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

May 29, 2020

Allison Taylor
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington Street, Room W461, MS25
Indianapolis, IN 46204

Dear Ms. Taylor:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain Act programs, including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Indiana's July 25, 2019 request to add the Workforce Bridge Account program to its section 1115 demonstration project entitled, "End Stage Renal Disease (ESRD)" (Project Number 11-W-00237/5), in accordance with section 1115(a) of the Act. This amendment is effective June 1, 2020 through December 31, 2020, upon which unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS's approval of this section 1115(a) demonstration amendment is subject to the limitations specified in the attached expenditure authority, Special Terms and Conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures or individuals covered by expenditure authority. Per longstanding policy, CMS considers each state amendment or demonstration request independently, and this action does not indicate likely approval or disapproval of any future requests.

Extent and Scope of Demonstration Amendment

To help mitigate disincentives for certain Medicaid beneficiaries to obtain employment that might cause them to lose their Medicaid benefits due to an increase in income, and in order to provide for continuity in what may otherwise be a gap as an individual transitions between Medicaid benefits and employer or other commercial coverage, on July 25, 2019, Indiana submitted the Workforce Bridge Account amendment, to the state's section 1115 demonstration entitled, Healthy Indiana Plan (HIP). During the review process, it was decided to instead seek to amend its current ESRD section 1115 demonstration (rather than HIP) to include the Workforce Bridge Account program. This would permit the state to reinvest budget neutrality savings achieved in the ESRD demonstration to support this initiative.

Under this amendment, eligible individuals will be informed that they would have access to financial resources, in an amount no greater than $1,000, for the purpose of temporarily paying for health insurance premiums and cost-sharing, or for the direct costs of prescription drugs and services otherwise coverable under section 1905(a) of the Social Security Act. This assistance is expected to act as a bridge to commercial insurance coverage. While individuals would be made aware that this resource would be available to them if they took steps that could raise their income enough to lose Medicaid eligibility, the accounts would only be activated when an individual is no longer Medicaid eligible. To be eligible for the Workforce Bridge Account, an individual must have been eligible for Medicaid under section 1902(a)(10)(A)(i)(VIII) of the Act[1] and now no longer eligible under this category or any other Medicaid category due to increased income. Individuals who have been most recently disenrolled for failure to meet conditions of eligibility, such as payment of premiums, will not qualify.

This program will be available to no more than 8,000 eligible individuals. Since this is a capped program, individuals who are eligible, once notified, must opt-in to the Workforce Bridge Account program. To opt-in to the Workforce Bridge Account, the eligible individual must acknowledge to the state, by phone or mail, an interest in participating. Individuals will have 30 days once notified to opt-in to the account. As part of this 30 day opt in process, individuals will be given the opportunity for a referral to a "health care navigator" who will be able to inform individuals about their health care options and provide choice counseling. Once individuals opt-in, the amounts associated with the Workforce Bridge Account will be available for 12 months or until the full amount has been expended, whichever comes first. Individuals are only allowed to use the account for premiums, cost-sharing or for the direct cost of services received within 12 months and once the 12 months is finished, individuals will not be able to access the Workforce Bridge Account. Reimbursement for health insurance premiums will be paid to the individual or at the request of the individual enrolled in a Marketplace health plan the state will pay for the premiums directly on behalf of the individual to the health plan. In addition, beneficiaries of this program will receive an insurance card that will contain information for providers on how to submit a claim to the Bridge Account for reimbursement of cost-sharing linked to the enrollees primary insurance or direct billing for enrollees who have not yet completed enrollment in primary insurance coverage. The card can also be used for the direct payment for the costs of most Medicaid coverable section 1905(a) services that would be otherwise available to Medicaid

[1] Under Indiana state code this eligibility group is described as the Healthy Indiana Plan (HIP).

beneficiaries. In order to receive reimbursement for these services, the services must be rendered by a Medicaid enrolled provider.

Elements of the Demonstration Request CMS is Not Approving at This Time

In its application, Indiana also made requests unrelated to the Workforce Bridge Account that CMS is not acting on at this time.

Determination that the Demonstration Project is Likely to Assist in Promoting Medicaid's Objectives

Under section 1901 of the Act, the Medicaid program provides federal funding to participating states "[f]or the purpose of enabling each state, as far as practicable under the conditions in such state, to furnish (l) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."

