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

State Demonstrations Group

December 21, 2016

MaryAnne Lindeblad
Medicaid Director
Washington Health Care Authority
626 8th Avenue, P.O. Box 45502
Olympia, WA 98504-5050

Dear Ms. Lindeblad:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of Washington's Take Charge section 1115 family planning demonstration (Project No. 11-W-00134/0) until December 31, 2017. This temporary extension will allow the state and CMS to continue working together on approval of the demonstration extension.

The demonstration will continue to operate under the authority of section 1115(a) of the Social Security Act. Additionally, the current list of expenditure authorities and Special Terms and Conditions will continue to apply to the Take Charge demonstration until December 31, 2017.

If you have any questions, please do not hesitate to contact your project officer, Ms. Patricia Hansen. Ms. Hansen can be reached at (410) 786-4252 or at patricia.hansen1@cms.hhs.gov. We look forward to continuing to work with you and your staff on this demonstration.

Sincerely,

/s/

Eliot Fishman
Director

cc: David Meacham, Associate Regional Administrator, CMS Seattle Regional Office
Janice Adams, Staff Lead, CMS Seattle Regional Office

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

Children and Adults Health Programs Group

June 27, 2013

MaryAnne Lindeblad
Medicaid Director
Health Care Authority
626 8th Avenue PO Box 45502
Olympia, WA 98504-5050

Dear Ms. Lindeblad:

With this letter, the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of Washington's Take Charge (Project No. 11-W-00134/0-01) demonstration until December 31, 2014. The demonstration is currently operating under the authority of section 1115(a) of the Social Security Act. The current lists of waiver and expenditure authorities and special terms and conditions will continue to apply to the Take Charge demonstration until December 31, 2014.

As you know, starting January 1, 2014, eligibility for Medicaid for most individuals will be determined using methodologies that are based on modified adjusted gross income (MAGI). This requirement applies to eligibility for family planning section 1115 demonstrations. In addition, starting October 1, 2013, states are also required to make available a single, streamlined application for MAGI-based eligibility.

We understand that there are special attributes of this demonstration to consider when deciding how to integrate family planning eligibility into the state's MAGI eligibility rules and the single, streamlined application process. Should you need additional time to integrate these features into your family planning section 1115 demonstration, CMS requests that you use the standard process of requesting acceptable mitigations. Your project officer, Shanna Wiley, with the Division of State Demonstrations and Waivers, is available to work with you to determine the appropriate approach for your state if you are not able to integrate these features into your family planning 1115 demonstration by January 1, 2014. Please do hesitate to contact Ms. Wiley at (410) 786-1370, or at shanna.wiley@cms.hhs.gov.

Sincerely,

/s/

Jennifer Ryan
Acting Director

cc: Carol Peverly, ARA, Region X
Janice Adams, Seattle Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

Mr. Doug Porter
Director
Health Care Authority
626 8th Avenue
P.O. Box 45502
Olympia, WA 98504

Dear Mr. Porter:

We are pleased to inform you that Washington's request for an extension of its section 1115 family planning demonstration entitled, "TAKE CHARGE" as modified by the Special Terms and Conditions (STCs) accompanying this award letter, has been approved as project number 11-W-00134/0-01.

Under this demonstration, the State will provide family planning and family planning-related services to women losing Medicaid pregnancy coverage at the conclusion of a 60 day postpartum period and to women and men who have family incomes at or below 250 percent of the Federal poverty level (FPL), who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). Approval of the extension of this demonstration is under the authority of section 1115(a) of the Social Security Act (the Act) and is effective as of the date of this approval letter through December 31, 2013.

As indicated over the course of our discussions, CMS is not approving the State's request that CMS not apply sections 1902(a)(17) and1902(a)(46)(B) of the Act to the expansion population, to the extent necessary to allow individuals to self-declare citizenship. Our rules at 42 CFR 435.406(a)(iii) state that citizenship documentation requirements apply to demonstrations under section 1115, including family planning demonstrations (see also 72 Fed. Reg. 38662, 38682, July 13, 2007). Additionally, CMS is not approving Washington State's requests to not apply the requirements of section 1137 of the Act in order to not require individuals to provide social security numbers at the time of application, and for the State to not conduct income verification for all applicants through available electronic data matches. In accordance with section 1137 of the Act and related regulatory guidance, the State currently has the flexibility to accept self attestation and follow-up with data matches after enrollment.

Our approval of this demonstration project is subject to the limitations specified in the enclosed approved expenditure authorities list and title XIX requirements made not applicable. The State may deviate from the Medicaid State plan requirements only to the extent those requirements have been specifically listed as granted expenditure authority or title XIX requirements not applicable. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not

expressly identified as not applicable in this letter, shall apply to the Washington TAKE CHARGE demonstration.

The approval is also conditioned upon continued compliance with the enclosed STCs defining the nature, character, and extent of Federal involvement in this project. This award letter is subject to our receipt of your written acceptance of the award, including the expenditure authority and STCs, within 30 days of the date of this letter.

Your contact for this demonstration is Ms. Kelly Heilman, who may be reached at (410) 786-1451 and through e-mail at Kelly.Heilman@cms.hhs.gov. Ms. Heilman is available to answer any questions concerning the scope and implementation of the project. Communications regarding the program matters and official correspondence concerning the demonstration should be submitted to Ms. Heilman at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850

Official communication regarding program matters should be sent simultaneously to Ms. Heilman and to Ms. Carol Peverly, Associate Regional Administrator in our Seattle City Regional Office. Ms. Peverly's contact information is as follows:

Centers for Medicare & Medicaid Services
Seattle Regional Office
Division of Medicaid and Children's Health Operations
Blanchard Plaza Building
2201 Sixth Avenue
MS/RX-43
Seattle, WA 98121

We extend our congratulations to you on this award and look forward to working with you during the course of the demonstration extension.

