

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



Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

Doug Porter
Director
Health Care Authority
P.O. Box 45502
Olympia, WA 98504-5502

Dear Mr. Porter

We are pleased to inform you that the Centers for Medicare and Medicaid Services (CMS) has reviewed the various technical corrections requested by the State of Washington to the Transitional Bridge section 1115 demonstration project (11-W-00254/10). We have incorporated the agreed upon changes into the attached Special Terms and Conditions (STCs) and Expenditure Authorities. These technical corrections are effective from January 1, 2011 through December 31, 2013.

The STCs have been revised to reflect the current organizational and operating structure of the Medicaid state agency as the "Health Care Authority." In addition, references to the Disability Lifeline (DL) program have been revised to the Medical Care Services (MCS) program, but the STCs related to budget neutrality reference both programmatic names to insure that the State may continue to appropriately report expenditures for the Demonstration.

The title XIX Requirement Not Applicable on retroactive eligibility reflects our agreed upon understanding that the State is not required to offer retroactive coverage to the Transitional Eligibles populations prior to the individual's date of enrollment into the Demonstration.

The State's proposed changes to the appeals through the adjudication process cannot be accommodated as technical corrections and will require an amendment to the Demonstration.

Should you have any questions or concerns regarding this letter or the changes to the STCs, please feel free to contact your project officer, Kelly Heilman at 410-786-1451.

Sincerely,

/Richard Jensen/

Richard Jensen
Director
State Demonstrations and Waivers

Enclosures

cc: Carol Peverly, Associate Regional Administrator, Region X
Kelly Heilman, Project Officer, CAHPG

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: **11-W-00254/10** **Title XIX**

TITLE: **Transitional Bridge Demonstration**

AWARDEE: **Health Care Authority**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of January 1, 2011, through December 31, 2013, be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable Washington to implement the Medicaid section 1115 Demonstration (Transitional Bridge).

1. Expenditures for Demonstration Population: Transition Eligibles Group

Expenditures to provide Demonstration-approved coverage to non-pregnant individuals ages 19 through 64 who have countable incomes up to and including 133 percent of the Federal poverty level (FPL) who have not been found to be eligible for Medicaid or the Children's Health Insurance Program (CHIP), and who are currently enrolled, or become newly enrolled, in the following State programs:

- a. Basic Health;
- b. Medical Care Services; or
- c. Alcohol and Drug Addiction Treatment and Support.

2. Expenditures Related to Delivery Systems

Expenditures under contracts that do not meet the requirements in section 1903(m)(2)(A) of the Act regarding managed care organizations (MCOs), specified below. Any delivery system using managed care organizations which provides services under this Demonstration shall meet all requirements of section 1903(m) of the Act except the following:

- a. Section 1903(m)(2)(A)(vi) of the Act, but only insofar as it requires compliance with section 1932(a)(4) of the Act regarding the ability of enrollees to disenroll from an MCO providing services to Demonstration Population 1a (Basic Health) and to Demonstration Population 1b (Medical Care Services). The right of enrollees in Demonstration Population 1b to disenroll from an MCO will be restricted through June 30, 2012.
- b. Section 1903(m)(2)(A)(xii), but only insofar as it requires compliance with section 1932(a)(3)(A) (regarding offering a choice of at least two MCOs providing services to enrollees in Demonstration Population 1a (Basic Health) and in Demonstration Population 1b (Medical Care Services)) and with section 1932(a)(2)(c) (which limits mandatory managed care enrollment for Indians to Indian Health Service facilities that are MCOs). Enrollees shall have a choice of at least two

primary care providers, and may request change of primary care provider at least at the times described in Federal regulations at 42 CFR 438.56(c). Indians may be required to enroll in MCOs that are not Indian Health Service facilities.

Title XIX Requirements Not Applicable

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the following list, shall apply to expenditures for Transition Eligibles population through December 31, 2013, unless otherwise stated.

Eligibility and Enrollment

1. Reasonable Promptness

Section 1902(a)(8)

To enable the State to establish enrollment targets and maintain waiting lists for the Transition Eligibles population.

2. Freedom of Choice

Section 1902(a)(23)

To enable the State to restrict freedom of choice of provider for the Transition Eligibles population.

3. Retroactive Eligibility

Section 1902(a)(34)

To enable the State to exclude the Transition Eligibles population from receiving coverage for up to three months prior to the date of enrollment into the Demonstration.

4. Comparability of Eligibility Standards

Section 1902(a)(17)(D)

To enable the State, for purposes of determining income eligibility for the Basic Health program, to include a child under age 26 as a member of the household and count that child's unearned income even if not living in the household.

5. Liens, Adjustments, and Recoveries Collection of Sufficient Information

**Sections 1902(a)(18) and
1902(a)(25)(i) as well as
Sections 1902(a)(45) and
(60) insofar as they
incorporate Section 1917**

To enable the State, when operating the Basic Health program, not to collect sufficient information to comply with the provisions of 1917 with respect to liens, adjustments and recoveries of medical assistance correctly paid, transfers of assets, and treatment of certain trusts.

Benefits

6. Amount, Duration, and Scope of Services

Section 1902(a)(10)(B)

To enable the State to offer benefits that vary from the State plan to Transition Eligibles, to the extent authorized under section V of the Special Terms and Conditions.

7. Early and Periodic Screening, Diagnostic, And Treatment (EPSDT)

Section 1902(a)(43)

To enable the State to not provide coverage for EPSDT services to Transition Eligibles who are 19 or 20 years old.

8. Waiting Period for Pre-existing Conditions

Section 1902(a)(10)(b)(i)

To enable the State, until January 1, 2012, to impose a waiting period of not longer than 9 months, except for organ transplants which have a waiting period of not longer than 12 months, for new Transition Eligibles in the Basic Health program who do not have continuation of health care coverage as defined in the Health Insurance Portability and Accountability Act of 1996.

9. Fair Hearings

Section 1902(a)(3) only waived for purposes below

From the date of approval until July 1, 2011, only, to enable the State, not to offer a Medicaid fair hearing to Transition Eligibles enrolled in managed care organizations during this time period, for a grievance related to a service denial if the grievance has been adjudicated through two levels of review as required by State law.

Cost Sharing and Provider Payments

10. Public Process for Hospital Payments

Section 1902(a)(13)(A)

To enable the State to not use a public process for determination of rates of payment for hospital services under the Demonstration.

11. Cost Sharing

Section 1902(a)(14) insofar as it incorporates Section 1916

To enable the State to charge premiums and point-of-service cost sharing beyond applicable Medicaid limits to Transition Eligibles in the Basic Health program.

12. Payment for Services by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Section 1902(a)(15)

To enable the State to make payments to FQHCs and RHCs (except for those that are also Indian Health Service, Tribal section 638, or Urban Indian Organization (I/T/U) providers), for services using reimbursement methodologies other than those required by section 1902(bb) of the Act.