While this statutory text is not necessarily an exhaustive source of Medicaid objectives, it makes clear that at least one objective of Medicaid is to enable states to "furnish… medical assistance" (i.e., payment for certain healthcare services defined at section 1905 of the Act, the services themselves, or both). This demonstration promotes that Medicaid objective by providing coverage of health care costs to individuals who lose Medicaid coverage due to an increase in income that would otherwise not be available.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

The Affordable Care Act (ACA) specified that comment periods should be "sufficient to ensure a meaningful level of public input," section 1115(d)(2)(A) & (C) of the Act, but the statute imposed no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments. 42 CFR 431.416(d)(2).

CMS received sixteen comments during the federal comment period on the demonstration extension request. Although CMS is not legally required to provide written responses to comments, CMS is addressing some of the central issues raised by the comments and summarizing CMS's analysis of those issues for the benefit of stakeholders. After carefully

reviewing the public comments submitted during the federal comment period, CMS has concluded that the demonstration is likely to advance the objectives of Medicaid.

Most of the comments were in favor of the Workforce Bridge Account, acknowledging that there is a need to assist beneficiaries in maintaining coverage as they move towards gaining other coverage, including on the Marketplace. Some comments, which were originally in favor of the Workforce Bridge Account, expressed concern that the state is not putting guardrails around the types of health insurance coverage an individual eligible for the account can purchase. Commenters were concerned that individuals would purchase coverage that does not meet the ACA standards. To mitigate this concern, before eligible individuals can receive the benefits of this account, they must go through an "opt-in" process under which they will be provided with the option of a referral to a Navigator to get more information about their health insurance options, including the benefits of coverage that meets ACA standards, and so that they understand the options available, and the pros and cons of such options. Navigators will inform individuals about their health insurance options, including the benefits of coverage that meets ACA standards, and understand the options available, and the pros and cons of such options. This would allow them to benefit from the assistance of a Navigator in making an insurance selection.

Other comments mentioned the proposed changes to the Gateway to Work/community engagement program in the separate HIP demonstration. While CMS appreciates the comments, at this time CMS is not acting upon those components of the state's request, and those comments do not pertain to this amendment or the ESRD demonstration being amended by this amendment.

After carefully reviewing the public comments submitted during the federal comment period, CMS has concluded that the demonstration is likely to advance the objectives of Medicaid.

Other Information

CMS's approval of this demonstration amendment is conditioned upon compliance with the enclosed list of expenditure authorities and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

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

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

If you have questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Calder Lynch
Deputy Administrator and Director

Enclosures

cc: Mai Le-Yuen, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **No. 11-W-00237/5**

TITLE: **End Stage Renal Disease (ESRD)**

AWARDEE: **Indiana Family and Social Services Administration**

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, shall, for the period of this demonstration, be regarded as expenditures under the state's Medicaid title XIX state plan.

The following expenditure authorities shall enable Indiana to implement the End Stage Renal Disease (ESRD) Medicaid section 1115 demonstration. These expenditure authorities promote the objectives of title XIX by increasing overall coverage of low-income individuals with a diagnosis of ESRD in the state and ensuring access to comprehensive coverage for low-income individuals who have a diagnosis of ESRD and primary coverage through Medicare and by supporting individuals' ability to maintain continuous coverage and promote successful transitions to commercial insurance products.

1. **Demonstration Population 1:** Expenditures for health care related costs for individuals that were enrolled in Medicaid spend down as of May 31, 2014, continue to meet the requirements for spend down eligibility that were in effect on that date, have Medicare, meet resource requirements limit of $1,500 for an individual and $2,250 for a couple, over 150 percent of the federal poverty level (FPL), have a diagnosis of ESRD, are not institutionalized, and meet all other Medicaid non-financial eligibility criteria, but are not otherwise eligible for Medicaid.

2. **Demonstration Population 2:** Expenditures for health care related costs for individuals have incomes between 150 and 300 percent of the FPL, have Medicare, are diagnosed with ESRD, have resources less than $1,500 for an individuals and $2,250 for a couple, are not institutionalized, and meet all other Medicaid non-financial eligibility criteria, but are not otherwise eligible for Medicaid or Demonstration Population 1.