Sincerely,

Cindy Mann
Director

Enclosures

cc:

Carol Peverly, ARA, Seattle Regional Office
Janice Adams, State Representative
Kelly Heilman, CMCS

Centers for Medicare & Medicaid Services
SPECIAL TERMS AND CONDITIONS

NUMBER: **11 -W-00134/0-01**

TITLE: **TAKE CHARGE Section 1115 Family Planning Demonstration**

AWARDEE: **Washington Health Care Authority**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Washington family planning section 1115(a) Medicaid demonstration, entitled "TAKE CHARGE" (hereinafter "demonstration"). The parties to this agreement are the Washington Health Care Authority (the State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the State's obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter through December 31, 2013, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Benefits and Delivery Systems
VI. General Reporting Requirements
VII. General Financial Requirements
VIII. Monitoring Budget Neutrality
IX. Evaluation
X. Schedule of State Deliverables during the Demonstration
Appendix A: Template for Quarterly Operational Reports
Appendix B: Template for Annual Reports

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Washington family planning section 1115(a) Medicaid demonstration expands the provision of family planning and family planning-related services to women who are losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum period and individuals (men and women) who have family income at or below 250 percent of the Federal poverty level (FPL), and who are not otherwise enrolled in Medicaid or the Children Health Insurance Plan (CHIP).

Under this demonstration, Washington expects to promote the objectives of title XIX by:

- Increasing access to family planning services;
- Reducing the number of unintended pregnancies in Washington and;
- Reducing Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services.

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 programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

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

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

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

   b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day, such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment

process set forth in STC 6 below. The State will notify CMS of proposed demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. 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 impact of the proposed amendment on the current budget neutrality expenditure limit.

   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 must be modified to incorporate the amendment provisions.

7. **Demonstration Phase-Out.** The State may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

   a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

      The State must obtain CMS approval of approve the phase-out plan prior to the implementation of the phase-out activities. There must be a 14-day period between CMS approval of the phase-out plan and implementation of phase-out activities.

   b) Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State

will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d) 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.

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 with the terms of this agreement.

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

11. **Adequacy of Infrastructure.** CMS and the State acknowledge while funding is subject to appropriation from the State Legislature, the State must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with cost sharing requirements to the extent they apply; 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 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.

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)).

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, amendment 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.

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

IV. ELIGIBILITY

14. **Eligibility Requirements.** Family planning and family planning related services are provided to eligible individuals, provided the individual is redetermined eligible for the program on an annual basis. The State must enroll only individuals meeting the eligibility criteria below into the demonstration who are not otherwise enrolled in Medicaid or the Children's Health Insurance Plan (CHIP). Additionally, the State will provide 12 month continuous eligibility, and not require reporting of changes in income or household size for this 12-month period, for an individual found to be income-eligible for this demonstration upon initial application or annual redetermination.

    1) Women losing Medicaid pregnancy coverage (SOBRA pregnant women) at the conclusion of 60 days postpartum period and who have a family income at or below 250 percent of the Federal poverty level (FPL) at the time of annual redetermination; or

    2) Women who have family income at or below 250 percent of the FPL; or

    3) Men who have family income at or below 250 percent of the FPL.

15. **Eligibility Determinations.** Washington utilizes designated family planning providers to assist in collecting applications for the demonstration in order to facilitate streamlined access to eligibility determination with the ultimate goal of expanded access to family planning and family planning-related care. While providers assist in collecting applications, all eligibility

determinations are conducted by the State in conformance with required Medicaid provisions, including Single State Agency requirements. The State must utilize a Memorandum of Understanding (MOU) with each designated family planning provider to ensure that applications are forwarded to the State agency without delay for eligibility determinations.

Under the demonstration, the State will consider the date a signed application is received by a family planning provider as the date of application, and, if determined eligible, the eligibility effective date will be the first of the month in which a signed application was received by a family planning provider.

16. **Redeterminations.** The State must ensure that redeterminations of eligibility for the demonstration are conducted at least every 12 months. At the State's option, redeterminations may be administrative in nature.

17. **Demonstration Disenrollment.** If a woman becomes pregnant while enrolled in the demonstration, she may be determined eligible for Medicaid under the State plan. The State must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the demonstration.

V. BENEFITS AND DELIVERY SYSTEMS

18. **Family Planning Benefits.** Family planning services and supplies described in section 1905(a)(4)(C) and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:

    a) Approved methods of contraception;

    b) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams;
        i) Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

    c) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and

    d) Contraceptive management, patient education, and counseling.

19. **Family Planning-Related Benefits.** Family planning-related services and supplies are

defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the State's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:

a) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.

b) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.

c) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.

d) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

e) Treatment of major complications arising from a family planning procedure such as:
   i) Treatment of a perforated uterus due to an intrauterine device insertion;
   ii) Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
   iii) Treatment of surgical or anesthesia-related complications during a sterilization procedure.

20. **Primary Care Referrals.** Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The State must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.

21. **Services.** Services provided through this demonstration are paid fee for service (FFS).

VI. GENERAL REPORTING REQUIREMENTS

22. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in section VII.

23. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII.

24. **Monitoring Calls.** CMS and the State will participate in quarterly conference calls following the receipt of the quarterly reports unless CMS determines that more frequent calls are necessary to adequately monitor the demonstration. 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, quality of care, access, benefits, anticipated or proposed changes in payment rates, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any demonstration amendments the State is considering submitting. The State and CMS will discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS will update the State on any amendments under review as well as Federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls.

25. **Quarterly Operational Reports.** The State must submit progress reports no later than 60 days following the end of each quarter for every demonstration year (DY) within the format outlined in Appendix A. The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

    a) Quarterly expenditures for the demonstration population, with administrative costs reported separately;

    b) Quarterly enrollment reports for demonstration enrollees (enrollees include all individuals enrolled in the demonstration) that include the member months for each DY, as required to evaluate compliance with the budget neutral agreement and as specified in STC 33;

    c) Total number of participants served monthly during the quarter for each DY (participants include all individuals who obtain one or more covered family planning services through the demonstration);

    d) Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, benefits, enrollment, systems, grievances, quality of care, access, payment rates, pertinent legislative activity, eligibility verification activities, eligibility redetermination processes (including the option to utilize administrative redetermination), and other operational issues;

    e) Notification of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY;

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

g) An updated budget neutrality monitoring worksheet;

h) Progress updates to the transition plan as specified in STC 27; and

i) Evaluation activities and interim findings.

