary would not be eligible for Alternative Care. If the long term care insurance only paid for a portion of the beneficiary's assessed needs, AC could pay for other assessed needs that need to be met.
- c. Community First Services and Supports Eligibility. CFSS is modeled after the 1915(k) Community First Choice Option for people who meet an institutional level of care. The component of the program for people who do not meet an institutional level of care is modeled after the 1915(i) state plan option. The program is designed for people in need of personal care assistance to maintain and increase independence by directing and managing their own care services.
- i. The 1915(k)-like population must:
 - A. Meet non-financial requirements for Medical Assistance;
 - B. Not meet financial eligibility factors for a Medicaid state plan group;
 - C. Have income and assets that meet requirements for Medical Assistance using the rules of the special home and community-based waiver eligibility group of 42 CFR 435.217;
 - D. Meet one of the following financial eligibility factors for payment of Medicaid long-term care services:
 - a) age 65+, eligible without a spenddown with income at or below 300% of SSI and spousal impoverishment rules if applicable; or,
 - b) disabled and under age 65 and above age 21 eligibility without a spenddown with income at or below the relevant state plan standard with special institutional rules including an exemption from spousal deeming; or,
 - c) children under age 21 eligible using special institutional rules including exemption from parental deeming;
 - E. Not be currently receiving services under an approved 1915(c) waiver;
 - F. Meet an institutional level of care for a NF, a PTRF, ICF-IID or hospital; and,
 - G. Meet the personal care assistance criteria which are defined as having an assessed need for assistance with at least one ADL or demonstrating physical aggression toward oneself or others or destruction of property that requires immediate intervention by another person.

- ii. The 1915(i)-like population must:
 - A. Be enrolled in Medical Assistance under a state plan eligibility group that includes eligibility for persons with incomes above 150 percent of the Federal Poverty Level and at or below the relevant state plan limit;
 - B. Not meet an institutional level of care;
 - C. Not meet the Medicaid financial eligibility criteria to be eligible for the 1915(i) state plan benefit and,
 - D. Meet the personal care assistance criteria which are defined as having an assessed need for assistance with at least one ADL or demonstrating physical aggression toward oneself or others or destruction of property that requires immediate intervention by another person.

V. ELIGIBILITY PROCESS

19. **Alternative Care Eligibility Process.** Applicants must submit applications to lead agencies. Lead agencies must annually redetermine financial and service eligibility. Applicants may be required to provide all information necessary to determine eligibility for Alternative Care and potential eligibility for Medical Assistance, including the client's Social Security number. Applicants for Alternative Care who appear to be categorically eligible for Medical Assistance may receive Alternative Care for up to 60 days while MA eligibility is determined. The state is authorized to maintain a waiting list any time it is not enrolling people into Alternative Care. This is discussed in detail in STC 25 (AC Enrollment).

20. CFSS Eligibility Process.

- a. 1915(k)-like eligibility process. The 1915(k)-like eligibility process will be very similar to Medicaid HCBS waiver enrollment, except that 1915(k)-like CFSS participants receive their home and community-based services via only CFSS instead of both CFSS and HCBS waiver services. Lead agencies (which may be a county or tribal entity) administer both HCBS waivers and CFSS for the 1915k-like group.
 - i. Each individual will receive a comprehensive assessment under the Long Term Care Consultation process. The certified assessor/case manager discusses the option of receiving benefits via CFSS as an alternative to an HCBS waiver. For people with 1915(k)-like eligibility who meet institutional level of care and are using the special institutional rules to qualify, CFSS will be treated as a long term care service. Long term care eligibility rules applicable under HCBS waivers will apply.
 - ii. If the CFSS 1915(k)-like option is selected, the assessor/case manager develops a person-centered service plan that identifies the amount, frequency and duration of services needed by the beneficiary and, where appropriate, caregiver supports. Approved services are prior authorized in the MMIS system. Reassessments are done at least annually or sooner if individual needs change.

- b. 1915(i)-like Eligibility Process. Financial and benefit eligibility for the 1915(i)-like CFSS population are identical to eligibility procedures for 1915(i) state plan eligibles.