3. **Demonstration Population 3:** Expenditures for health insurance premiums and cost-sharing, or the costs of Medicaid covered services by individuals, age 19-64, who were, but due to an increase in verified income, are no longer, eligible for Medicaid under section 1902(a)(10)(A)(i)(VIII) and otherwise not eligible for Medicaid.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00237/5**

TITLE: **End Stage Renal Disease (ESRD)**

AWARDEE: **Indiana Family and Social Services Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Indiana's End Stage Renal Disease (ESRD) section 1115(a) Medicaid demonstration (hereinafter referred to as "demonstration"). The parties to this agreement are the Indiana Family and Social Services Administration (hereinafter referred to as "state") and the Centers for Medicare & Medicaid Services (CMS). These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective July 28, 2016 unless otherwise specified. This demonstration is approved through December 31, 2020.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Affected Populations and Populations Made Eligible under the Demonstration
V. Benefits
VI. Workforce Bridge Account Program
VII. Cost Sharing
VIII. Delivery System
IX. General Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality for the Demonstration
XII. Evaluation of the Demonstration
XIII. Schedule of State Deliverables During the Demonstration

II. PROGRAM DESCRIPTION AND OBJECTIVES

This demonstration, originally titled as Indiana's HIP 1.0 demonstration, began in 1994 to supplement state plan benefits for Medicaid eligible children and otherwise eligible adults who are not aged, blind or disabled. HIP 1.0 utilized an account similar to a health savings account called a Personal Wellness and Responsibility (POWER) account to cover uninsured parents as well as childless adults whose incomes are below 200 percent of the federal poverty level (FPL).

HIP 1.0 was scheduled to expire at the end of 2013, but was extended for an additional year through December 31, 2014.

In May 2014, CMS approved an amendment to the HIP 1.0 demonstration to include former spend down enrollees diagnosed with End Stage Renal Disease (ESRD) as a new HIP 1.0 demonstration population. The ESRD enrollees at issue are Medicare beneficiaries in need of supplemental health care coverage. By providing coverage through HIP, these beneficiaries were able to access kidney transplant and related services that they might not otherwise be able to afford without the additional supplemental benefits.

In January 2015, CMS approved the Healthy Indiana Plan 2.0 (HIP 2.0) demonstration, which provides health care coverage for adults through a managed care plan and a POWER account. The demonstration includes POWER account contributions, implements healthy behavior incentives, and a premium assistance program for individuals with employer sponsored insurance. HIP 1.0 enrollees who originally were part of this demonstration were transitioned from this demonstration to the new HIP 2.0 demonstration, and as a result the ESRD enrollees became the only population remaining in the original HIP 1.0 demonstration. Since the ESRD population was the only one receiving benefits under this demonstration, it was renamed the End Stage Renal Disease (ESRD) demonstration. This demonstration will continue to provide coverage for individuals with ESRD that are not currently eligible under the Medicaid state plan. The ESRD demonstration currently expires December 31, 2020.

In an amendment to this ESRD demonstration dated June 1, 2020, the state received authority to create a Workforce Bridge Account Program, under which certain Medicaid beneficiaries will be informed that, if they lose their Medicaid eligibility due to an increase in income, they will be eligible for up to $1,000 for the purpose of temporarily paying for costs that include premiums and copayments for health insurance coverage, or the direct costs of health care services that would be covered by Medicaid. While reimbursement for health insurance premiums will be paid to the individual or at the request of the individual enrolled in a Marketplace health plan the state will pay for the premiums directly to the plan, coverage of plan cost-sharing, or of direct services, will be paid for with a card that will be issued to beneficiaries. The card can only be used for Medicaid covered services received by a Medicaid enrolled provider. Thus, if a beneficiary who purchases health insurance wants to have cost-sharing covered, he or she must use a Medicaid enrolled provider.

With this demonstration, Indiana expects to continue to achieve the following Medicaid program objectives:

- Increase overall coverage of low-income individuals with a diagnosis of ESRD in the state; and
- Ensure access to comprehensive coverage for low-income individuals who have a diagnosis of ESRD and primary coverage through Medicare.

With this demonstration amendment, Indiana expects to achieve the following Medicaid program objectives:

- Through the Workforce Bridge Account program, support for the successful transition from Medicaid to commercial insurance will be provided to mitigate disincentives associated with increasing income and losing access to Medicaid coverage, and reduce healthcare coverage gaps and improve overall access to care.