26. **Annual Report.** The annual report is due 90 days following the end of the fourth quarter of each DY within the format outlined in Appendix B. The report must include a summary of the year's preceding activity as well as the following:

a) Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

b) The average total Medicaid expenditures for a Medicaid-funded birth each DY. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants);

c) The number of actual births that occur to family planning demonstration participants within the DY. (participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year);

d) 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 as specified in STC 33;

e) Total number of participants for the DY (participants include all individuals who obtain one or more covered family planning services through the demonstration);

f) Progress updates to the transition plan as specified in STC 27;

g) A summary of program integrity and related audit activities for the demonstration, including an analysis of point-of-service eligibility procedures;

h) Evaluation activities and interim findings; and

i) An updated budget neutrality monitoring worksheet.

27. **Transition Plan.** The State is required to prepare and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the family planning demonstration. The transition plan must provide details on how the State plans to coordinate the transition of these individuals to a more comprehensive coverage option available under the Affordable Care Act, including the Medicaid eligibility group described in §1902(a)(10)(A)(i)(VIII), the American Health Benefit Exchange or other coverage options available in 2014, without interruption in coverage or access to care to the

maximum extent possible. The State must submit a draft to CMS by November 1, 2012, with progress updates included in each quarterly and annual report thereafter. The State will revise the transition plan as needed.

28. **Final Report.** The State must submit a final demonstration report to CMS to describe the impact of the demonstration, including the extent to which the State met the goals of the demonstration. The draft report will be due to CMS 180 days after the expiration of the demonstration. CMS must provide comments within 60 days of receipt of the draft final demonstration report. The State must submit a final demonstration report within 60 days of receipt of CMS comments.

VII. GENERAL FINANCIAL REQUIREMENTS

29. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS must 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.

30. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Agreement.** The following describes the reporting of expenditures subject to the budget neutrality limit:

    a) Tracking Expenditures. In order to track expenditures under this demonstration, Washington must report demonstration expenditures through the Medicaid and CHIP 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 assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made.

    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 other cost settlements not attributable to this demonstration, the adjustments should be reported on lines 9 or 10C as instructed in the State Medicaid Manual.

    c) Use of Waiver Forms. The State must report demonstration expenditures on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report title XIX expenditures for demonstration services.

31. **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.

32. **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. 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.

33. **Reporting Member Months.** The following describes the reporting of member months for the demonstration:

    a. For the purpose of calculating the budget neutrality expenditure limit, the State must provide to CMS, as part of the quarterly and annual reports as required under STC 25 and 26 respectively, the actual number of eligible member months for all demonstration enrollees. The State must submit a statement accompanying the quarterly and annual reports, certifying the accuracy of this information.

    b. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration 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 4 eligible member months.

34. **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 Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration 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.

35. **Extent of Federal Financial Participation (FFP) for the Demonstration.** CMS shall provide FFP for family planning and family planning-related services and supplies at the applicable Federal matching rates described in STC 18 and 19, subject to the limits and processes described below:

a) For family planning services, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

b) Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in STC 18, should be entered in Column (D) on the Forms CMS-64.9 Waiver.

c) Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in STC 19, should be entered in Column (B) on the Forms CMS-64.9 Waiver.

d) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, no FFP will be available.

e) Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

36. **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 shall review the sources of the non-Federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS 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.

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

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

VIII. MONITORING BUDGET NEUTRALITY

39. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding it may receive on selected Medicaid expenditures during the period of approval of the demonstration. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to budget neutrality expenditure limit shall be reported by the State using the procedures described in STC 30.

40. **Risk.** Washington shall be at risk for the per capita cost (as determined by the method described below in this section) for the Medicaid family planning enrollees, but not for the number of demonstration enrollees. By providing FFP for enrollees in this eligibility group, Washington shall not be at risk of changing economic conditions that impact enrollment

levels. However, by placing Washington at risk for the per capita costs for enrollees in the demonstration, CMS assures that Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

41. **Budget Neutrality Annual Expenditure Limits.** For each DY, an annual budget limit will be calculated for the demonstration. For the purposes of this demonstration, the DY is based off the calendar year (SFY) of July 1 to June 30. The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share.

    PMPM Cost. The following table gives the PMPM (Total Computable) costs for the calculation described above by DY. The PMPM cost was constructed based on State expenditures for DY 9 and increased by the rate of growth included in the President's Federal fiscal year 2012 budget for DYs 11, 12 and 13 as outlined below.

		SFY 2012	**SFY 2013**	**SFY 2014**
	Trend	**DY 11**	**DY 12**	**DY 13**
Demonstration Enrollees	**6.2%**	**$39.81**	**$42.28**	**$44.90**

a) 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 30 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 STCs 7 and 8), 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.

b) Structure. The demonstration is structured as a "pass-through" or "hypothetical" population. Therefore, the State may not derive savings from the demonstration.

c) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures, as reported by the State on the CMS-64 forms. If at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess Federal funds will be returned to CMS.

42. **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.

43. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality over the life of the demonstration, rather than annually. However, no later than 6 months after the end of each DY or as soon thereafter as the data are available, the State will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the State exceeds these targets, it will submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Year	Cumulative Target Expenditures	Percentage
DY 2012	DY 11 budget limit amount	+2 percent
DY 2013	DYs 11 through 12 combined budget limit amount	+0 percent

a) Failure to Meet Budget Neutrality Goals. The State, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which must include submitting a corrective action plan to CMS within 21 days of the date the State is informed of the problem. While CMS will pursue corrective actions with the State, CMS will work with the State to set reasonable goals that will ensure that the State is in compliance.

