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

July 24, 2015

David J. Dzielak, PhD
Executive Director
State of Mississippi, Department of Human Services, Division of Medicaid
550 High Street Suite 1000, Walters Sillers Building
Jackson, MS 39201-1325

Dear Dr. Dzielak:

We are pleased to inform you that the extension of the Mississippi Medicaid section 1115 demonstration, "Healthier Mississippi" (No. 11-W-00185/4), has been approved in accordance with section 1115(a) of the Social Security Act.

This renewal is effective as of the date of this letter through September 30, 2018, upon which date, unless reauthorized, all authorities granted to operate this demonstration will expire. Our approval of this demonstration project is subject to the limitations specified in the attached expenditure authority. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as not applicable to expenditures for the demonstration population in the expenditure authority.

The state is receiving approval to raise the enrollment cap from 5,500 to 6,000. We are also approving the state's request to add the following services: podiatry, eyeglasses, dental, and chiropractic services.

The approval is conditioned upon continued compliance with the enclosed Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The approval is also subject to our receiving your written acknowledgement of this award and acceptance of the STCs and expenditure authorities within 30 days of the date of this letter.

Your project officer for this demonstration is Jeremy Bates. He is available to answer any questions concerning your section 1115 demonstration renewal. Mr. Bates' contact information is as follows:

Centers for Medicare & Medicaid Services
State Demonstrations Group
7500 Security Boulevard, Mailstop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-2613
Facsimile: (410) 786-8534
E-mail: Jeremy.Bates@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Bates and to Ms. Jackie Glaze, Associate Regional Administrator in our Atlanta Regional Office. Ms. Glaze's contact information is as follows:

Centers for Medicare and Medicaid Services
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have questions regarding the terms of this approval, please contact Eliot Fishman, Director, State Demonstrations Group, at (410) 786-5647. We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Vikki Wachino
Director

Enclosures

cc: Jackie Glaze, ARA, Region IV

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY LIST

NUMBER: 11-W-00185/4

TITLE: Healthier Mississippi Medicaid Section 1115 Demonstration

AWARDEE: Mississippi Division of Medicaid

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

The expenditure authority listed below promotes the objectives of title XIX in the following ways: by increasing overall coverage of low-income individuals in the state and improving health outcomes for Medicaid and low-income populations in the state.

The following expenditure authority shall enable Mississippi to implement its section 1115 Healthier Mississippi demonstration.

1. **Demonstration Population 1.** Expenditures for health care services provided to individuals with income up to 135 percent of the federal poverty level who are aged or disabled, and are not eligible for Medicare, and are not eligible under the Medicaid state plan.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the demonstration population beginning as of the date of the approval letter through September 30, 2018.

Title XIX Requirements Not Applicable

1. **Amount, Duration, and Scope** **Section 1902(a)(10)(B)**

   To enable the state to provide a different benefit package to individuals covered under the demonstration.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00185/4**

TITLE: **Healthier Mississippi Demonstration**

AWARDEE: **Mississippi Division of Medicaid**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Healthier Mississippi section 1115(a) Medicaid demonstration extension (hereinafter "demonstration"). The parties to this agreement are the Mississippi Division of Medicaid (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The demonstration extension is approved through September 30, 2018. The STCs are effective as of the date of the approval letter through September 30, 2018, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

- Program Description and Objectives;
- General Program Requirements;
- Eligibility, Benefits, and Cost Sharing;
- Delivery Systems;
- General Reporting Requirements;
- General Financial Requirements;
- Monitoring Budget Neutrality for the demonstration;
- Evaluation of the demonstration; and,
- Schedule of State Deliverables.

Additionally, one attachment has been included to provide supplementary guidance.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Healthier Mississippi demonstration was approved in September 2004 and provides coverage for aged or disabled individuals with incomes at or below 135 percent of the federal poverty level (FPL) who are not eligible for Medicare and do not otherwise qualify for Medicaid.

In the 2004 legislative session, the Mississippi Legislature voted to discontinue Medicaid coverage for the optional Poverty Level Aged and Disabled (PLAD) group effective July 1, 2004. Concerned that this population was at risk for costly adverse events, including institutional placement, if medical regimens were not maintained, the state applied and received approval for a section 1115 demonstration to continue coverage for this population.

The demonstration was predicated on the assumption that continued access to medical care by the PLAD population, will delay deterioration in health status which drives hospitalization and/or institutionalization in a nursing facility. Under the 2010 renewal, the state requested and CMS increased the enrollment cap from 5,000 to 5,500. Under the 2015 renewal, CMS approved two changes: increasing the enrollment limit from 5,500 to 6,000 and adding to the benefit package the following previously excluded services: podiatry, eyeglasses, dental, and chiropractic services.