13. Payment Methodologies

Section 1902(a)(30)(A)

To allow the State to establish rates with providers on an individual or class basis without regard to the rates set forth in the current approved State plan.

14. Prompt Payment

Section 1902(a)(37)

To enable the State, for calendar years 2011 and 2012 only, not to meet the clean claims payment requirements for any supplemental payments owed to Indian Health Service, Tribal section 638, and Urban Indian Organization (I/T/U) providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: 11-W-00254/10 (Title XIX)

TITLE: Transitional Bridge Demonstration

AWARDEE: Health Care Authority

DEMONSTRATION PERIOD: January 1, 2011 – December 31, 2013

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I. PREFACE

The following are the Special Terms and Conditions (STCs) for Washington State's Medicaid section 1115(a) Demonstration entitled the "Transitional Bridge" (project number 11-W-00254/10) (hereinafter referred to as "Demonstration"). The parties to this agreement are the Health Care Authority ("State" or "HCA") 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, and are effective January 1, 2011 unless otherwise specified.

This Demonstration is approved through December 31, 2013, and will not be renewed for individuals made eligible under the State plan after December 31, 2013.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Washington's Transitional Bridge is a statewide section 1115 Demonstration to sustain coverage for early expansion-eligible individuals (Transition Eligibles) with countable household incomes up to and including 133 percent of the Federal poverty level (FPL) who are enrolled in the State-only Basic Health (BH), Medical Care Services (MCS), or Alcohol and Drug Addiction Treatment and Support Act (ADATSA) programs. The goal of this Demonstration is to help the State sustain these programs, which provide health care benefits for enrolled individuals, but would be eliminated without Federal financial support. Should these programs be eliminated, the enrolled individuals would lose their health care coverage until 2014 when they will become Medicaid-eligible due to passage of the Affordable Care Act.

Transition Eligibles enrolled in the BH program receive a comprehensive package of primary, acute and mental health benefits delivered through managed care organizations. Transition Eligibles enrolled in the MCS program receive a comprehensive package of physical and behavioral health benefits delivered through a capitated managed care organization, and hospital services (at the start of the Demonstration) are delivered on a fee-for-service basis. At the onset of this Demonstration, Transition Eligibles enrolled in the ADATSA program receive services on a fee-for-service basis. This Demonstration will provide the State with Federal financial participation for approximately 63,300 people in order to help the State sustain coverage, based on available State funds, for the 90,000 low-income adults who currently are served through the State-only funded Basic Health (BH), Medical Care Services (MCS), and Alcohol and Drug Addiction Treatment and Support Act (ADATSA) programs. [Note: Washington will sustain coverage, within available State funding, for approximately 30,000 individuals that will remain in the State-only programs as they would not currently meet the 2014 Affordable Care Act eligibility criteria]. In addition to sustaining coverage, the Transitional Bridge Demonstration further serves the objectives of title XIX of the Social Security Act (the Act) by requiring Washington to seamlessly transition enrolled individuals to a coverage option available under the Affordable Care Act; and setting system modification milestones that will expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation.

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 and CHIP programs expressed in law, regulation, or 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 or CHIP programs 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, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements 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 title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are

not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

- 7. Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved.
 - a. Amendment requests must include, but are not limited to, the following:
 - i. An explanation of the public process used by the State, consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;
 - ii. 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;
 - iii. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - iv. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
 - b. Changes to benefits described in the State plan shall be made by State plan amendment. Changes to benefits not described in the State plan shall be made by amendment to the Demonstration. Changes in benefits shall be implemented in accordance with the process set forth in section V of these STCs.
- 8. Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least six (6) months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 9, a phase-out plan shall not be shorter than six (6) months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.
- 9. Enrollment Limitation during the Phase-Out.** If the State elects to suspend or terminate this Demonstration as described in paragraph 8 during the last 6 months of the

Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be newly enrolled in the Demonstration.

- 10. 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.
- 11. Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.
- 12. 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 and/or XXI of the Act. 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 for reconsideration of the 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.
- 13. 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.
- 14. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994), and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act (as added by section 5006(e)(2) of the American Recovery and Reinvestment Act of 2009 (the Recovery Act)), when any program changes to the Demonstration, including, but not limited to, those referenced in paragraph 6 are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and / or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and / or renewal of this Demonstration. In the event that the State conducts additional consultation activities consistent with these requirements prior to the implementation of the Demonstration, documentation of these activities must be provided to CMS.
- 15. 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

16. Eligibility Criteria.

Individuals eligible for the Demonstration are referred to as Transition Eligibles (as defined below), and are not enrolled in, or otherwise eligible for, Medicaid under the State plan. The State may claim FFP pursuant to the terms and conditions as detailed in this document.

17. Eligibility Groups. The Transition Eligibles population is comprised of three groups:

- a. Basic Health (BH) –
 - i. Consists of individuals age 19 through 64 who are enrolled in the Basic Health (BH) program, and have countable household income at or below 133 percent of the Federal poverty level (FPL); and are U.S. citizens/qualified non-citizens and residents of Washington; and who either do not meet the standards for Medicaid or CHIP eligibility, or who have not been found to be Medicaid eligible in the initial BH certification or annual BH recertification (within established timeframes). This population does not include pregnant women (including through the 60th day post partum). There is no resource limit.
 - ii. Enrollment for the BH group may be temporarily closed based on an annual average enrollment target of 43,300. The State may temporarily exceed the enrollment target in order to accommodate members of the “priority population” as defined in Attachment C.
 1. The State may increase the enrollment target by notifying CMS of its intent and submitting the associated budget neutrality modifications within 90 days of increasing the enrollment target. Such a submission is consistent with efforts to expand enrollment of early expansion populations, and will automatically amend the annual average enrollment target for this Demonstration.
 2. The State may lower the BH average annual enrollment limit, but must sustain coverage for current enrollees. At least 90 days prior to making a change in the BH target limit, Washington must submit written notification to CMS. Such a submission will be considered an amendment to the terms of this Demonstration.
 3. As individuals enrolled in the BH program become eligible for this Demonstration, the State must obtain CMS approval before changing the eligibility criteria for the BH program.