VI. BENEFITS

21. Benefits under the Alternative Care Program. The AC program provides an array of home and community-based services based on assessed need and amounts determined in a plan for each beneficiary. The services covered by Alternative Care are the same as the services covered under the federally approved Elderly Waiver, except that Alternative Care covers nutrition services and Alternative Care does not cover transitional support services, assisted living services, adult foster care services, and residential care and benefits that meet primary and acute health care needs. Alternative Care benefits include but are not limited to:

- a. Adult day service/adult day service bath;
- b. Caregiver training and education;
- c. Case management and conversion case management;
- d. Chore services;
- e. Companion services;
- f. Consumer-directed community supports;
- g. Home health services;
- h. Home-delivered meals;
- i. Homemaker services;
- j. Environmental accessibility adaptations;
- k. Nutrition services;
- l. Personal care;
- m. Respite care;
- n. Skilled nursing and private duty nursing;
- o. Specialized equipment and supplies including Personal Emergency Response System (PERS); and,
- p. Non-medical Transportation.

22. Benefits under the Community First Services and Supports Program. The Community First Services and Supports Program, redesigns the state plan Personal Care Assistance Services (PCA) benefit and expands self-directed options in order to maintain and increase independence. The 1915(k)-like benefit must meet all federal requirements as written in the 1915(k) regulations, except those identified as not applicable in the Expenditure Authorities , but is not eligible to receive the enhanced FMAP available under the 1915(k) state plan option for the demonstration population . The 1915(i)-like benefit must meet all Federal requirements for the 1915(i) state plan benefit except those identified as not applicable in the Expenditure Authorities.

The 1915(i)-like and 1915(k)-like CFSS demonstration populations will not be eligible for CFSS services until both a 1915(i) state plan amendment (SPA) and a 1915(k) SPA have been approved. All of the CFSS requirements including services, supports and safeguards approved in the two SPAs will apply to the 1915(i)-like and 1915(k)-like demonstration populations.

VII. COST-SHARING

23. Alternative Care program Cost-Sharing. Individuals in the AC program pay cost-sharing fees up to 30 percent of the average monthly cost of the individual's AC services.

- a. **Determining Fees.** Minnesota uses adjusted income and gross assets and the average monthly amount of services authorized for the beneficiary. Adjusted income for a married applicant who has a community spouse is calculated by subtracting the following amounts from gross income: the monthly spousal income allowance to the community spouse (which is calculated using the spousal impoverishment rules applicable under the Elderly Waiver); recurring and predictable medical expenses; and the federally indexed clothing and personal needs allowance. Adjusted income for all other applicants is calculated by subtracting the following amounts from gross income: recurring and predictable medical expenses; and the federally indexed clothing and personal needs allowance.

AC Adjusted Income	Gross Assets	Monthly Fee Charge (percentage of average monthly cost of services)
Less than 100% of the FPL	Less than \$10,000	No monthly fee
At or greater than 100% of the FPL up to 150% of the FPL	Less than \$10,000	5 percent
At or greater than 150% of the FPL up to 200% of the FPL	Less than \$10,000	15 percent
At or greater than 200% of the FPL	At or greater than \$10,000	30 percent

- b. **Billing and Non-payment of Fees.** Client fees are billed the month after services begin. If client fees are not paid within 60 days, the lead agency works with the client to arrange a payment plan. The lead agency can extend the client's eligibility as necessary while making arrangements to rectify nonpayment of past due amounts and facilitate future payments. If no arrangements can be made, a notice is issued 10 days prior to termination stating that the beneficiary will be disenrolled from the program. The beneficiary may appeal the disenrollment under the standard State Fair Hearing process. Following disenrollment due to nonpayment of a monthly fee, eligibility may not be reinstated for 30 days.

24. CFSS program cost-sharing. State plan cost-sharing requirements apply to CFSS program participants.

VIII. ENROLLMENT

25. AC Enrollment. Enrollment procedures for Alternative Care are very similar to Medicaid HCBS waiver enrollment, except that Alternative Care enrollees do not need to select a health plan. Lead agencies (which may be a county or tribal entity) administer both Alternative Care and the Elderly Waiver. Lead agencies determine financial and program eligibility.