IX. EVALUATION

44. **Submission of Draft Evaluation Design.** A draft evaluation design report must be submitted to CMS for approval within 120 days from the award of the demonstration extension. At a minimum, the evaluation design should include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those of other initiatives occurring in the State. The report should also include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the demonstration) that are being tested. The report will also discuss the outcome measures that will be used in evaluating the impact of the demonstration, particularly among the target population. It will also discuss the data sources and sampling methodology for assessing these outcomes. The State must implement the evaluation design and report its progress in each of the demonstration's quarterly and annual reports.

45. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the demonstration described in STC 44, within 60 days of receipt of CMS comments.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

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.

Timeline	Deliverable	STC Reference
Within 120 days from the award of the demonstration	Submit Draft Evaluation Design	STC 44
Within 60 days receipt of CMS comments	Submit Final Evaluation Plan	STC 45
November 1, 2012	Submit Draft Transition Plan	STC 27
Annually within 90 days following the end of the 4th quarter for each DY	Submit Annual Report	STC 26
Quarterly within 60 days following the end of each quarter	Submit Quarterly Operational Reports	STC 25
Within 180 days after the expiration of the demonstration	Submit Draft Final Report	STC 28
60 days receipt of CMS comments	Submit Final Report	STC 28

APPENDIX A: Template for Quarterly Operational Report

State
Name of Demonstration
Section 1115 Quarterly Report
Demonstration Year, Quarter X
Fiscal Quarter
Date Submitted

Introduction

Narrative on a brief introduction of demonstration, provide historical background from previous demonstration years and trends.

Executive Summary

- *Brief description of Demonstration population*
- *Goal of Demonstration (list out)*
- *Program highlights* (e.g. summary of benefits provided to the demonstration population)

(Fill in chart- Indicate when each quarter begins and when it ends, see example below)

Demonstration Year (DY)	Begin Date	End Date	Quarterly Report Due Date (60 days following end of quarter)
Quarter 1	July 1st	September 30th	November 29th
Quarter 2	October 1st	December 31st	March 1st
Quarter 3	January 1st	March 31st	May 30th
Quarter 4	April 1st	June 30th	August 29th

- *Significant program changes*
  - Narrative describing any administrative and operational changes to the demonstration, such as eligibility and enrollment processes, eligibility redetermination processes (including the option to utilize administrative redetermination), systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes; and
  - Narrative on any noteworthy demonstration changes, such as changes in enrollment, service utilization, education and outreach, and provider participation. Discussion of any action plan if applicable.

- *Policy issues and challenges*
  - Narrative providing an overview of any policy issues the State is considering, including pertinent legislative/budget activity and potential demonstration amendments;
  - Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable;
  - Narrative on progress updates to the transition plan as specified in STC 27.

Enrollment

- Provide narrative on observed trends and explanation of data. As per STC 25, the State must include a narrative of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter with the same demonstration year (DY) and the same quarter in the previous DY.

- Enrollment figures- Please utilize the chart below to provide data on the enrollees and participants within the demonstration in addition to member months. The chart should provide information to date, over the lifetime of the demonstration extension.
  - As outlined in STCs 25 and 33,

    1. Enrollees are defined as all individuals enrolled in the demonstration,
       - The number of newly enrolled should reflect the number of individuals enrolled for the quarter reported.
       - The number of total enrollees should reflect the total number of individuals enrolled for the current DY.

    2. Participants are defined as all individuals who obtain one or more covered family planning services through the demonstration, and

    3. Member months refers to the number of months in which persons enrolled in the demonstration are eligible for services. For example, a person who is eligible for 3 months contributes to 3 eligible member months to the total.

  - This demonstration has three eligible populations, as described in STC 14.

    Population 1: Women losing Medicaid pregnancy coverage the conclusion of 60 days postpartum.

    Population 2: Women who have an income at or below 250 percent of the FPL.

    Population 3: Men who have family income at or below 250 percent of the FPL

DY 11: 20XX	**Quarter 4 (fill in quarter dates)**			
	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled				
# of Total Enrollees				
# of Participants				
# of Member Months				

DY 12: 20XX	**Quarter 1 (fill in quarter dates)**				**Quarter 2 (fill in quarter dates)**			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

DY 12: 20XX	**Quarter 3 (fill in quarter dates)**				**Quarter 4 (fill in quarter dates)**			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

DY 13: 20XX	**Quarter 1 (fill in quarter dates)**				**Quarter 2 (fill in quarter dates)**			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

Service and Providers

- *Service Utilization*
  - Provide a narrative on trends observed with service utilization. Please also describe any changes in service utilizations or change to the demonstration's benefit package.

- *Provider Participation*
  - Provide a narrative on the current provider participation in rendering services during this quarter highlighting any current or expected changes in provider participation, planned provider outreach and implications for health care delivery.

Program Outreach Awareness and Notification

- *General Outreach and Awareness*
  - Provide information on the public outreach activities conducted this quarter; and
  - Provide a brief assessment on the effectiveness of outreach programs.

- *Target Outreach Campaign(s) (if applicable)*
  - Provide a narrative on who the targeted populations for these outreaches are, and reasons for targeted outreach; and
  - Provide a brief assessment on the effectiveness of the targeted outreach program(s).

Program Evaluation, Transition Plan and Monitoring

- Identify any quality assurance and monitoring activities in current quarter. Also, please discuss program evaluation activities and interim findings;

- Provide a narrative of any feedback and grievances made by beneficiaries, providers and the public, including any public hearings or other notice procedures, with a summary of the State's response or planned response; and

- Provide progress updates to the transition plan as specified in STC 27.

Quarterly Expenditures

- The State is required to provide quarterly expenditure reports using the Form CMS-64 to report expenditures for services provided under the demonstration in addition to administrative expenditures. Please see Section VII of the STCs for more details.