- b. Medical Care Services (MCS) (formerly referred to in the STCs as Disability Lifeline (DL))
 - i. Consists of individuals age 19 through 64 who are enrolled in the Medical Care Services (MCS) program, and who: are not otherwise eligible for Medicaid or CHIP; are physically or mentally incapacitated and expected to be unable to work for at least ninety days; have countable household income at or below 133 percent of the FPL; and who are U.S. citizens/qualified non-citizens and residents of Washington.
 - ii. Enrollment for the MCS group may be temporarily closed based on an annual average enrollment target of 16,000. The State must sustain coverage for current enrollees. At least 90 days prior to temporarily closing enrollment to the MCS population, the State must submit notification to CMS.
 - iii. As individuals enrolled in the MCS program become eligible for this Demonstration, the State must obtain CMS approval before changing the eligibility criteria for the MCS program.
- c. Alcohol and Drug Addiction Treatment Support Act (ADATSA)
 - i. Consists of individuals age 19 through 64 who are enrolled in the ADATSA program, and are individuals with a primary incapacity of drug or alcohol addiction; are not otherwise eligible for Medicaid or CHIP; have countable household income at or below 133 percent of the FPL; and are U.S. citizens/qualified non-citizens and residents of Washington.
 - ii. Enrollment for the ADATSA group may be temporarily closed based on an annual average enrollment target of 4,000. The State must sustain coverage for current enrollees. At least 90 days prior to temporarily closing enrollment to the ADATSA population, the State must submit notification to CMS.
 - iii. As individuals enrolled in the ADATSA program become eligible for this Demonstration, the State must obtain CMS approval before changing the eligibility criteria for the ADATSA program.

18. Moving Additional Individuals Already Enrolled as a Transition Eligibles Population into Managed Care. Consistent with the State's intent to Transition this Demonstration toward compliance with the Affordable Care Act, the State may expand its managed care delivery system to cover individuals who are approved for receipt of services in accord with the terms and conditions detailed in section VIII of these STCs and who have been receiving services through the fee-for-service delivery system. The State must notify CMS of proposed changes at least 90 days prior to the proposed implementation date, and CMS reserves the right to require an amendment be submitted for approval prior to the State implementing such changes.

V. BENEFITS

19. Benefits for Transition Eligibles. Except as specified in Table 1 and other variations described in these STCs, the Transitional Bridge Demonstration provides physical and behavioral benefits for Transition Eligibles equal to the Washington State plan, limited by medical necessity as defined by the State, and subject to cost-effective alternatives provided by a managed care organization.

20. Other Variations from the State Plan. In addition to the differences identified in Table 1:

- a. Services provided in Institutions for Mental Disease (IMDs) are not considered a benefit under this Demonstration. In accord with section X of these STCs, the State must exclude costs of such services from its claims for FFP, and from managed care capitation rate determination.
- b. Mental health services provided through the State's 1915(b) waiver are not considered a benefit under this Demonstration. In accord with section X of these STCs, the State must not use Demonstration financial reporting forms to claim FFP for these expenditures.
- c. Individuals enrolled in ADATSA must comply with the requirements for treatment to remain eligible for benefits under this Demonstration.

21. Mental Health Parity. For individuals enrolled in managed care (as detailed in section VIII of these STCs), the State must ensure that the managed care organization (MCO) is providing equivalence, or parity, in coverage of mental and physical ailment consistent with Federal law.

22. Cost-Effective Alternatives. For individuals enrolled in managed care (as detailed in section VIII), nothing in these STCs precludes the MCO from providing services not listed in, or exceeding the individual service limits in, the Medicaid State plan or Table 1 of these STCs. Provision of these services is at the sole discretion of the MCO, and is not factored into the determination of the capitated rate. Capitation for the MCOs must be certified as actuarially sound (in accord with 42 CFR section 438.6), and comply with the Federal managed care regulations at 42 CFR 438 et seq.

VI. Table 1: Comparative Summary of 2010 Public Program Benefits for Adults

The following Table serves as a baseline of the services covered as of the date of this approval and does not limit the State’s ability to change the State Plan benefits through State Plan Amendments.

MEDICAL CARE SERVICES (MCS), ALCOHOL AND DRUG ADDICTION TREATMENT AND SUPPORT ACT (ADATSA) & BASIC HEALTH (BH) COVERAGE FOR ADULTS				
Legend: * delivered under fee-for-service; Y = Covered Service; L = Limited covered service; N = May be provided under managed care as a cost effective alternative but not required under contract				
Services	Medical Care Services	ADATSA *	Basic Health	Comments
Ambulance/Ground and Air	Y	Y	Y	
Anesthesia Services	Y	Y	Y	
Audiology	Y	Y	N	
Blood/Blood Administration	Y	Y	Y	
Case Management	Y	Y	N	
Chiropractic Care	N	N	L	BH – covers maximum of 6 visits annually; must be tied to reconstructive joint surgery.
Dental Services	L	L	L	Limited to emergency dental services
Detox Alcohol or Detox Drugs (Inpatient – hospital or freestanding treatment facility)	L *	L	Y	MCS/ADATSA – limited to 3 days (detox alcohol) and 5 days (detox drugs)
Diabetes Education	Y	Y	L	BH – up to 10 hours per year
Drugs and supplies, prescription	Y	Y	Y	
Emergency Room Services	Y	Y	Y	
Emergency Surgery	Y	Y	Y	
Eye Exams	Y	Y	N	
Family Planning Services	Y	Y	Y	
Home Health Services	Y	Y	Y	
Hospice	N	N	Y	
Inpatient Hospital Care	Y *	Y	Y	
Interpreter Services	Y	Y	Y	
Maternity Support Services	N	N	L	Pregnant women are covered through Medicaid / CHIP and return to BH, MCS, or ADATSA post-partum. Family characteristics may result in some women receiving maternity coverage in BH due to Medicaid/CHIP ineligibility
Medical Equipment	L	L	L	BH - covered only during inpatient hospital stay.

MEDICAL CARE SERVICES (MCS), ALCOHOL AND DRUG ADDICTION TREATMENT AND SUPPORT ACT (ADATSA) & BASIC HEALTH (BH) COVERAGE FOR ADULTS				
Legend: * delivered under fee-for-service; Y = Covered Service; L = Limited covered service; N = May be provided under managed care as a cost effective alternative but not required under contract				
Services	<u>Medical Care Services</u>	<u>ADATSA *</u>	<u>Basic Health</u>	Comments
Nursing Facility Services	Y *	Y	N	
Organ Transplants	Y	Y	L	BH - must be enrolled for 12 consecutive months before service is covered, unless newborn, or if condition is contracted while enrolled in BH.
Outpatient Hospital Care	Y *	Y	Y	
Oxygen/Respiratory Therapy	Y	Y	Y	
Pain Management (chronic)	Y	Y	Y	BH - may be covered by Health Plan as cost containment mechanism.
Physical/Occupational/Speech Therapy	L	L	L	BH - covers physical or occupational therapy for maximum of 6 visits annually- tied to reconstructive joint surgery.
Physician-Related Services	Y	Y	Y	
Prosthetic Devices & Mobility Aids	L	L	N	
Psychological Evaluations	Y	Y	N	
Inpatient Mental Health	Y *	Y	L	BH - covers up to 10 inpatient days; Medicaid has no inpatient limits. Parity by January 1, 2011.
Outpatient Mental Health	L	L	Y	BH - 12 visits per calendar year. Medicaid – adults up to 12 visits per calendar year. Parity by January 1, 2011.
Smoking cessation services	Y	Y	N	BH – provided by MCOs as a cost effective alternative.
Substance Abuse/Outpatient (including Detox Drugs)	Y *	Y	Y	BH - up to \$5,000 in 24 consecutive month period or \$10,000 lifetime maximum
Total Enteral/Parenteral Nutrition	Y	Y	L	BH - covered at the discretion of Health Plans
Transportation Other Than Ambulance	L	L	N	MCS and ADATSA provide non-emergency transportation for medical services only.
X-ray and Lab Services	Y	Y	Y	

VI. ENROLLMENT AND IMPLEMENTATION

23. General Requirements

- a. **Medicaid Administrative Requirements.** Unless otherwise specified in these STCs, all processes (e.g., eligibility, enrollment, redeterminations, terminations, appeals) must comply with Federal law and regulations governing the Medicaid program.
- b. **Facilitating Medicaid Enrollment.** The State must screen new applicants for Medicaid eligibility, and if determined eligible, enroll the individual in Medicaid, and must screen current enrollees at least annually upon recertification / renewal of enrollment.
 - i. The State must ensure that new applicants for the BH, MCS, and ADATSA programs who meet the categorical requirements for Medicaid will be processed and enrolled in the State's Medicaid program. The application packets for the BH, MCS, and ADATSA programs must continue to provide information regarding Medicaid eligibility and application that is subject to CMS review. The State may enroll potential Medicaid eligibles in the BH, MCS, and ADATSA programs (either as Transition Eligibles or State-only eligibles) pending completion of the Medicaid application and determination processes.
 - ii. Transition Eligibles who are currently enrolled in BH, MCS or ADATSA will be processed and enrolled in the State's Medicaid program, if eligible, upon their next certification / redetermination date.
 - iii. The State must ensure that individuals disenrolled from the BH program for failure to pay the monthly premium will continue to be provided information regarding Medicaid eligibility and application, which is subject to CMS review.
- c. **Mandatory Basic Health Enrollment in Managed Care.** All Transition Eligibles, including American Indian / Alaska Native (AI/AN) individuals (as defined in statute¹), enrolled in the BH program will receive Demonstration benefits consistent with the delivery system described in section VIII of these STCs.

¹ *Indian* means any individual defined at 25 USC 1603(c), 1603(f), or 1679(b), or who has been determined eligible as an Indian, pursuant to 42 CFR 136.12. This means the individual:

- (1) Is a member of a Federally recognized Indian tribe;
 - (2) resides in an urban center and meets one or more of the four criteria:
 - (a) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
 - (b) is an Eskimo or Aleut or other Alaska Native;
 - (c) is considered by the Secretary of the Interior to be an Indian for any purpose; or
 - (d) is determined to be an Indian under regulations promulgated by the Secretary;
 - (3) is considered by the Secretary of the Interior to be an Indian for any purpose; or
 - (4) is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
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- d. **Choice of Managed Care Organizations (MCOs).** Except as specified below, the State must ensure that all Transition Eligibles are provided with a choice of MCOs:
- i. Transition Eligible enrollees in the Basic Health program who live in designated rural areas (e.g., Clallam, Cowlitz, Garfield, Island, Jefferson, Klickitat, Lincoln, Mason, San Juan, Skagit, Skamania, and Wahkiakum counties) may not be provided a choice of MCOs. The State must ensure that these individuals are given a choice of primary care providers. The State will provide notification to CMS should additional choice of MCOs be made available in these counties. [A list of Contracted Managed Care Health Plans by County is provided in Attachment B, and will be updated by the State at least annually or as necessary to reflect current contracts].
 - ii. Transition Eligibles in the Medical Care Services program have complex health needs and receive services through a single MCO; expenditure authority accompanying these STCs permits the State to continue that delivery system through June 30, 2012.
 - iii. Transition Eligibles in the ADATSA program have complex health needs with services delivered on a fee-for-service basis. The State may expand managed care coverage of individuals and/or benefits in accord with paragraph 18, paragraph 22, and section VIII (*Delivery System*) of these STCs.
- e. **Enrollment Waiting Lists.** The State will adhere to the enrollment targets presented in section IV of these STCs.
- i. The State may maintain a wait list for the Basic Health program consistent with the operational policy in effect on January 1, 2011. Unless otherwise specified in State rules as a “priority population” (refer to the definition in Attachment C), new applicants will be placed on a list behind those already waiting. The State will have continuous open enrollment so when space becomes available in the future, Basic Health will release names from the waiting list in date-received order and notify applicants. Changes to the waiting list operational policy that affect the Demonstration will be submitted to CMS for approval prior to implementation.
 - ii. To the extent that the State imposes a limit on enrollment of Transition Eligibles in the MCS or ADATSA programs, within 60 days after notifying CMS of such a limit, the State must submit to CMS the criteria for administering the waiting lists and enrolling new applicants.
- f. **No Pre-existing Condition Exclusion.** The State may impose a waiting period for pre-existing conditions of not longer than 6 months for individuals enrolled from the BH waiting list into the BH program between January 1, 2011, and December 31, 2011. All

pre-existing waiting periods will expire January 1, 2012. The State must not impose a waiting period for pre-existing conditions for any Transition Eligible individual who is:

- i. Eligible for enrollment into the MCS or ADATSA programs;
 - ii. Enrolled from Medicaid, or other HCA medical programs, directly into the BH program or had other health care coverage in accord with the Health Insurance Portability and Accountability Act of 1996; or
 - iii. Enrolled in the BH program on or after January 1, 2012.
- g. **Elimination of Time Limits.** The State must eliminate the maximum eligibility period (i.e., maximum eligibility period of 24 months in a 5-year period) for individuals enrolled in the MCS program as soon as possible, but not later than July 1, 2011.

VII. COST SHARING

24. Cost Sharing. The State may impose cost sharing (e.g., premiums, deductibles, coinsurance payments, copayments) on individuals covered under this Demonstration, consistent with subsections 24(a) and 24(b) below.

- a. **Premiums.** Throughout the duration of this Demonstration, the State:
 - i. May impose premiums, equal to or lower than those in effect on January 1, 2011, for BH enrollees with the exception of individuals who have been determined to be American Indians/Alaska Natives (AI/ANs). This limitation gives effect to the exemptions permitted under section 5006 of the American Recovery and Reinvestment Act of 2009.
 - ii. Must, effective January 1, 2011, reduce monthly premiums to 2009 levels (from \$34 to \$17) for the lowest income BH enrollees (i.e., individuals with family income from 0 to 65 percent of the FPL using the BH household income determination).
- b. **Point of Service and Annual Cost Sharing for BH enrollees.** Throughout the duration of this Demonstration, the State will impose the following cost sharing charges, except that no such charges may be imposed on individuals who have been determined to be American Indians/Alaska Natives (AI/ANs) to the extent that such charges are precluded by section 5006 of the American Recovery and Reinvestment Act of 2009:
 - i. An annual deductible of no more than \$250 per individual, per calendar year.
 - ii. An annual out-of-pocket maximum of no more than \$1,500 per individual, per calendar year.

- iii. Copayments on benefits and services including office visits, pharmacy benefits, emergency room visits, out-of-area emergency services, organ transplants consistent with those in place as of January 1, 2010. The State must submit an amendment for CMS approval before implementing any increases in out-of-pocket costs for Transition Eligibles.

25. Cost Sharing for MCS and ADATSA Enrollees. Cost sharing, in any form or format, on individuals enrolled in the MCS or ADATSA program must be consistent with the cost sharing limits applicable under the State plan.

26. No Cost Sharing for Preventive Care Services. Consistent with current practice, the State must not impose cost sharing for preventive care services, including routine physicals, immunizations, Pap smears, mammograms, and other screening and testing when provided as part of the preventive care visit (and as defined in Attachment D) provided to any individual covered under this Demonstration.

VIII. DELIVERY SYSTEMS

27. Managed Care. The State will require all Transition Eligibles enrolled in the BH program to be enrolled in and receive the health care benefits for which they are eligible (as described in section V of these STCs) through a managed care delivery system. Transition Eligibles enrolled in the MCS program may be enrolled in and receive certain benefits to which they are entitled (as described in section V of these STCs), through a managed care delivery system.

28. Managed Care Contracts.

- a. No FFP is available for activities covered under contracts for services under the Demonstration prior to CMS approval of such contracts and/or contract amendments. The State will provide CMS with a minimum of 60 days to review and approve initial contracts and contract amendments. CMS reserves the right as a corrective action to withhold FFP (either partial or full) for the Demonstration until the contract compliance requirement is met.
- b. The State shall modify the Basic Health contract by April 1, 2011 to comply with all requirements of 42 CFR Part 438, unless expenditure authority is granted for elements that are not compliant with these requirements.
- c. The State shall modify the Medical Care Services contract by July 1, 2011 to comply with all requirements of 42 CFR Part 438, unless expenditure authority is granted for elements that are not compliant with these requirements.
- d. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing

covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

- e. The State will monitor the medical/loss ratio of MCOs providing services under this Demonstration.

29. Supplemental Payments.

- a. Washington is required to make supplemental payments to Indian health providers (I/T/Us) as required by section 5006 of the Recovery Act, to ensure there is no reduction in the full Medicaid State plan payment rate for these providers.
- b. In accord with the accompanying expenditure authorities, the State has until 2013 to modify their systems in order to accurately determine and pay the supplemental payments to these providers.
- c. The State is required to make retroactive supplemental payments to these providers for calendar years 2011 and 2012. To demonstrate active efforts in implementing this requirement, the State must:
 - i. Determine and distribute to providers all of the required data elements that will facilitate accurate supplemental payments. The State shall make this information available as soon as practicable, but no later than July 1, 2011, with retroactive payments to January 1, 2011.
 - ii. Providers wishing to avail themselves of the retroactive supplemental payments must collect and maintain accurate hardcopy accountings of all the required data elements.
 - iii. For all supplemental payments requested for calendar years 2011 and 2012, providers eligible under this section must submit a complete copy of the required data elements to the State's designee between January 1, 2013 and June 30, 2013.
 - iv. The State must review and complete all retroactive payments by December 31, 2013. These supplemental payments are Demonstration-related expenditures, and must be reported in accord with the requirements in sections IX (*General Reporting Requirements*), X (*General Financial Requirements*), and XI (*Monitoring Budget Neutrality for the Demonstration*) of these STCs.

30. Fee-For-Service. In accord with section V of these STCs, the State will provide certain Demonstration-covered benefits to individuals enrolled in the MCS program, and all Demonstration-covered benefits to individuals enrolled in the ADATSA program on a fee for service basis until such time as CMS approves the transition of these services into mandated managed care.

31. Readiness Review. Prior to implementation and in accord with the Readiness Review checklist, the State must work with CMS to assess and gain approval of the State’s readiness to implement the Transitional Bridge Demonstration.

IX. GENERAL REPORTING REQUIREMENTS

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

33. Monthly Enrollment Report. Within 20 days following the first day of each month, the State must report via e-mail the Demonstration enrollment figures for the month just completed to the CMS Project Officer, the Regional Office contact, and the CMS FCHPG Enrollment mailbox, using the table below.

- a. The reported Demonstration enrollment for individuals eligible for Federal match based on the Family Medicaid (TANF) methodology. Upon CMS approval of Washington’s Modified Adjusted Gross Income (MAGI) calculation for BH program eligibility, the State may, upon notification to the CMS Project Officer and the Regional Office contact, begin determining and reporting Demonstration enrollment using the MAGI eligibility calculation.
- b. Mental health services provided through the section 1915(b) waiver are not considered a benefit under this Demonstration. In accord with paragraph 40, the State will not use Demonstration financial reporting forms to claim FFP for these expenditures.

The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A (III), except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	Point In Time Enrollment (last day of month)	Newly Enrolled Last Month	Disenrolled Last Month
Basic Health			
Medical Care Services			
Alcohol and Drug Addiction Treatment and Support Act			

34. Monitoring Calls. CMS will schedule 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, the benefit package, audits, lawsuits,

financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any Demonstration amendments the State is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS will jointly develop the agenda for the calls.

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

- a. An updated budget neutrality monitoring spreadsheet;
- b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, grievances, quality of care, and access that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;
- c. Action plans for addressing any policy, administrative, or budget issues identified;
- d. Quarterly enrollment reports for Transition Eligibles that include the member months and end of quarter, point-in-time enrollment for each Demonstration population, and other statistical reports listed in Attachment A; and
- e. Evaluation activities and interim findings.

36. Annual Report.

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

37. Annual Review Plan. Consistent with the concept of a dynamic demonstration, CMS and the State will review annually the State's economic condition and budget neutrality in order to negotiate additional changes to the Demonstration. By July 1 of each Demonstration year, the State must submit to CMS the plan to further modify enrollment, benefits, and cost-sharing that further transitions the Demonstration toward full compliance with the provisions of the Affordable Care Act. Given the State's fiscal status, Washington may submit a revised

plan at any time. Such changes will be submitted for CMS approval at least 90 days before implementation.