- a. Comprehensive Assessment. Each individual will receive a comprehensive assessment under the Long Term Care Consultation process. The certified assessor/case manager also evaluates financial eligibility. Applicants who would be eligible for Medical Assistance (MA) under State Plan categorical eligibility standards are referred for MA. The certified assessor/case manager also discusses with applicants the option of qualifying MA under a medically needy basis.
- b. Service Plan. If Alternative Care is selected, the assessor/case manager develops a person-centered service plan that identifies the amount, frequency and duration of services needed by the beneficiary and, where appropriate, caregiver supports. Approved services are prior authorized in the MMIS system. Reassessments are done at least annually or sooner if individual needs change.
- c. Wait List. The state is authorized to maintain a waiting list any time it is not enrolling people into Alternative Care. The state must notify CMS at least 60 days prior to implementing a waiting list for people covered under Alternative Care. The state will provide written notification to CMS at least 15 days before re-opening enrollment of the demonstration.
 - i. *Notice to beneficiary.* The state must provide notice of enrollment to the beneficiary.
 - ii. *Waiting List Management Plan.* The CMS notification described above must include a plan, to be approved by CMS, for how the waiting list will be implemented.
 - iii. *Reporting.* If a waiting list is implemented, the quarterly report required per STC 33 must include data regarding the number of demonstration-eligible beneficiaries on the waiting list, including how many have been added to the waiting list and how many have moved from the waiting list to the demonstration for each month of the quarter. The state must also provide an overview of the status of the waiting list in the annual report required per STC 34.

26. CFSS Enrollment. All 1915(i)-like and 1915(k)-like populations will enroll using the same process as approved in the 1915(i) and 1915(k) SPAs.

IX. DELIVERY SYSTEM

27. AC Delivery System

- a. The AC program services are provided fee for-service and are administered by counties and tribal health agencies. The service definitions and standards for Alternative Care services are the same as the service definitions and standards specified in the federally approved Elderly Waiver plan, except that the lead agency may contract with a beneficiary's relative to meet the relative hardship waiver requirements in order to provide personal care services under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional. Approved services are prior authorized in the MMIS system. Services are provided by qualified providers who are enrolled as Medicaid providers.
- b. The state must provide reports as required in quarterly and annual reporting for the demonstration, per STCs 33 and 34. This must include monitoring, remediating and reporting on any critical incidents including but not limited to maltreatment, abuse, neglect, or exploitation of individuals consistent with both requirements for Minnesota's Elderly Waiver (a 1915(c) home and community-based waiver and section 1115 demonstration quarterly and annual reporting requirements.
- c. The state will also monitor and report on provision of services and assure that provider qualifications as identified in program policy are met.

28. CFSS Delivery System. Individuals will receive services through the delivery system options approved in the 1915(i) and 1915(k) SPAs.

X. GENERAL REPORTING REQUIREMENTS

29. General Financial Requirements. The state must comply with all general financial requirements under Title XIX of the Social Security Act, including reporting requirements related to monitoring budget neutrality as set forth in Section XII of these STCs.

30. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality as set forth in Section XI of these STCs, including the submission of corrected budget neutrality data upon request.

31. Monthly Monitoring Calls. CMS will convene monthly monitoring 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, transition and implementation activities, stakeholder concerns raised at the Native American Advisory Board and the Native American Technical Advisory Subcommittee, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes in payment rates, progress on evaluations, state legislative developments, any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring

budget neutrality. CMS 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 shall jointly develop the agenda for the calls.

32. **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 STC 33, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 34.
33. **Quarterly Reports:** The state must submit progress reports in accordance with the guidance 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 under the demonstration. These quarterly reports must include, but not be limited to:
- a. An updated budget neutrality monitoring spreadsheet;
 - b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues;; benefits; enrollment; grievances; critical incidents; quality of care; changes in provider qualification standards; access; pertinent legislative activity; and other operational issues;
 - c. Adverse incidents including but not limited to abuse, neglect and exploitation consistent with requirements for both Minnesota's 1915(c) Elderly Waiver and section 1115 quarterly and annual reporting requirements;
 - d. Updates on the post award forums required under STC 32
 - e. Action plans for addressing any policy, administrative, or budget issues identified;
 - f. Updates on HCBS quality strategies per the state's 1915(c) waivers, 1915(i), and 1915(k) state plan amendments;
 - g. Information on beneficiary complaints, grievances and appeals filed during the quarter by type and a description of the resolutions and outcomes;
 - h. Monthly enrollment reports that include the member months for each demonstration population and the end-of-quarter, point-in-time enrollment for each demonstration population, and number of individuals enrolling in the Alternative Care program

diverted from a nursing facility/institutional stay or the Elderly Waiver;

- i. Evaluation activities and interim findings. The state must include a summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. The discussion must also include interim findings when available; status of contracts with independent evaluator(s), if applicable; status of Institutional Review Board approval, if applicable; and status of study participant recruitment, if applicable.
- i. Identify any quality assurance/monitoring activity in current quarter. As part of the annual report, pursuant to STC 34, the state must also report on the implementation and effectiveness of the Comprehensive Quality Strategy as it impacts the demonstration.