III. GENERAL PROGRAM REQUIREMENTS

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

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents, of which these terms and conditions are part, must apply to the demonstration, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the time frames specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operation nature without requiring the state to submit an amendment to the demonstration under STCs 6 and 7. CMS will notify the state within 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

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

    b. If mandated changes in the federal law require state legislation, the changes shall 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 shall not be required to submit title XIX state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population covered through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.

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

7. **Demonstration Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the 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 herein. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the state, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment.

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

    c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX state plan amendment, if necessary; and,

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

8. **Extension of the Demonstration**. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) are advised to observe the

timelines contained in those statutes. Otherwise, no later than 6 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 9. As part of the demonstration extension requests, the state must provide the documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in STC 14.

9. Demonstration Phase-Out. The state may 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 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

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

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 sections 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 sections 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 section 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 the October 1, 2010 CMS 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.

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 shall 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 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. CMS shall promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and shall 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.

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 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 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. section 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, and/or renewal of this demonstration (42 C.F.R. section 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.

15. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

16. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

IV. AFFECTED POPULATIONS AND POPULATIONS MADE ELIGIBLE UNDER THE DEMONSTRATION

17. **Populations.** This demonstration includes populations and benefits made eligible under the demonstration; no state plan populations are affected by the demonstration. Table 1 contains an overview of eligibility under the demonstration.

Table 1: ESRD Demonstration Populations

Description	FPL Level and/or other qualifying criteria	Demonstration Population
Former spend down enrollees effective May 31, 2014	Enrolled in Medicaid spend down effective May 31, 2014, have Medicare, have resources less than $1,500 for an individual and $2,250 for a couple, have income over 150% of FPL, have a diagnosis of ESRD, are not institutionalized, and meet all other Medicaid non-financial eligibility criteria, but not otherwise Medicaid eligible.	Population 1
New Enrollees	Income between 150 and 300% FPL, have Medicare, have a diagnosis of ESRD, have resources less than $1,500 for an individuals and $2,250 for a couple, are not institutionalized, and meet all other Medicaid non-financial eligibility criteria but not otherwise eligible for Medicaid or Demonstration Population 1.	Population 2
Workforce Bridge Account	Individuals who are no longer eligible for Medicaid under section 1902(a)(10)(A)(i)(VIII) due to a verified increase in income.	Population 3

18. **Enrollment.** Former spend down enrollees will maintain seamless Medicaid coverage with no administrative action required as long as they continue to meet the applicable eligibility criteria for the demonstration (or for Medicaid coverage on another basis). New enrollees are required to submit an application and complete an in-person assessment.

19. **Redetermination of Eligibility**. Enrollees are required to complete annual eligibility redeterminations. Former spend down enrollees will maintain their ESRD eligibility during their annual redetermination if they meet the following criteria:

    a. Meet the eligibility criteria in effect May 31, 2014 for the aged, blind and disabled groups, including use of a spend down;
    b. Continue to have a physician-verified ESRD diagnosis
    c. Are not institutionalized;
    d. Do not qualify for Medicaid on another basis.

    Individuals are also eligible if they meet the following criteria:

    a. Have been diagnosed with ESRD;
    b. Have a household income below 300 percent of the federal poverty line (FPL);
    c. Have resources below $1,500 for an individual or $2,250 for a couple
    d. Are not institutionalized;
    e. Meet all other Medicaid non-financial eligibility criteria; and
    f. Are not Medicaid eligible on another basis, or eligible in the prior group

V. BENEFITS

20. ESRD Covered Benefits. Individuals eligible for the demonstration will be eligible for state plan benefits after they meet their ESRD liability. The liability will be calculated using spend down methodology based on incurred medical costs. This coverage is considered Minimal Essential Coverage (MEC).

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

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

21. Non-Emergency Medical Transportation (NEMT). Individuals affected by this demonstration shall receive benefits in the form of an administrative activity or service to assure non-emergency transportation to and from providers. The state must report in the quarterly reports any complaints or issues regarding NEMT.