With this demonstration, Mississippi expects to achieve the following to promote the objectives of title XIX:

- Increase access to primary and preventive services which will reduce hospitalizations, premature nursing facility placements, and improper use of the emergency department; and,
- Slow the deterioration of health status for the demonstration population.

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

    a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. 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.** The state will not be required to submit a title XIX state plan amendment for changes to any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to program design, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

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

   a) An explanation of the public process used by the state, consistent with the requirements of STC 12, to reach a decision regarding the requested amendment;

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

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

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

8. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it

determines following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

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

10. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. 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.

11. **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.

12. **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 implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §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 7 are proposed by the state.

    a) *Consultation with Federally Recognized Tribes on New Demonstration Proposals Applications and Renewals of Existing Demonstrations*. 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) *Seeking Advice and Guidance from Indian Health Programs Demonstration Proposals, Renewals, and Amendments*. In states with 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 in accordance with the process in the state's approved Medicaid state plan prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.

13. FFP. No federal matching funds for expenditures for this demonstration will be made available to the state until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY, BENEFITS AND COST SHARING

14. Demonstration Eligibility.

a) The group described in STC 14(b), which is made eligible for the demonstration by virtue of the expenditure authority expressly granted in this demonstration, is subject to all applicable Medicaid laws or regulations in accordance with the state plan, except as specified as not applicable in the expenditure authority for this demonstration.

b) Eligibility for the Healthier Mississippi demonstration is limited to aged or disabled individuals who are not eligible for Medicare and do not otherwise qualify for Medicaid, who are not inpatients in a long term care institution, and whose:

i. Income is at or below 135 percent of the FPL for an individual or couple, calculated using a methodology based on the SSI program, as well as income exclusions approved under the state plan under the authority of section 1902(r)(2) of the Social Security Act; and,

ii. Resources are below $4,000 for an individual and $6,000 for a couple.

15. Enrollment Cap. Effective as of the date of the approval letter through September 30, 2018, the Healthier Mississippi enrollment cap will be 6,000. When enrollment reaches 6,000, further enrollment is suspended and individuals making an application are placed on a waiting list. Individuals are moved off the waiting list and enrolled in the demonstration as openings become available.

16. Benefit Package. Children (ages 0 through 20) enrolled in the demonstration receive all Medicaid state plan benefits, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Adults (ages 21 and older) enrolled in the demonstration receive most services covered under the Medicaid state plan with the same service limits per the Medicaid state plan. Maternity and newborn care are available to individuals who need them by enrolling in Medicaid on a different basis.

Services Not Covered for Adults
Swing bed in a skilled nursing facility
Long-term care services (nursing facility, home and community based waiver, and ICF/IID services)
Maternity and Newborn Care

Admission to Nursing Facilities: Expenditures incurred for any services received while a Healthier Mississippi enrollee is an inpatient in a long term care institutional setting will not be claimed under the demonstration. Any individual enrolled in Healthier Mississippi who is admitted to a nursing facility or other long term care setting, either temporarily (for less than 30 days) or for a longer admission, will be assessed for eligibility under a Medicaid State Plan covered category. Such individuals will be disenrolled from the demonstration upon admission to an institution and assessed for re-enrollment into the demonstration upon discharge from the institutional setting.

17. **Cost Sharing.** There are no cost-sharing requirements for children enrolled in the demonstration. Adult recipients are subject to cost sharing requirements that would be applicable if they were provided coverage under the state plan. A family's total annual out-of-pocket cost sharing cannot exceed five percent of the family's gross income.

V. DELIVERY SYSTEMS

18. **Service Delivery.** Demonstration services are delivered through the state's fee-for-service provider network.

VI. GENERAL REPORTING REQUIREMENTS

19. **General Financial Requirements.** The state must comply with all general financial requirements set forth in section VII.

20. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements set forth in section VIII.

21. **Bi-Monthly Call.** CMS shall schedule bi-monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, cost sharing, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under

review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

22. **Quarterly Reports.** The state must submit progress reports in the format specified in Attachment A, no later than 60 days following the end of each quarter. The intent of these reports is to present the state's data along with an analysis of the various operational areas under the demonstration.

23. **Annual Report.** The state must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under STC 22. The state must submit this report no later than 90 days after the end of each demonstration year.

24. **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 will take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 60 days after receipt of CMS' comments.

VII. GENERAL FINANCIAL REQUIREMENTS

25. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section VIII.

26. **Expenditures Subject to the Budget Neutrality Expenditure Limit.** All expenditures for health care services for demonstration participants, as defined in STC 27(d), are subject to the budget neutrality agreement.

27. **Reporting Expenditures Subject to the Budget Neutrality Expenditure Limit.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

    a) **Tracking Expenditures.** In order to track expenditures, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64. 9 Waiver and/or 64. 9P Waiver, identified by the demonstration project number (11-W-00185/4) assigned by CMS, including the

project number extension which indicates the demonstration year (DY) in which services were rendered.

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) **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64. 9 Waiver for the demonstration, and not on any other CMS-64. 9 form (to avoid double counting). Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d) **Use of Waiver Forms.** For each DY, a Waiver Form CMS-64.9 Waiver and/or 64. 9P Waiver must be submitted each quarter to report title XIX expenditures associated with the demonstration. The expression in quotations marks, for the Population below, is the waiver name to be used to designate this waiver form in the MBES/CBES system.

    i. **Demonstration Population 1 "Medicaid Only":** Aged or disabled individuals enrolled in the demonstration below 135 percent of the FPL who are not eligible for Medicare and do not otherwise qualify for Medicaid.

e) **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64. 10 Waiver and/or 64. 10P Waiver.

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

28. **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 limit and separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and state and Local Administrative Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

29. **Extent of FFP.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in section

    a) Administrative costs, including those associated with the administration of the demonstration; and,

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

30. **Sources of Non-federal Share.** The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures that such funds shall not be used as the 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 at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

    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.

31. **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; and,

e) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state 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, and 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.

32. Monitoring the Demonstration. The state must provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

33. 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.

VIII. MONITORING BUDGET NEUTRALITY

34. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures

during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS's assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

35. Risk. Mississippi shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not for the number of demonstration eligibles. Because CMS provides FFP for all demonstration eligibles, Mississippi shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Mississippi at risk for the per capita costs for current, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

36. Demonstration Population Used to Calculate the Budget Neutrality Expenditure Cap. The following describes the method for calculating the budget neutrality expenditure cap for the demonstration:

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group (EG) described as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under STC 22 for the demonstration population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (ii) below.

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

Eligibility Group	Growth Rate	DY 11 10/01/2014 through 09/30/2015	DY 12 10/01/2015 through 09/30/2016	DY 13 10/01/2016 through 09/30/2017	DY 14 10/01/2017 through 09/30/2018
Demonstration Population 1 – Medicaid only	4.2%	$2,269.32	$2,364.63	$2,463.95	$2,567.44

iii. The annual budget neutrality expenditure cap for the demonstration as a whole is the sum of the projected annual expenditure cap for the demonstration population calculated in subparagraph (i) above.

b) Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the extension approval period, as reported on the forms listed in STC 27 above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.

c) The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a)(iii). The federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration population described in STC 27 during the demonstration period reported in accordance with STC 27.

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

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

Demonstration Year	Cumulative Expenditure Cap Definition	Percentage
Year 1	Budget neutrality expenditure cap plus	1 percent
Years 1 and 2	Combined budget neutrality expenditure caps plus	.5 percent
Years 1, 2, and 3	Combined budget neutrality expenditure caps plus	0 percent

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

IX. EVALUATION OF THE DEMONSTRATION

40. Submission of Draft Evaluation Design. The state shall submit to CMS for approval, within 120 days from the award of the demonstration, a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the demonstration. The draft design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

The state must evaluate the extent to which the demonstration successfully prevents nursing facility, emergency department, and inpatient hospitalization admissions.

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

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

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	STC Reference
Date Specific	Draft Evaluation Design – Due 120 days from the date of the approval letter	Section IX, STC 40
Annual	Annual Report - Due December 31st	Section VI, STC 23
Quarterly	Quarterly Progress Reports – Due 60 days following the end of the quarter	Section VI, STC 22
Quarterly	Quarterly Expenditures Reports – Due 30 days following the end of each quarter using Form CMS-64	Section VII, STC 25

ATTACHMENT A

QUARTERLY OPERATIONAL REPORT FORMAT

Under STC 22, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

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

NARRATIVE REPORT FORMAT

Title Line One – Healthier Mississippi

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 12 (10/01/2015 - 09/30/2016)
Federal Fiscal Quarter: 1/2016 (10/1/2015 - 12/31/2015)

Introduction

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

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0". Enrollment counts should be person counts.

Participant Populations	Total as of end of Current Quarter	Voluntary Disenrolled in Current Quarter	No. Involuntary Disenrolled in Current Quarter
Population 1 – Medicaid Only			

Outreach/Innovative Activities

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

Operational/Policy Developments/Issues

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

Consumer Issues

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

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address these issues.

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