34. **Annual Report.** The annual report must, at a minimum, include the requirements outlined below. The state must submit the draft annual report no later than April 1 after the close of each demonstration year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

- a. All items included in the quarterly report pursuant to STC 33 must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
- c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement, and the total number of unique enrollees within the DY;
- d. Comprehensive Quality Strategy. Pursuant to STC 62, the state must report on the implementation and effectiveness of the updated Comprehensive Quality Strategy as it impacts the demonstration;
- e. Updates on HCBS quality strategies per the state's 1915(c) waivers, 1915(i), and 1915(k) state plan amendments;

35. **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.

XI. GENERAL FINANCIAL REQUIREMENTS

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.

- 36. Quarterly Financial Reports.** The state must provide quarterly Title XIX expenditure reports using Form CMS-64 to separately report total Title XIX expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XII of the STCs.
- 37. Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
- a. Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of Title XIX and section 1115 of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension which indicates the DY in which services were rendered or for which capitation payments were made). 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 10C. 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 38.
 - b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
 - c. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

- d. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.
- e. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The Federal Government a federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state must exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. Should the state elect this, these amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their “P” counterparts), and not on any waiver form.
- f. Demonstration Years. The first demonstration Year (DY1) will be the date of the approval letter through June 30, 2014, and subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	Date of approval to June 30, 2014	8 months
Demonstration Year 2 (DY2)	July 1, 2014 to June 30, 2015	12 months
Demonstration Year 3 (DY3)	July 1, 2015 to June 30, 2016	12 months
Demonstration Year 4 (DY4)	July 1, 2016 to June 30, 2017	12 months
Demonstration Year 5 (DY5)	July 1, 2017 to June 30, 2018	12 months

- g. Use of Waiver Forms. For each quarter of each demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, must be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The state must complete separate waiver forms for the following Medicaid eligibility groups/waiver names:
 - i. Alternative Care [“Alt Care”]
 - ii. 1915(i)-like [“1915i-like”]
 - iii. 1915(k)-like [“1915k-like”]
 - iv. ADL Children [“ADL Children”]

38. Expenditures Subject to the Budget Neutrality Limit. For purposes of this section, the term “expenditures subject to the budget neutrality limit” must include:

- a. All demonstration medical assistance expenditures (including those authorized through the Medicaid state plan, and through the section 1115 waiver and

expenditures authorities), but excluding the increase expenditures resulting from the mandated increase in payments to physicians per STC 37(e) made on behalf of all demonstration participants listed in the tables in STC 18, with dates of services within the demonstration's approval period; and

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.

39. **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".
40. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
41. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:
 - a. For the purpose of calculating the budget neutrality limit and for other purposes, the state must provide to CMS on a quarterly basis, as part of the quarterly report requirement in STC 33, the actual number of eligible member months for the demonstration populations described in STC 37. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of the information. Member-month enrollment information must be provided to CMS in conjunction with the quarterly reports pursuant to STC 33.
 - b. The state must report the actual number of member months for Eligibility Groups i through iv as defined in STC 37(g).
 - c. 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.
 - c. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

42. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS 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.
43. **Extent of Federal Financial Participation for the demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section X of the STCs:
- a. Administrative costs, including those associated with the administration of the demonstration;
 - b. Net medical assistance expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan; and,
 - c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.
44. **Sources of Non-Federal Share.** The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.
- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
 - b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.
 - c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as

the approved Medicaid state plan.

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

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

46. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration (including but not limited to primary data on enrollment, quality, encounters, and expenditures), upon request, in a reasonable time frame.

47. 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.