VI. WORKFORCE BRIDGE ACCOUNT PROGRAM

22. Workforce Bridge Account Program. This program provides up to $1,000 for eligible individuals for the purpose of paying health insurance premiums, cost-sharing, and/or the direct costs of prescription drugs and services otherwise coverable under section 1905(a) of the Social Security Act. The state may claim as allowable expenditures under the demonstration funds as described below.

23. Eligibility. Individuals who qualify for this program are those who are no longer eligible under section 1902(a)(10)(A)(i)(VIII) or any other Medicaid eligibility category due to increased income. Individuals who are not eligible for Medicaid based on a failure to meet conditions for eligibility will not qualify for the Workforce Bridge account. Multiple individuals in the same household, if they meet the eligibility requirements, will have access to their own account. These qualified individuals will be notified of their eligibility and opt in opportunity consecutive with their notice of disenrollment. Accounts may be closed if an individual moves out of state, voluntarily withdraws, ages out, becomes incarcerated, enrolls in Medicare, or regains Medicaid or Presumptive Medicaid eligibility. Eligibility for the Workforce Bridge Account program is for one 12-month period and is not eligible to be renewed.

24. Enrollment. The state will send notification to individuals who are eligible for the Workforce Bridge Account due to a loss in Medicaid eligibility based on an increase in income. Individuals will have 30 days from receipt of the notice informing them of eligibility to opt-in to this program to activate the account. The state will be allowed to effectuate an enrollment cap of up to 8,000 individuals.

25. Benefits. The state will provide funds to the account of no more than $1,000 to those eligible individuals who opt-in to the account. As part of the opt-in process, individuals will have the option to be referred to Navigators who will inform individuals of their health insurance options, and the benefits of purchasing Affordable Care Act compliant coverage. The funds are limited to payments for premiums, to pay cost-sharing, such as copayments, coinsurance and deductibles, or the direct costs for otherwise Medicaid-eligible services rendered by a Medicaid provider, with the exception of long term care, hospice, waiver and 1915(i) services, Medicaid Rehabilitation Option (MRO), NEMT, and some specialty services that are not covered under the HIP 2.0 program. Reimbursement for health insurance premiums will be paid to the individual or paid directly on behalf of the individual. Individuals will be issued a card that provides details for providers to bill the Workforce Bridge Account for cost sharing or direct costs of covered services via standard fee for service methodology. The funds in the account will be available to individuals for 12 months or until the full amount has been expended, whichever comes first, after the individual opts-in to the account. Individuals will only be allowed to use the funds for expenses incurred or services received within 12 months and once the 12 months is complete, the individual will not be able to access the account. If a former or current Workforce Bridge Account recipient reenrolls in Medicaid they again could be found subsequently eligible for a Workforce Bridge Account if they meet the qualifying criteria.

26. Delivery System. Claims received under the Workforce Bridge Account program will be processed through the fee-for-service (FFS) arrangement.

27. Minimum Essential Coverage (MEC). The Workforce Bridge Accounts are limited to the provision of services described in STC 24 and, and consequently, is not recognized as Minimum Essential Coverage (MEC) as outlined in section 5000A(f)(1)(A)(ii) of the Internal Revenue Code of 1986. The state shall adhere to all applicable Internal Revenue Service (IRS) reporting requirements with respect to MEC for demonstration enrollees.

28. Reporting. The state must provide data regarding the operation of this program in the quarterly and annual monitoring reports per STC 33. This data must, at a minimum, include:

a. Number of beneficiaries under 1902(a)(10)(A)(i)(VIII) who lost Medicaid eligibility due to mid-year change in circumstance
    i. Number of beneficiaries extended an opt-in offer for the Workforce Bridge

b. The number of individuals served by the program monthly, reflecting counts of beneficiaries both new and continuing on a monthly basis;
c. Amount paid per beneficiary (average) from the Bridge Account cap of $1000 and the average number of months for beneficiaries to reach the cap of $1000;
d. If applicable, the number of beneficiaries deemed eligible for the Workforce Bridge Account Program but cannot be included in the program because of the cap of 8,000; and
e. Percent of claims paid as primary insurance and as third party liability (TPL) from the Bridge Account.

VII. COST SHARING

29. Allowable Cost Sharing. ESRD enrollees will be subject to the same cost sharing as described in the approved Medicaid state plan. No additional cost sharing will be imposed on individuals enrolled in the Workforce Bridge Account Program.