- Please utilize the chart below to include expenditure data, as reported on the Form CMS-64. Provide information to date, over the lifetime of the demonstration extension.

	Demonstration Year 11 (fill in dates)			
	Service Expenditures as Reported on the CMS-64	Administrative Expenditures as Reported on the CMS-64	Total Expenditures as Reported on the CMS-64	Expenditures as requested on the CMS- 37
Quarter 4 Expenditures				
Total Annual Expenditures				

	Demonstration Year 12 (fill in dates)			
	Service Expenditures as Reported on the CMS -64	Administrative Expenditures as Reported on the CMS -64	Total Expenditures as Reported on the CMS -64	Expenditures as requested on the CMS- 37
Quarter 1 Expenditures				
Quarter 2 Expenditures				
Quarter 3 Expenditures				
Quarter 4 Expenditures				
Total Annual Expenditures				

	Demonstration Year 13 (fill in dates)			
	Service Expenditures as Reported on the CMS -64	Administrative Expenditures as Reported on the CMS -64	Total Expenditures as Reported on the CMS -64	Expenditures as requested on the CMS- 37
Quarter 1 Expenditures				
Quarter 2 Expenditures				
Total Annual Expenditures				

Activities for Next Quarter

- Provide details and report on any anticipated activities for next quarter.

APPENDIX B: Template for Annual Report

State
Name of Demonstration
Section 1115 Annual Report
Demonstration Year, Annual Report (list dates covered)
Fiscal Year
Date Submitted

*****Please include a cover page and a table of contents***

Introduction
Narrative on a brief introduction of demonstration, provide historical background, such as amendment changes, extension request and dates of CMS approvals.

Executive Summary

- *Brief description of demonstration population*
- *Goal of demonstration* (list out)
- *Program highlights* (e.g. summary of benefits provided to the demonstration population)

Demonstration Year	Begin Date	End Date	Annual Report Due Date (90 days following end of Annual date)
DY 11	July 1, 2011	June 30, 2012	September 28, 2012
DY 12	July 1, 2012	June 30, 2013	September 28, 2013
DY 13	July 1, 2013	December 31, 2013	March 31, 2014

(Fill in chart- Indicate when each annual year begins and when it ends, see example below)

- *Significant program changes from previous demonstration years*
  - Narrative describing any administrative and operational changes to the demonstration, such as eligibility and enrollment processes, eligibility redetermination processes (including the option to utilize administrative redetermination), systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes; and
  - Narrative on any noteworthy demonstration changes, such as changes in enrollment, service utilization, education and outreach, and provider participation. Please include a description of action plan if applicable.

- *Policy issues and challenges*
  - Brief narrative on noteworthy policy issues and challenges from previous demonstration years and actions if applicable;
  - Narrative providing an overview of any policy issues the State has dealt with in the reporting year, including pertinent legislative/budget activity and potential demonstration amendments;

- Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable;
- Narrative on progress updates to the transition plan as specified in STC 27; and
- Narrative on any budget neutrality issues the State has identified. Please include a description of action plan if applicable.

Enrollment and Renewal

- Enrollment figures- Please utilize the chart below to provide data on the enrollees and participants within the demonstration in addition to member months. The chart should provide information to date, over the lifetime of the demonstration extension.
  - As outlined in STCs 25, 26 and 33,
    1. Enrollees are defined as all individuals enrolled in the demonstration,
       i. The number of newly enrolled should reflect the number of individuals enrolled for the quarter reported.
       ii. The number of total enrollees should reflect the total number of individuals enrolled for the current DY.
    2. Participants are defined as all individuals who obtain one or more covered family planning services through the demonstration
    3. Member months refers to the number of months in which persons enrolled in the demonstration are eligible for services. For example, a person who is eligible for 3 months contributes to 3 eligible member months to the total.

  - This demonstration has three eligible populations, as described in STC 14.

    Population 1: Women losing Medicaid pregnancy coverage the conclusion of 60 days postpartum.

    Population 2: Women who have an income at or below 250 percent of the FPL.

    Population 3: Men who have family income at or below 250 percent of the FPL

	Demonstration Year 11 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees				
# of Participants				
# of Member Months				

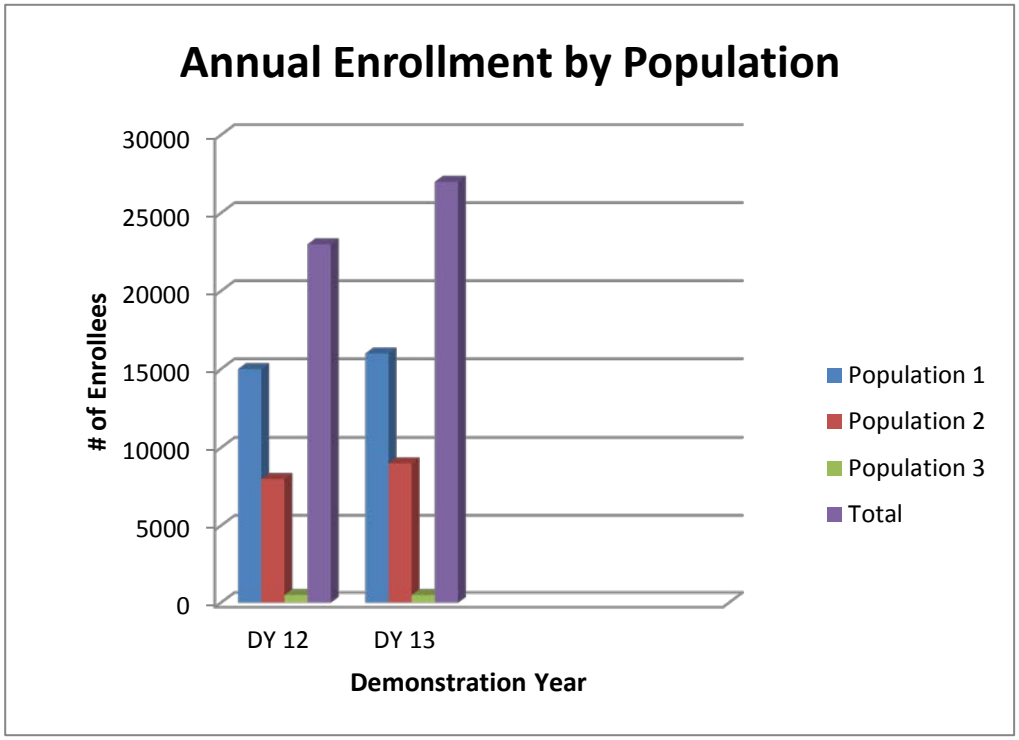
	Demonstration Year 12 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees				
# of Participants				
# of Member Months				

	Demonstration Year 13 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees				
# of Participants				
# of Member Months				

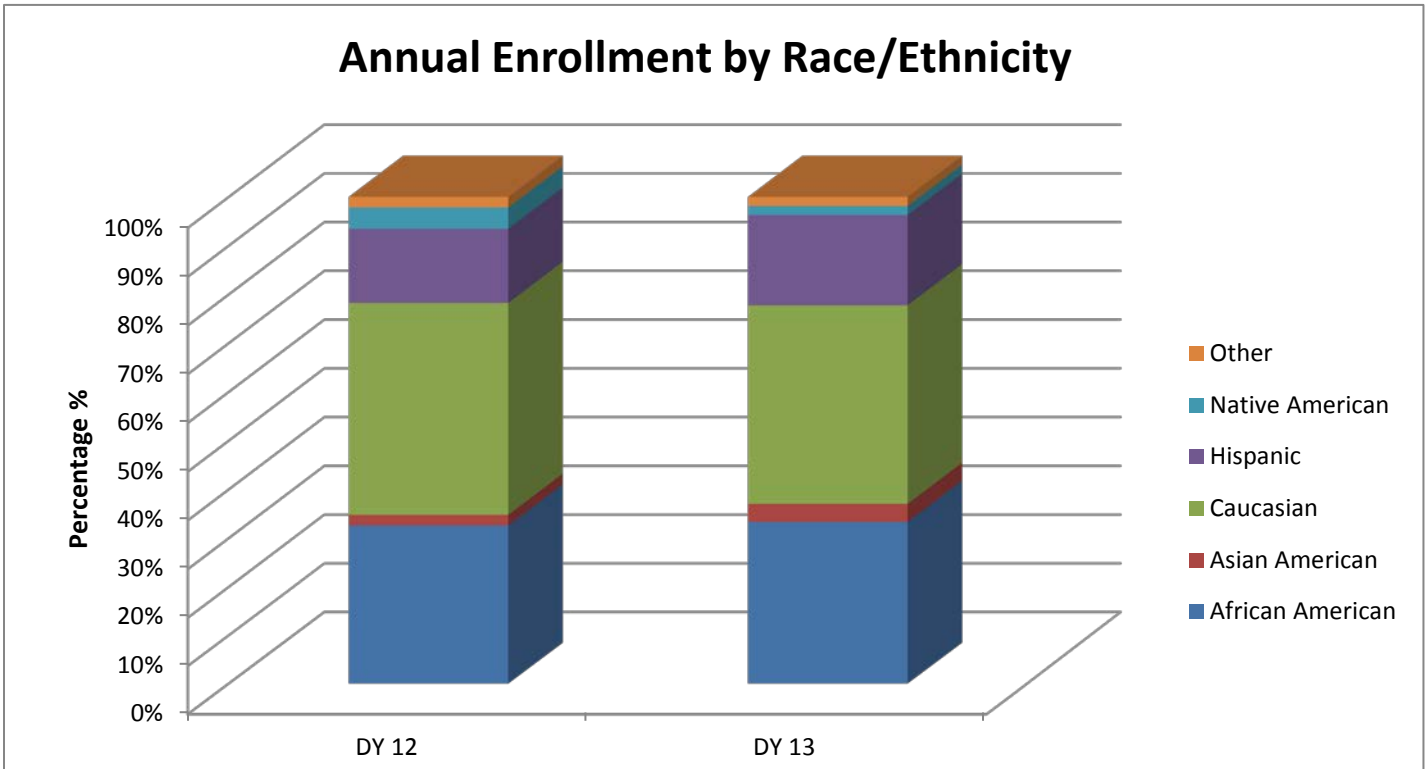
- Provide narrative on observed trends and analysis of data, including any proposed actions for improvement. As per STCs 25 and 26, the State must include a narrative of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous demonstration year (DY). Also discuss actions identified that could improve enrollment numbers, if applicable.

- Provide graphs/ charts for the data indicated below (samples of the graph structure are included):

  1) Annual enrollment by population for each demonstration Year over the lifetime of the demonstration.