48. **T-MSIS.** On August 23, 2013, a State Medicaid Director Letter entitled, “Transformed Medicaid Statistical Information System (T-MSIS) Data”, was released. It states that all states are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Minnesota against which the premium assistance demonstration will be compared. Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the State Medicaid Manual Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

XII. MONITORING BUDGET NEUTRALITY

49. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on the Medicaid and demonstration expenditures identified in paragraph 37 during the period of approval of the demonstration. The limit is determined using a nursing facility and Elderly Waiver diversion model for the Alternative Care component and a PMPM method for the remaining components. Budget neutrality limits are set on a yearly basis with a cumulative budget neutrality limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality limit. CMS’ assessment of the state’s compliance with these annual limits will be done using the Schedule C report from the CMS-64.
50. **Risk.** The state will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 18, but is not at risk for the number of participants in the demonstration population. By providing FFP for all demonstration eligibles, the state shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have been realized had there been no demonstration.
51. **Expenditures Excluded From Budget Neutrality Limit.** Regular FFP will continue for costs not subject to budget neutrality limit. These exclusions include:
- a. Allowable administrative expenditures;
 - b. Mandated increase in physician payment rates in 2013 and 2014 (as specified in STC 37(e));
 - c. Disproportionate Share Hospital (DSH) payments;
 - d. Graduate Medical Education (GME) payments;

- e. Pharmacy rebates (see STC 37(e)); and

52. Calculation of the Budget Neutrality Limit and How It Is Applied. The budget neutrality limit is determined using a nursing facility and Elderly Waiver diversion model for the Alternative Care component and a PMPM method for the remaining components (CFSS and children who would otherwise lose Medicaid eligibility).

The following are the PMPM costs for the calculation of the budget neutrality limit for the demonstration enrollees in the MEGs listed in STC 37(h) under this approval period. *The demonstration year is July 1 through June 30.*

- a. The PMPM costs for the calculation of the annual budget neutrality limit for the eligibility groups subject to the budget neutrality limit under this demonstration are specified below. The 1915(i) like EG consists only of CFSS services. The 1915(k) like EG consists of CFSS services and Medicaid state plan benefits. The ADL Children EG consists of Medicaid state plan benefits and HCBS waiver services, if applicable. These are “pass-through” or “hypothetical” populations. Therefore, the state may not derive savings from these populations.

Demonstration Eligibility Groups	Trend Rate	DY 1 (SFY 2014)	DY 2 (SFY 2015)	DY 3 (SFY 2016)	DY 4 (SFY 2017)	DY 5 (SFY 2018)
1915(i)-like	2.51%	\$950.00	\$973.85	\$998.29	\$1,023.35	\$1,049.04
1915(k)-like	2.51%	\$2,542.62	\$2,606.44	\$2,671.87	\$2,738.93	\$2,807.68
ADL Children	3.70%	\$8,672.32	\$8,993.20	\$9,325.95	\$9,671.01	\$10,028.84

- b. For each year of the budget neutrality agreement, an annual budget neutrality expenditure limit is calculated for each MEG. An annual MEG estimate must be calculated as a product of the number of eligible member months reported by the state under STC 41 for each MEG, times the appropriate per member per month (PMPM) costs from the table in STC (this item)(a).
- c. The annual budget neutrality limit for the demonstration as a whole is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (b) above.

53. Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the forms listed in STC 37(h) above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the approval period (see STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of the Composite Federal Share may be used.

54. Lifetime Demonstration Budget Neutrality Limit. The lifetime (overall) budget neutrality limit for the demonstration is the sum of the annual budget neutrality limits calculated in STC 52(c). The federal share of the overall budget neutrality limit (calculated as the product

of the overall budget neutrality limit times the Composite Federal Share) represents the maximum amount of FFP that the state may receive for demonstration expenditures during the demonstration period reported in accordance with STC 37.

55. Future Adjustments to the Budget Neutrality Limit. CMS reserves the right to adjust the budget neutrality limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

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

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 5	Cumulative budget neutrality limit plus:	0 percent

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

XIII. EVALUATION OF THE DEMONSTRATION

58. Submission of Draft Evaluation Design. The state must submit to CMS for approval, within 120 days of the approval date of the new demonstration/renewal, a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan must cover all elements in STC 60. The updated design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented. The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. 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. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.

The design must describe the state's process to contract with an independent evaluator, ensuring no conflict of interest.

The design, including the budget and adequacy of approach, to assure the evaluation meets the requirements of STC 60(a), is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected in the paragraph above. The rigor also described above also applies as appropriate throughout Sections XIII and XIV. The approved evaluation design will be found in Attachment B of these STCs once approved by CMS.

59. Cooperation with Federal Evaluators. Should HHS undertake an evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by HHS. The state shall submit the required data to HHS or its contractor

60. Evaluation Design.

- a. Domains of Focus – The state must propose as least one research question that it will investigate within each of the domains listed below. The research questions should focus on processes and outcomes that relate to the CMS Three-Part Aim of better care, better health, and reducing costs.
 - i. Quality. The effect of the demonstration on quality of the LTSS system through better health outcomes, increased independence and recovery and increased community integration;
 - ii. Access. The effect of the demonstration on access to LTSS and simplification of LTSS program administration;
 - iii. Costs. The effect of the demonstration on the financial sustainability of the LTSS system through reduced reliance on institutional care and reduced medically necessary costs through improved health outcomes.
 - iv. The impact of the demonstration as a deterrent against Medicaid fraud and abuse;
- b. Measures. 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:

- i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);
 - ii. The measure steward;
 - iii. The baseline value for each measure;
 - iv. The sampling methodology for assessing these outcomes; and
 - v. The methods of data collection.
- c. Sources of Measures. 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).
 - d. The evaluation design must also discuss the data sources used, including 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.

61. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design and the draft Minnesota Reform 2020 evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS' comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation final report by 120 days of the end of the demonstration period. CMS will provide comments on the final report within 60 days of receipt and the state must submit the final evaluation report within 60 days after receipt of CMS' comments.

The final report must include the following:

- a) An executive summary;
- b) A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;
- c) A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;

- d) A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);
- e) Final evaluation findings, including a discussion of the findings (interpretation and policy context); and,
- f) Successes, challenges, and lessons learned.

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

62. Comprehensive Quality Strategy (CQS). The state shall incorporate into its overall quality improvement strategy specific measures and processes related to the programs affected by this demonstration. The state's overarching comprehensive and dynamic continuous quality improvement strategy should integrate all aspects of quality improvement programs, processes, and requirements across the state's Medicaid program, including but not limited to: fee for service populations, Reform 2020, Prepaid Medical Assistance Plus (PMAP+), and managed long term services and supports, managed care and any section 1915(c) HCBS waivers.

- a) The Comprehensive Quality Strategy should include:
 - i. The state's goals for improvement, identified through claims and encounter data, quality metrics and expenditure data. The goals should align with the three part aim but should be more specific in identifying specific pathways for the state to achieve these goals.
 - ii. The associated interventions for improvement in the goals. All programmatic performance improvement plans (PIPs) must be included in the comprehensive quality strategy.
 - iii. The specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the Medicaid and CHIP adult and child core measures, and should also align with other existing Medicare and Medicaid federal measure sets where possible. The metrics should go beyond HEDIS and CAHPS data, and should reflect cost of care.
 - iv. Metrics should be measured at the following levels of aggregation: the state Medicaid agency, each health plan or program, if applicable, and potentially at each direct health services provider. The state will work with CMS to further define metrics as appropriate for the plan.
 - v. The specific methodology for determining benchmark and target performance on these metrics for each aggregated level as planned.
 - vi. Specific metrics related to each population covered by the Medicaid program. HCBS performance measures, consistent with the corrective action plan, in the areas of: level of care determinations, person-centered service planning process, outcome of person-centered goals, health and welfare, and assuring there are qualified providers and appropriate HCBS settings.
 - vii. Monitoring and evaluation. This should include specific plans for continuous quality improvement, which includes transparency of performance on metrics and

structured learning, and also a rigorous and independent evaluation of the demonstration, as described in STC 60. The evaluation should reflect all the programs covered by the CQS as mentioned above.

- b) The CQS components that apply to this demonstration should include a timeline that considers metric development and specification, contract amendments, data submission and review, incentive disbursement (if available), and the potential re-basing of performance data.
- c) The CQS should include state Medicaid agency and any contracted service providers' responsibilities, including managed care entities, and providers enrolled in the state's FFS program. The state Medicaid agency must retain ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The CQS must include distinctive components for discovery, remediation, and improvement.
- d) The first draft of the elements of the CQS related to this demonstration is due to CMS no later than 120 days following the approval of this new demonstration/amendment/renewal. CMS will review this draft and provide feedback to the state. The state must revise and resubmit the CQS to CMS for approval within 45 days of receipt of CMS comment. The state must revise (and submit to CMS for review and approval) their CQS whenever significant changes are made to the associated Medicaid programs and the content of the CQS. Revisions to the CQS must be submitted to CMS for review and approval within 90 days of approval. Because Minnesota plans to crosswalk the quality improvement process already required for the five home and community-based waiver programs, and the 1915(k) and 1915(i) state plan, CMS will coordinate approval of the five home and community-based waivers and the 1915(k) and 1915(i) state plan amendments, which contain comprehensive quality strategies, with the approval of the quality strategy for the Alternative Care Program and the 1915(k)-like and 1915(i)-like populations covered by this section 1115 demonstration.