VIII. DELIVERY SYSTEM

29. Fee for Service. The participants in the demonstration will receive services through a fee-for-service delivery system.

IX. GENERAL REPORTING REQUIREMENTS

30. General Financial Requirements. The state shall comply with all general financial requirements under title XIX set forth in these STCs.

31. Reporting Requirements Relating to Budget Neutrality. The state shall comply with all reporting requirements for monitoring budget neutrality set forth in this agreement. The state must submit any corrected budget neutrality data upon request.

32. Monitoring Calls. CMS will have monitoring calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration.

33. Quarterly Monitoring Reports: The state must submit progress reports in accordance with the guidelines in Attachment A by no later than 60 days following the end of each quarter (March, June, September, and December of each year). The intent of these reports is to present the state's analysis and the status of the various operational program areas. These quarterly reports must include, but not be 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: approval and contracting with new plans, benefits, enrollment and disenrollment,

grievances, quality of care, access, health plan contract compliance and financial performance 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 demonstration eligibles that include the member months for each demonstration population, as required to evaluate compliance with the budget neutrality agreement, and as specified in Section IX, STC 29; and other statistical reports listed in Attachment A.

34. Annual Monitoring Report.

a. The state shall submit a draft annual monitoring report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.

b. The state shall submit the draft annual report by no later than 120 days after the end of each demonstration year (DY) for CMS review. The state shall finalize and submit the final draft report within 60 days from receipt of CMS' comments.

IX. GENERAL FINANCIAL REQUIRMENTS

35. 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, and to separately identify expenditures provided through the demonstration under section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX of the STCs.

36. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Indiana must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number 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 this purpose, DY 9 is defined as the year beginning January 1, 2016. Subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures and are not part of any other title XIX waiver program should be reported on Forms CMS-64.9 Base/64.9P Base.

b. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c. **Use of Waiver Forms**. The following waiver Form CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

    i. **Demonstration Population 1: Former Spend Down Individuals** that were enrolled in Medicaid spend down effective May 31, 2014, have Medicare, meet resource requirements limit of $1,500 for an individual and $2,250 for a couple, over 150 percent of the FPL, have a diagnoses of ESRD, not institutionalized, and meet applicable non-financial Medicaid eligibility requirements; and

    ii. **Demonstration Populations 2: New Enrollees** with incomes between 150 and 300 percent of the FPL, have Medicare, are diagnosed with ESRD, have resources less than $1,500 for an individuals and $2,250 for a couple, at not institutionalized, and meet applicable non-financial Medicaid eligibility criteria requirements, but are not eligible for Medicaid or Demonstration Population 1.

    iii. **Demonstration Population 3: Workforce Bridge Accounts** are available to individuals who are no longer eligible for Medicaid under section 1902(a)(10)(A)(i)(VIII) or other Medicaid coverage due to an increase in verified income.

d. **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the

demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

e. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit**. For the purpose of this section, the term "expenditures subject to the budget neutrality expenditure limit" refers to all title XIX expenditures on behalf of individuals who are enrolled in this demonstration, as defined in Section IV, STC 16, including all service expenditures net of premium collections and other offsetting collections. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

f. **Administrative Costs.** The following provisions govern reporting of administrative costs during the demonstration.

i. Administrative costs attributable to the demonstration must be reported under the waiver name "ESRD." These expenses are not subject to the budget neutrality limit.

ii. Administrative costs not related to the demonstration should be reported on the appropriate CMS-64.10 Base or 64.10P Base, or another waiver schedule as appropriate, and not subject to the budget neutrality test for this demonstration.

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

37. Reporting Member Months: The following describes the reporting of member months for ESRD:

a. For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the quarterly report required under Section VIII, STC 25, the actual number of eligible member months for all eligibility groups defined in Section IV, STC 16.

b. Member months are defined as 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 4 eligible member months.

38. **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 (narrative section) 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.

39. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section IX.

    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 Medicaid state plan and waiver authorities;

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

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

    a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

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

of funding.

c. Under all circumstances, health care providers must retain 100 percent of the ESRD reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid 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.

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

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

42. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period demonstration approval period. The limit will consist of two parts, and is determined by using a per capita cost method, with an aggregate adjustment for projected DSH payments. 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 the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section VIII, STC 23.