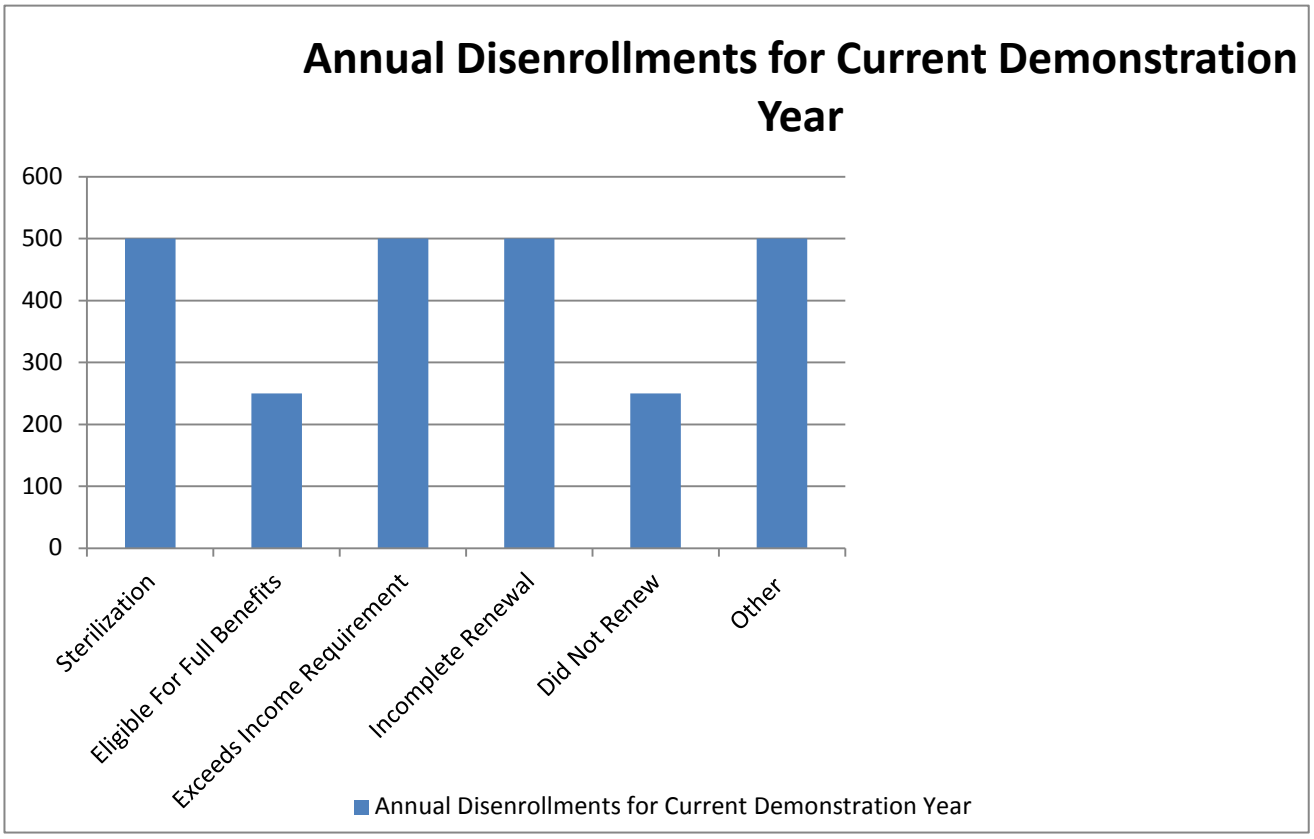


2) It is the State's option to provide graphs and analysis of annual enrollment by characteristics, such as race/ethnicity, and age. Two examples of such information is included below.



	African American (Enrollees/ Percentage %)	Asian American	Caucasian	Hispanic	Native American	Other	Total enrollees
DY 12	7500(32.6%)	500 (2.17%)	10000(43.4%)	3500(15.2%)	1000(4.34%)	500(2.17%)	23000
DY 13	9000(33.3%)	1000(3.70%)	11000(40.7%)	5000(18.5%)	500(1.85%)	500(1.85%)	27000

3) Annual Disenrollment and Retention figures
   - Discuss the current demonstration year's retention and disenrollment figures, including top reasons for disenrollment, compared to last demonstration year and trends observed throughout the current demonstration year's quarters.
   - Provide charts/graphs to illustrate the data, please see examples below on disenrollment figures.

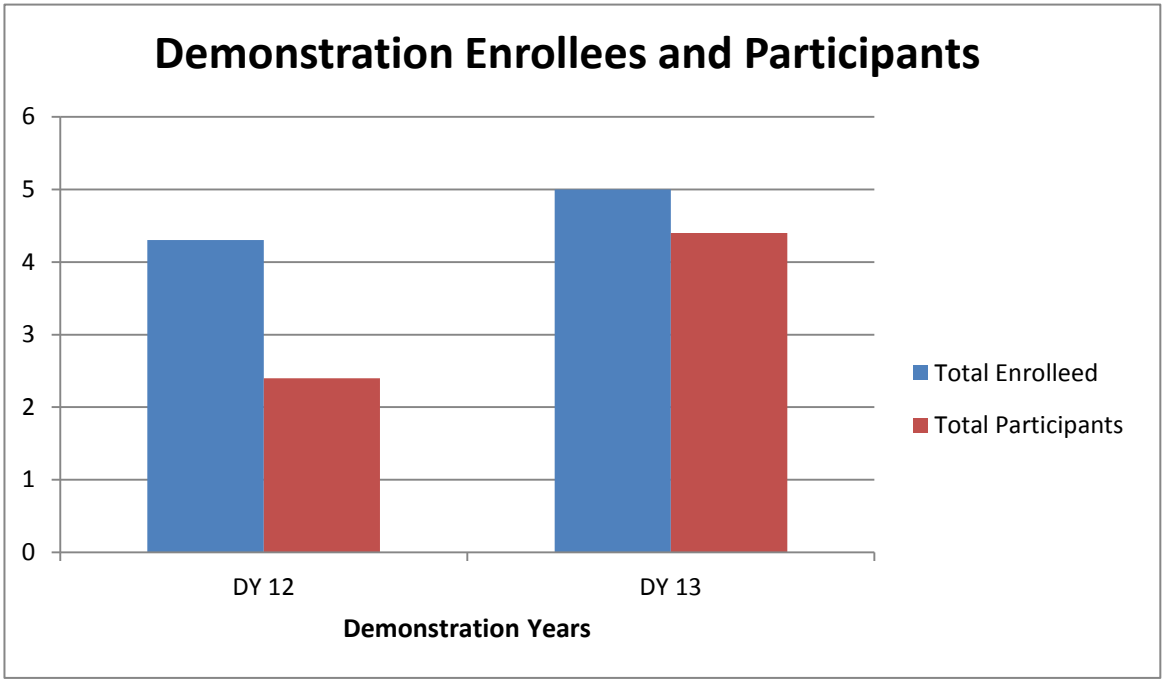


	Sterilization (Enrollees/ Percentage %)	Eligible for Full Benefits	Exceeds income requirement	Incomplete Renewal	Did not Renew	Other	Total Disenrollment Numbers
DY 12	500(20.0%)	250(10.0%)	500(20.0%)	500(20.0%)	250(10.0%)	500(20.0%)	2500
DY 13	500(16.67%)	750(25%)	500(16.67%)	250(8.33%)	500(16.7%)	500(16.7%)	3000

Service and Providers

- *Service Utilization*
  - Provide a narrative on trends observed with family planning and family planning-related services and supplies utilization. Please also describe any changes in service utilizations or change to the demonstration's benefit package. Provide any relevant charts/graphs illustrating data found.

  - Provide a cumulative graph highlighting the enrollees and participants over the lifetime of the demonstration.



- *Provider Participation*
  - Provide a narrative on the current provider participation in rendering services during this demonstration year highlighting any current or expected changes in provider participation, planned provider outreach and implications for health care delivery.

Program Outreach Awareness and Notification

- *General Outreach and Awareness*
  - Provide information on the public outreach activities conducted this demonstration year, and

    - Provide a brief assessment on the effectiveness of outreach programs throughout the demonstration Year.

- *Target Outreach Campaign(s) (if applicable)*
    - Provide a narrative on who the targeted populations for these outreaches are, and reasons for targeted outreach,
    - Provide a brief assessment on the effectiveness of the targeted outreach program(s); and
    - Describe any trends observed and any identified actions that could improve the outreach programs.

Program Evaluation, Transition Plan and Monitoring

- A summary of program integrity and related audit activities for the demonstration, including an analysis of point-of-service eligibility procedures;

- Identify any quality assurance and monitoring activities in current quarter. Also, please discuss program evaluation activities and interim findings;

- Provide a narrative of any feedback and grievances made by beneficiaries, providers and the public, including any public hearings or other notice procedures, with a summary of the State's response or planned response;

- Provide progress updates to the transition plan as specified in STC 27.

Provide an Interim Evaluation of Goals and Progress

Goal 1:
Progress Update:

Goal 2:
Progress Update:

Goal 3:
Progress Update:

Annual Expenditures

- The State is required to provide quarterly expenditure reports using the Form CMS-64 to report expenditures for services provided under the demonstration in addition to administrative expenditures. Please see Section VII of the STCs for more details.
- Please utilize the chart below to include this expenditure data, as reported on the Form CMS-64. The chart should provide information to date, over the lifetime of the demonstration extension.

	Service Expenditures as reported on the CMS-64		Administrative Expenditures as reported on the CMS-64		Expenditures as requested on the CMS-37	Total Expenditures as reported on the CMS-64
	Total Computable	Federal Share	Total Computable	Federal Share		
Demonstration Year 11						
Demonstration Year 12						
Demonstration Year 13						

	Demonstration Year 11 (fill in dates)
	Total Demonstration Population
# Member Months	
PMPM	
Total Expenditures *(Member months multiplied by PMPM)*	

	Demonstration Year 12 (fill in dates)
	Total Demonstration Population
# Member Months	
PMPM	
Total Expenditures *(Member months multiplied by PMPM)*	

	Demonstration Year 13 (fill in dates)
	Total Demonstration Population
# Member Months	
PMPM	
Total Expenditures *(Member months multiplied by PMPM)*	

Actual Number of Births to Demonstration Population

- Provide the number of actual births that occur to family planning demonstration participants within the DY over the lifetime of the demonstration (participants include all individuals who obtain one or more covered family planning services each year).

	# of Births to Demonstration Participants
Demonstration Year 11	
Demonstration Year 12	
Demonstration Year 13	

Cost of Medicaid Funded Births

- For each demonstration year, provide the average total Medicaid expenditures for a Medicaid-funded birth. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants);

Activities for Next Year

- Report on any anticipated activities for next year.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11 -W-00134/0-01**

TITLE: **TAKE CHARGE Section 1115 Family Planning Demonstration**

AWARDEE: **Washington Health Care Authority**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Washington 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 extension, be regarded as expenditures under the State's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authorities and the provisions specified as "not applicable" enable Washington to operate its section 1115 Medicaid family planning demonstration, entitled "TAKE CHARGE" effective as of the date of the approval letter through December 31, 2013, unless otherwise stated.

Expenditures for extending Medicaid eligibility for family planning and family planning-related services, subject to an annual redetermination, to individuals who are not otherwise enrolled in Medicaid or the Children's Health Insurance Program (CHIP), and are:

a) Women losing Medicaid pregnancy coverage (SOBRA pregnant women) at the conclusion of 60 days postpartum and who have a family income at or below 250 percent of the Federal poverty level (FPL) at the time of annual redetermination; or

b) Men and women who have family income at or below 250 percent of the FPL.

<u>Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:</u>

All Medicaid requirements apply, except the following:

1. Methods of Administration: Transportation **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable the State to not assure transportation to and from providers for the demonstration population.

.

2. Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)

To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of family planning services and family planning-related services.

3. Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics Section 1902(a)(15)

To the extent necessary for the State to establish reimbursement levels to these clinics that will compensate them solely for family planning and family planning-related services.

4. Eligibility Procedures Section 1902(a)(17)

To the extent necessary to allow the State to not include parental income when determining a minor's (individual under age 18) eligibility for the family planning demonstration.

To the extent necessary to allow the State to not require reporting of changes in income or household size for 12 months, for a person found income-eligible upon application or annual redetermination when determining eligibility for the family planning demonstration.

5. Retroactive Coverage Section 1902(a)(34)

To the extent necessary to enable the State to not provide medical assistance to the demonstration population for any time prior to the first of the month in which an application for the demonstration is made.

6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section 1902(a)(43)(A)

To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the demonstration population.