38. Transition Plan. As this Demonstration will not be extended by CMS beyond December 31, 2013, the State is required to prepare, and incrementally revise, a Transition Plan. By July 1, 2012, the State must submit to CMS for review and approval an initial Transition Plan, consistent with the provisions of the Affordable Care Act for all individuals enrolled in the Demonstration. The plan must contain the required elements and milestones described in subsections 38(a-f) outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

- a. **Seamless Transitions.** Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on the State's plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and to coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:
 - i. Determine eligibility under all eligibility groups in effect beginning January 1, 2014, for which the State is required or has opted to provide medical assistance, including the group described in section 1902(a)(10)(A)(i)(VIII) of the Act for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
 - ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act, and explain what coverage options and benefits these individuals will have effective January 1, 2014.
 - iii. Implement a process for considering, reviewing, and making preliminary determinations under all eligibility groups in effect beginning January 1, 2014, for new applicants for Medicaid eligibility.
 - iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act, and the authorities the State identifies that may be necessary to continue coverage for these individuals.
 - v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility. The State may implement prior to January 1, 2014.

b. Access to Care and Provider Payments.

- i. **Provider Participation.** The State must identify the criteria that will be used for reviewing provider participation in (e.g., demonstrated data collection and reporting capacity), and means of, securing provider agreements for the transition.
- ii. **Adequate Provider Supply.** The State must provide the process that will be used to assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of service delivery. The report must separately address each of the following provider types:
 - a. Primary care providers
 - b. Specialty providers.
 - c. Mental Health services.
 - d. Substance Use Services.
 - e. Dental Services/Providers.
- iii. **Provider Payments.** The State will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all inclusive payment rate (e.g., certain Indian Health providers).

c. Systems Development or Remediation. The Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include:

- i. Implementing citizenship determinations based on data matching through the Social Security verification system, including development of an automated interface for childless adults and parents/caretaker relatives;
- ii. Tracking out-of-pocket charges in order to implement a 5 percent aggregate family cost sharing cap for low income population coverage options;
- iii. Replacing manual administrative controls with automated processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries;

d. Pilot Programs. The State will show progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act-defined "medical homes," "accountable care organizations," and / or "person-centered health homes" to allow for more efficient and effective management of the highest risk individuals.

e. **Progress Updates.** After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

f. **Implementation.**

- i. By July 1, 2013, the State must begin implementation of a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange, or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State Plan, the State will not require these individuals to submit a new application.
- ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination.

39. Penalty. CMS reserves the right to impose a penalty should the State fail to implement or operationalize the milestones listed in paragraph 38. The penalty amount will result in the loss of some percentage of the expenditures attributable to the Demonstration. If the State continues to fail to meet the Transition Plan requirements or milestones, CMS may impose incrementally larger percentages by which the annual expenditure authority cap will be reduced. The reduction in expenditure authority will be applied to the claims for Federal match of each Federal quarter. Once the requirement or milestone has been met, no further associated penalties will be imposed.

X. GENERAL FINANCIAL REQUIREMENTS

40. Reporting Expenditures under the Demonstration. The State will 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 will provide FFP for allowable Demonstration expenditures only so long as those expenditures do not exceed the pre-defined limits as specified in these STCs. FFP will be provided for expenditures net of collections in the form of pharmacy rebates, cost sharing, or third party liability. Consistent with section V of these STCs, FFP under the Demonstration will not be provided for services provided in Institutions for Mental Disease (IMDs).

- a. In order to track expenditures under this Demonstration, the State will report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality limit will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the Demonstration project

number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.c. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, “expenditures subject to the budget neutrality limit,” is defined below in item 2. DY1 will be the year beginning January 1, 2011, and ending December 31, 2011, and subsequent DYs will be defined accordingly.

- b. Premium offsets and enrollment fees that are collected by the State for enrollees under this Demonstration shall be reported to CMS on the CMS-64 summary sheet. Enrollment fees shall be reported as an Administrative offset on Line 9.d., columns c and d. Premium offsets shall be reported as a Services offset on Line 9.d., columns a. and b. In order to assure that the Demonstration is properly credited with these collections, the State shall provide the appropriate information on the CMS-64 narrative.
- c. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the Demonstration, subject to the budget neutrality limit (section XI of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:
 - i. Basic Health (1),
 - ii. Disability Lifeline / Medical Care Services (2), and
 - iii. Alcohol and Drug Addiction Treatment and Support Act (3).

41. Expenditures Subject to the Budget Agreement. For the purpose of this section, the term “expenditures subject to the budget neutrality limit” will include all Medicaid expenditures on behalf of all Demonstration participants (i.e., Transition Eligibles enrolled in the BH, DL / MCS, or ADATSA programs), as defined in section IV of the STCs.

42. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name “ADM”.

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

44. Reporting Member Months. For the purpose of calculating the budget neutrality expenditure limit and other purposes, the State must provide to CMS on a quarterly basis the

actual number of eligible member/months for the Eligibility Groups (EGs) as defined in section IV and section X of these STCs. Enrollment information should be provided to CMS in conjunction with the quarterly and monthly enrollment reports referred to in section IX of these STCs. If a quarter overlaps the end of one DY and the beginning of another DY, member/months pertaining to the first DY must be distinguished from those pertaining to the second.

- a. The term “eligible member/months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.
- b. There will be three “Transition Eligibles” Demonstration populations that will be reported for the purpose of calculating the without waiver baseline (budget neutrality expenditure limit) using the following waiver names. The groups used for calculating the budget neutrality expenditure limit are described below:
 - i. “Basic Health” is a hypothetical group as defined in section IV of these STCs, whose members would be eligible for Medicaid as an early Medicaid expansion population, as created by the Affordable Care Act.
 - ii. “Disability Lifeline / Medical Care Services” is a hypothetical group as defined in section IV of these STCs, whose members would be eligible for Medicaid as an early Medicaid expansion population, as created by the Affordable Care Act.
 - iii. “Alcohol and Drug Addiction Treatment and Support Act” is a hypothetical group as defined in section IV of these STCs, whose members would be eligible for Medicaid as an early Medicaid expansion population, as created by the Affordable Care Act.

45. Standard Medicaid Funding Process. The standard Medicaid funding process will be used during the Demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality limit. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 quarterly with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

46. Extent of FFP for the Demonstration. CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in section XI:

- a. Administrative costs, including those associated with the administration of the Demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
- c. Medical Assistance expenditures made under section 1115 Demonstration authority, including those made in conjunction with the Demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

47. Sources of Non-Federal Share. The State certifies that the matching non-Federal share of funds for the Demonstration is State /local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS 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.

48. State Certification of Funding Conditions. 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.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

49. Limit on Title XIX Funding. The State will be subject to a limit on the amount of Federal funding under title XIX of the Act that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using the per capita cost method described in paragraph 51, and budget neutrality expenditure limits 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 caps are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS will assess the State's compliance

with these annual limits using the Schedule C report from the CMS-64.

50. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for Transition Eligibles, but not at risk for the number of Transition Eligibles. By providing FFP for all Transition Eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Transition Eligibles, CMS assures that the Demonstration expenditures do not exceed the levels that would have been realized had there been no Demonstration.

51. Calculation of the Budget Neutrality Limit: General. For the purpose of calculating the overall budget neutrality limit for the Demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in paragraph 54 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire Demonstration period. The Federal share of this limit will represent the maximum amount of FFP that the State may receive during the Demonstration period for the types of Demonstration expenditures described below. The Federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in paragraph 55 below.

52. Impermissible Disproportionate Share Hospital (DSH), Taxes, or Donations. CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

53. “Hypothetical” Eligibility Groups. Budget neutrality agreements may include optional Medicaid populations that could be added under the State plan, but were not included in current expenditures. For this Demonstration, these are the “Basic Health,” “Disability Lifeline / Medical Care Services,” and “Alcohol and Drug Addiction Treatment and Support Act” groups. However, the agreement will not permit access to budget neutrality “savings” from the addition of the group. A prospective per capita cap on Federal financial risk is established for these groups based on the costs that the population is expected to incur under the demonstration.

54. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of Demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in section X of these STCs. The trend rates and per capita cost estimates for each EG for each year of the Demonstration are listed in the table below.

DY	Basic Health Per Capita *additional programmatic changes required	Basic Health Trend	Disability Lifeline / Medical Care Services Per Capita	Disability Lifeline / Medical Care Services Trend	Alcohol and Drug Addiction Treatment and Support Act Per Capita**	Alcohol and Drug Addiction Treatment and Support Act Trend
1	\$184.00	5.30%	\$713.96	5.30%	\$469.94	5.30%
2	\$203.44	5.30%	\$751.80	5.30%	\$573.27	5.30%
3	\$214.22	5.30%	\$791.64	5.30%	\$603.65	5.30%

**Should the State not transition the ADATSA program into managed care in 2012 with all of the agreed to benefit changes for the Transition Eligibles enrolled in that program, the PMPM for this population will revert to CY12 = \$494.85 and CY13 = \$521.08.

55. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable Demonstration offsets such as, but not limited to, premium collections) by total computable Demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

56. Exceeding Budget Neutrality. The budget neutrality limit calculated above in paragraph 51 will apply to actual expenditures for Demonstration services as reported by the State under section X of these STCs. If at the end of the Demonstration period the budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the Demonstration period, the budget neutrality test will be based on the time period through the termination date.

57. Enforcement of Budget Neutrality. The CMS shall enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. In addition, no later than 6 months after the end of each DY, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, it must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
DY 1	DY 1 budget neutrality cap	+2.5 percent
DY 2	DYs 1 and 2 combined budget neutrality limit	+75 percent
DY 3	DYs 1 through 3 combined budget neutrality limit	+0 percent

XII. EVALUATION OF THE DEMONSTRATION

58. Submission of a Draft Evaluation Plan. The State shall submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS approval of the Demonstration. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall 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 shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

As a component of the draft evaluation plan for the Demonstration, the State will conduct an outcomes analysis of the impact of CMS approved cost-sharing changes on enrollment and utilization of services.

Evaluation Topics. In preparation for implementation of the provisions of the Affordable Care Act, the State will:

- a. Evaluate key program outcomes to determine the program's effectiveness;
- b. Include any limitations, challenges, or opportunities presented by the Demonstration;
- c. Include successes or best practices, interpretations or conclusions reached during the Demonstration;
- d. Examine and review the objectives and the hypotheses proposed as part of this Demonstration; and
- e. Inform CMS of the status of the State's evaluation in the quarterly and annual reports using the timeframes specified herein.

59. Final Evaluation Design and Implementation. The CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The State shall submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration or with the State's application for renewal. CMS shall provide comments within 60 days after receipt of the report. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

60. CMS Independent Evaluation. Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	Paragraph
30 days after approval date	State acceptance of Demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
60 days after approval date	Criteria for administering the waiting lists and enrolling new applicants.	Paragraph 23(e)(ii)
120 days after approval date	Submit Draft Design for Evaluation Report	Paragraph 58(a)-(e)
July 1, 2012	Submit a Transition Plan	Paragraph 38
120 days after expiration of the Demonstration	Submit Draft Final Evaluation Report	Paragraph 59
60 days after receipt of CMS comments	Submit Final Evaluation Report	Paragraph 59
Monthly Deliverables	Monitoring Call	Paragraph 34
	Monthly Enrollment Report	Paragraph 33
Quarterly Deliverables Due 60 days after end of each quarter, except 4 th quarter	Quarterly Progress Reports	Paragraph 35 and Attachment A
	Quarterly Expenditure Reports	Section X
Annual Deliverable – Due July 1 of each year	Annual Review Plan	Paragraph 37
Annual Deliverables - Due 120 days after end of each 4 th quarter	Annual Reports	Paragraph 36 and Attachment A

ATTACHMENT A

Under section IX, paragraph 4 (*Quarterly Progress Report*) of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

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

NARRATIVE REPORT FORMAT:

Title Line One – Washington Transitional Bridge Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example: Demonstration Year: 9 (1/1/2011 – 12/31/2011)

Federal Fiscal Quarter: 3/2011 (10/07 - 12/07)

Footer: Approval Period January 1, 2011 – December 31, 2013

I. Introduction

Present information describing the goal of the Demonstration, what it does, and the status of key dates of approval/operation.

II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any Demonstration amendments related to eligibility or benefits.

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”.

III. Enrollment Counts for Quarter

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

Demonstration Populations	Total No. Transition Eligibles in current Quarter	Total No. Enrollees (including non-Transition Eligibles)
Basic Health		
Disability Lifeline/Medical Care Services		
Alcohol and Drug Addiction Treatment and Support Act		

IV. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for Demonstration enrollees or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

VI. Operational/Policy/Systems/Fiscal Developments/Issues

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VII. Action Plans for Addressing Any Issues Identified

Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

VIII. Financial/Budget Neutrality Development/Issues

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

IX. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group (Transition-Eligibles Only)	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Basic Health				
Disability Lifeline/ Medical Care Services				
Alcohol and Drug Addiction Treatment and Support Act				

X. Consumer Issues

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

XI. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XII. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XIII. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XIV. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

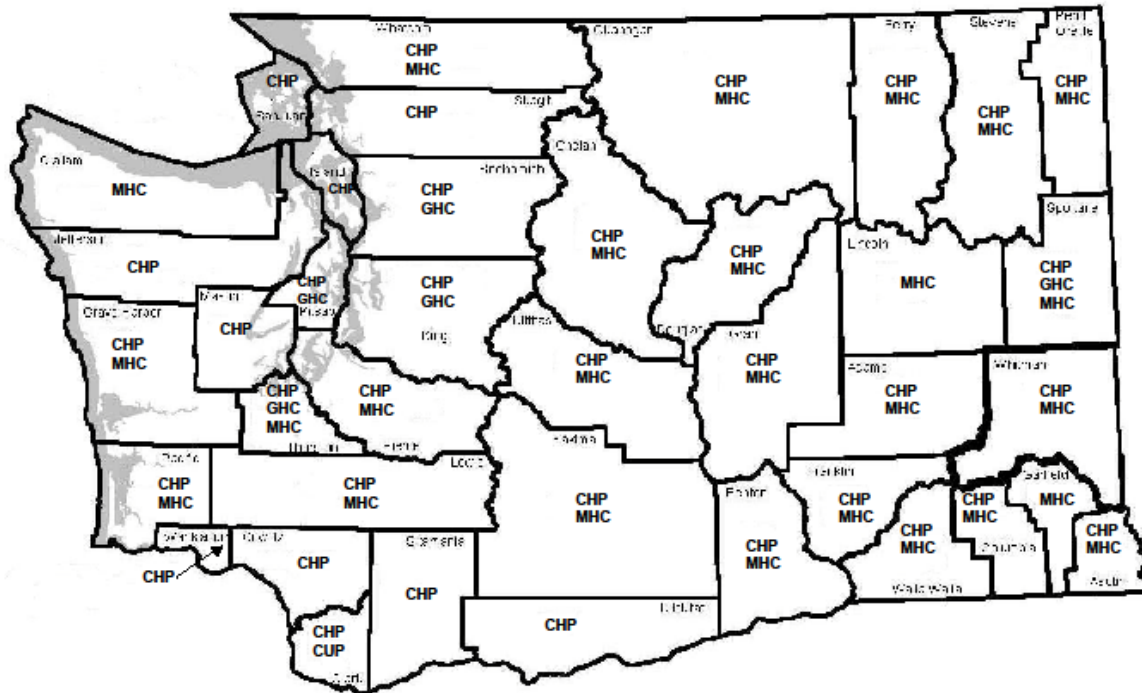
XV. Date Submitted to CMS

ATTACHMENT B
CONTRACTED BASIC HEALTH PLANS 2011 BY COUNTY

County	Community Health Plan of WA	Columbia United Providers	Group Health Cooperative	Molina
Adams	X			X
Asotin	X			X
Benton	X			X
Chelan	X			X
Clallam				X
Clark	X	X		
Columbia	X			X
Cowlitz	X			
Douglas	X			X
Ferry	X			X
Franklin	X			X
Garfield				X
Grant	X			X
Grays Harbor	X			X
Island	X			
Jefferson	X			
King	X		X	
Kitsap	X		X	
Kittitas	X			X
Klickitat	X			
Lewis	X			X
Lincoln				X
Mason	X			
Okanogan	X			X
Pacific	X			X
Pend Oreille	X			X
Pierce	X			X
San Juan	X			
Skagit	X			
Skamania	X			
Snohomish	X		X	
Spokane	X		X	X
Stevens	X			X
Thurston	X		X	X
Wahkiakum	X			
Walla Walla	X			X
Whatcom	X			X
Whitman	X			X
Yakima	X			X

BASIC HEALTH 2011 CONTRACTED MANAGED CARE PLAN SERVICE AREAS

**2011 Health Plan Service Areas
Effective January 1, 2011 – December 31, 2011**



CHP – Community Health Plan
 CUP – Columbia United Providers
 GHC – Group Health Cooperative
 MHC – Molina Healthcare of Washington

ATTACHMENT C
Definition of the Basic Health Priority Populations

For purposes of this Demonstration, a Priority Population has the following definition:

(4)(b) If the administrator closes or limits enrollment, to the extent funding is available, BH will continue to accept and process applications for enrollment from:

- (i) Children eligible for BH, who were referred for BH coverage, but were found ineligible for BH for reasons other than noncompliance;
- (ii) Employees of a home care agency group enrolled or applying for coverage under WAC 182-22-220;
- (iii) Eligible individual home care providers;
- (iv) Licensed foster care workers;
- (v) Persons who disenrolled from BH in order to enroll in Medicaid, and subsequently became ineligible for Medicaid;
- (vi) Limited enrollment of new employer groups;
- (vii) Members of the Washington National Guard and Reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents; and
- (viii) Subject to availability of funding, additional space for enrollment may be reserved for other applicants as determined by the administrator, in order to ensure continuous coverage and service for current individual and group accounts. (For example: Within established guidelines, processing routine income changes that may affect subsidy eligibility for current enrollees; adding new family members to an existing account; transferring enrollees between group and individual accounts; restoring coverage for enrollees who are otherwise eligible for continued enrollment under WAC 182-24-070(7)(b) after a limited suspension of coverage due to late payment or other health care coverage; adding newly hired employees to an existing employer group; or adding new or returning members of federally recognized Native American tribes to that tribe's currently approved financial sponsor group.)

(c) If the administrator has closed or limited enrollment, applicants for BH who are not in any of the categories in (b) of this subsection may reserve space on a waiting list to be processed according to the date the waiting list request or application is received by BH. When enrollment is reopened by the administrator, applicants whose names appear on the waiting list will be notified by BH of the opportunity to enroll. BH may require new application forms and documentation from applicants on the waiting list, or may contact applicants to verify continued interest in applying, before determining their eligibility.

ATTACHMENT D

Definition of Preventive Care Services

For purposes of this Demonstration, Preventive Services, has the following definition (this language is linked *directly* to the U.S. Preventive Services Task Force (USPSTF) guidelines).

5.3.1. Primary and secondary preventive care services shall be provided in accordance with the edition of the “Guide to Clinical Preventive Services” of the U.S. Preventive Services Task Force as of the effective date of this Agreement and as follows:

5.3.1.1. Those services rated “A” shall be covered and CONTRACTOR shall take active steps to assure their provision.

5.3.1.2. Those services rated “B” shall be covered.

5.3.1.3. Those services rated “D” shall not be covered.

5.3.1.4. Those services rated “I” shall not be covered, and CONTRACTOR shall take steps to determine that if those services are provided, there is informed consent.

5.3.1.5. Those services rated “C” and those services not rated shall be provided at the discretion of CONTRACTOR to determine the appropriate level of care for the Enrollee consistent with the terms of the COC (Exhibit 2) and this Agreement.

5.3.2. CONTRACTOR may substitute generally recognized accepted guidelines, as long as such substitution is approved in advance, in writing, by HCA.

5.3.3. CONTRACTOR shall provide the Enrollee with a description of preventive care benefits to be used by CONTRACTOR in the materials required by Section 2.4.

For purposes of this Demonstration, Office Appointment Standards for Non-Symptomatic (Preventive Services), is as follows:

12.1.3. Office Appointment Standards. CONTRACTOR shall comply with appointment standards that are no longer than the following:

12.1.3.1. Non-symptomatic (e.g., preventive care) office visits shall be available from the Enrollee’s PCP or an alternative provider within 30 calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or children and adult immunizations.