Any further revisions must be submitted accordingly:

- i. Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver renewals) so that CMS may ensure coordination of approval; and/or,
 - ii. Changes to an existing, approved CQS due to fundamental changes to the CQS must be submitted for review and approval to CMS no later than 60 days prior to the contractual implementation of such changes. If the changes to the CQS do not impact any provider contracts, the revisions to the CQS may be submitted to CMS no later than 60 days following the changes.
- e) To the extent the quality strategy contains components in addition to the HCBS waiver programs and the 1915(k) and 1915(i) state plan, which already have transparency requirements, the state must solicit for and obtain the input of

beneficiaries, the Medical Care Advisory Committee (MCAC), and other stakeholders in the development of its CQS and make the initial CQS, as well as any significant revisions, available for public comment prior to implementation. Pursuant to STC 34, Annual Report, the state must also provide CMS with annual reports on the implementation and effectiveness of their CQS as it impacts the demonstration. These annual reports may be aligned with reporting already required through the HCBS waivers and the 1915(k) and 1915(i) state plan.

- f) As required by 42 C.F.R. §438.360(b)(4), the state must identify in the CQS any standards for which the EQRO will use information from private accreditation reviews to complete the compliance review portion of EQR for participating MCOs or PIHPs. The state must, by means of a crosswalk included in the CQS, set forth each standard that the state deems as duplicative to those addressed under accreditation and explain its rationale for why the standards are duplicative.
- g) Upon approval by CMS, this document will be found as Attachment C to these STCs.

XV. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION APPROVAL PERIOD

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

Date - Specific	Deliverable	STC Reference
Within six months of demonstration implementation and annually thereafter	Post Award Forum	Section X, STC 32
60 days following the end of the quarter	Quarterly Operational, Progress and Enrollment Reports	Section X, STC 33
120 days following the end of the demonstration year	Annual Report	Section X, STC 34
60 days following the end of the quarter	CMS-64 Reports	Section XI, STC 37
60 days following the end of the quarter	Eligible Member Months	Section XI, STC 41
30 days following the end of the quarter	Quarterly Financial Reports	Section XI, STC 36
120 days following approval of the demonstration	Draft Evaluation Design	Section XIII, STC 58

Within 60 days of receipt of CMS comments	Final Evaluation Design	Section XIII, STC 58
120 days following approval of the demonstration	Draft Comprehensive Quality Strategy	Section XIV, STC 62
Within 45 days of CMS comments	Final Comprehensive Quality Strategy	Section XIV, STC 62
120 days following the end of the demonstration period	Draft Final Evaluation Report	Section XIII, STC 61
120 days following the end of the demonstration	Draft Final Report	Section X, STC 35
90 days of receipt of CMS comments	Final Evaluation Report	Section XIII, STC 61
Within 90 days of receipt of CMS comments	Final Report	Section X, STC 35

ATTACHMENT A

QUARTERLY REPORT CONTENT AND FORMAT

Under Section X, STC 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. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is required.

NARRATIVE REPORT FORMAT:

Title Line One – Reform 2020

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 1 (date of approval letter – 06/30/2014)

Federal Fiscal Quarter: 2/2014(1/14 - 3/14)

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: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the CMS 64)	Enrollees at close of quarter (date)	Current Enrollees (to date)	Disenrolled in Current Quarter
<u>Population 1:</u> Alternative Care			
<u>Population 2:</u> 1915(i)-like			
<u>Population 3:</u> 1915(k)-like			
<u>Population 4:</u> ADL Children			

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
<u>Population 1:</u> Alternative Care				
<u>Population 2:</u> 1915(i)-like				
<u>Population 3:</u> 1915(k)-like				
<u>Population 4:</u> ADL Children				

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

**RESERVED FOR OPERATIONAL PROTOCOL
FOR THE ALTERNATIVE CARE PROGRAM**