43. 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 ESRD demonstration.

Calculation and Application of Budget Neutrality Limit

The state is paying for the ESRD expenditure population with accumulated total computable budget neutrality savings. The demonstration is expected to cost $9,445,617 (total computable) over the five years.

The cost of the ESRD expenditure population for each year of the extension period is expected to be:

	DY09 (CY2016)	DY10 (CY2017)	DY11 (CY2018)	DY12 (CY2019)	DY 13 (CY2020)
Eligible Member Months	4,290	4,247	4,205	4,163	4,121
PMPM with Trend Rate of 4%	$424.04	$436.38	$449.18	$462.25	$475.70

The state is paying for the Workforce Bridge Account Program population with accumulated total computable budget neutrality savings. This program will be capped at 8,000 eligible individuals with a monetary cap of $1,000 per eligible individual. The amendment is expected to cost $4,666,667.

	DY09 (CY2016)	DY10 (CY2017)	DY11 (CY2018)	DY12 (CY2019)	DY 13 (CY2020)
Eligible Member Months					56,000
PMPM					$83.33

44. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis, by combining the annual limits calculated into lifetime limits for the demonstration. The following describes how budget neutrality will be enforced.

a. If the demonstration is terminated prior to the end of the budget neutrality agreement, an assessment of the state's compliance with these requirements shall be based on the time elapsed through the termination date.

b. **Interim Checks/Corrective Action Plan.** If the state exceeds the calculated cumulative target limit combined by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Year 9	Cumulative budget neutrality expenditure cap plus:	1 percent
Year 10	Cumulative budget neutrality expenditure cap plus:	1 percent
Year 11	Cumulative budget neutrality expenditure cap plus:	0.5 percent
Year 12	Cumulative budget neutrality expenditure cap plus:	0.5 percent
Year 13	Cumulative budget neutrality expenditure cap plus:	0 percent

XI. EVALUATION OF THE DEMONSTRATION

45. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval an updated draft evaluation design for an overall evaluation of the demonstration by no later than 120 days after the effective date of the demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.
    a. Workforce Bridge Account Program. The state must submit to CMS for approval a draft evaluation design for evaluation of the Workforce Bridge Account Program component of the demonstration by no later than 180 days after the effective date of the amendment. At a minimum, the state's evaluation hypotheses must include, but not limited to, the following outcomes: percent of beneficiaries with the Workforce Bridge Account who maintained coverage through the end of the year, continuity of coverage when switching between Medicaid and Marketplace or other coverage; measures of access to care and health outcomes; take-up rates; and healthcare expenditures. The state must use the expertise of an independent evaluator in the implementation of the draft Evaluation design.

46. **Interim Evaluation Report**. In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

47. **Final Evaluation Design and Implementation**. CMS shall provide comments on the draft evaluation design, and the state shall submit a final design within 60 days after receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation report within 18 months after the end of the demonstration period of performance. CMS will provide comments after receipt of the report. Unless otherwise agreed upon in writing by CMS, the state must submit the final evaluation report within 60 days after receipt of CMS comments. The final evaluation report must be posted to the state's Medicaid website within 30 days of approval by CMS.

48. **Cooperation with Federal Evaluators**. 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.

XII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date Specific	Deliverable	STC Reference
180 days after date of approval letter	Submit Draft Evaluation Design	STC 45 a
60 days after receipt of CMS comments	Final Evaluation Design	STC 47
Annual	By May 1st - Draft Annual Report	STC 34
Quarterly		
	Deliverable	**STC Reference**
60 days after the end of the quarter	Quarterly Progress Reports	STC 33
	Quarterly Expenditure Reports	STC 36
	Eligible Member Months	STC 37

Attachment A

Quarterly Program Report Guidelines

Under Section VII, STC 26, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

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

NARRATIVE REPORT FORMAT:

Title Line One – End Stage Renal Disease Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 1 (1/01/16 - 12/31/16)
Federal Fiscal Quarter: 2/2016 (1/16 - 3/16)

Introduction:

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

1. Report member-months for budget neutrality:

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Former Spend Down Individuals				
New Enrollees				

Outreach/Innovative Activities:

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

Operational/Policy Developments/Issues:

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

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

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

Quality Assurance/Monitoring Activity:
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments:
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS: