CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00205/4**

TITLE: **Florida MEDS-AD Program**

AWARDEE: **Florida Agency for Health Care Administration**

I. PREFACE

The following are Special Terms and Conditions (STCs) for the Florida MEDS-AD section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the Florida Agency for Health Care Administration (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs are applicable to services provided and individuals applying for benefits under the Demonstration on or after January 1, 2015 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through December 31, 2015.

The STCs have been arranged into the following subject areas:

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

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Florida MEDS-AD Demonstration was approved in November 2005 and provides coverage for certain aged and disabled individuals with incomes up to 88 percent of the Federal poverty level (FPL).

In 2005, State legislation (Chapter 2005-60, Laws of Florida) directed the State to discontinue coverage of these individuals (an optional Medicaid eligibility group) under the Medicaid State plan. However, concerned that this population was at risk for costly adverse events, including institutional placement, in the absence of pharmacy and medical services, the same legislation directed the State to seek a section 1115 demonstration to provide benefits to a subset of the individuals in this eligibility

group. With CMS approval, the Demonstration began operating in January 2006.

The Demonstration was predicated on the assumption that continued access to medical care, including home and community-based services and pharmacy management services, for this population, will delay deterioration in health status which drives hospitalization and/or institutionalization.

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

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

5. **State Plan Amendments.** The State will not be required to submit a title XIX State plan amendment for changes to any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to program design, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All

amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in STC 7 below.

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

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

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

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

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

8. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing, that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

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

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

of disenrolling participants.

11. Adequacy of Infrastructure. The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) unless they are otherwise superseded by rules promulgated by CMS. Further, the State must comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, 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, 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.

13. FFP. No Federal matching funds for expenditures for this Demonstration will be made available to the State until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

14. Eligibility.

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

b) Eligibility under the Demonstration is limited to the following individuals not otherwise eligible for Medicaid:

Demonstration Eligible Groups	Additional Qualifying Criteria	Expenditure and Eligibility Group Reporting
Dual Eligibles	• Income at or below 88% FPL • Family assets that do not exceed $5,000 (individual) or $6,000 (couple) • Receiving hospice, home and community-based services, or institutional care services	Demonstration Population 1/ MA-Dual Eligible
Aged or disabled individuals	• Income at or below 88% FPL • Family assets that do not exceed $5,000 (individual) or $6,000 (couple) • Receiving hospice, home and	Demonstration Population 2/ MA-Medicaid Instit.

	community-based services, or institutional care services	
Aged or disabled individuals	• Income at or below 88% FPL • Family assets that do not exceed $5,000 (individual) or $6,000 (couple) • Not receiving hospice, home and community-based services, or institutional care services	Demonstration Population 3/ MA-Only

15. Benefit Package. Individuals enrolled in the Demonstration receive all services offered through the State plan as well as the community-based services provided in the programs identified below which are operated by the State under the authority of 1915(c) of the Act. Availability of the community-based services is subject to any numeric limitations on enrollment in such programs and the requirements that the individual meets the eligibility and level of care criteria for the services in these programs:

- PACE Program
- Developmental Disabilities Individual Budget Home and Community Based Waiver
- Model Waiver (Katie Becket Program)
- Brain and Spinal Cord Injury Waiver
- AIDS Waiver
- Adult Cystic Fibrosis Waiver
- Long-term Care Waiver

16. High Intensity Pharmacy Case Management Services. High Intensity Pharmacy Case Management services, as described below, are provided to enrollees in Demonstration Population 3 who are selected for review.

a) The Agency for Health Care Administration (AHCA) identifies appropriate candidates for review, chosen at random from all MEDS AD enrollees who are not Medicare eligible, institutionalized, or in hospice care.

b) For enrollees selected for review, a Medicaid Pharmacist contacts the enrollee to obtain the enrollee's agreement to participate in the review. AHCA sends the contact information, for consenting enrollees, to the Medication Therapy Management (MTM) Call Center, College of Pharmacy, University of Florida.

c) The MTM Call Center schedules calls with the enrollee and conducts the Comprehensive Medication Review (CRM). The Pharmacy reviewers consider all State plan requirements including use of the State's preferred drug list, step therapy, prior authorizations, and dosing limitations;

d) Upon completion of the CRM, reviewers develop a Patient Medication Action Plan. Recommendations are immediately communicated to the treating provider via fax, and mailed to the enrollee upon request.

e) Quarterly follow up calls are completed with the enrollee and recommendations communicated to the treating provider, as necessary.

f) Case reviews are maintained by the State for evaluation activities.

V. COST SHARING

17. Cost Sharing. Co-payments assessed under the Demonstration are consistent with those applicable under the State plan.

VI. DELIVERY SYSTEMS

18. Service Delivery. Demonstration Population 3 enrollees will receive services through the State's managed care delivery system for acute and long term care services.

VII. PROGRAM MONITORING

19. Data Mining Activities. The State is permitted to receive FFP for data mining activities performed by the State's Medicaid Fraud Control Unit (MFCU) consistent with the Memorandum of Understanding (MOU) between the State and the Florida Office of the Attorney General, which operates the MFCU. Data mining refers to the practice of electronically sorting Medicaid Management Information Systems claims through statistical models and intelligent technologies to uncover patterns and relationships contained within the Medicaid claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent.

20. MOU. The State and the MFCU must comply with the MOU concerning data mining activities, which was executed by both parties September 2010. Compliance with the MOU and any activities related to the State receiving FFP for data mining activities is subject to review and audit.

VIII. GENERAL REPORTING REQUIREMENTS

21. General Financial Requirements. The State must comply with all general financial requirements set forth in Section IX.

22. Reporting Requirements Related to Budget Neutrality. The State must comply with all reporting requirements set forth in Section X.

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

neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

24. Quarterly Reports: The State must submit progress reports in the format specified in Attachment A, no later than 60 days following the end of each quarter. The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the Demonstration. These quarterly reports must include, 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; access; data mining activities, 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 for each Demonstration population as defined in STC 30(d).

e) Evaluation activities and interim findings; and,

f) Other items as requested.

Notwithstanding this requirement, the fourth-quarter Quarterly Report may be included as an addendum to the annual report required in paragraph 25.

25. Annual Report. The State must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the quarterly reports required under paragraph 24. The State must submit this report no later than 90 days after the close of each Demonstration year.

26. Transition Plan. The State is required to prepare, incrementally revise, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including details on how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The State must submit a draft to CMS by July 1, 2012, with progress updates included in each quarterly and annual report thereafter. The State will revise the Transition Plan as needed. The State must meet the following transition milestones.

a) Affordable Care Act 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

outline how the State will begin transition activities beginning July 1, 2013, including:

i. The State shall determine eligibility for coverage for these individuals beginning January 1, 2014 under all eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL. To ensure that eligibility for medical assistance is not disrupted for any individual covered who will be eligible under any such eligibility group as of January 1, 2014, prior to December 31, 2013, the State must obtain any additional information needed from each individual to determine eligibility under such eligibility groups beginning January 1, 2014 and must make and provide notice to the individual of such determination on or before December 31, 2013. In transitioning these individuals from coverage under the Demonstration to coverage under the State Plan, the State will not require these individuals to submit a new application.

ii. A plan to manage the transition to new Medicaid eligibility levels in 2014 by considering, reviewing, and preliminarily determining new applications for Medicaid eligibility beginning as early as July 1, 2013.

iii. The schedule of implementation activities for the State to operationalize the transition plan.

b) Progress Updates. After the State has submitted an initial transition plan for CMS approval, it must also include progress updates within each quarterly and annual report thereafter.

c) Implementation. By July 1, 2013, the State must begin implementation of a simplified, streamlined process for transitioning eligible enrollees from the Demonstration to Medicaid, the Exchange or other coverage options in 2014 without need for additional determinations of enrollees' eligibility.

27. Final Report. Within 120 days following the end of the Demonstration, the State must submit a draft final report to CMS for comments. The State will take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 60 days after receipt of CMS' comments.

IX. GENERAL FINANCIAL REQUIREMENTS

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

29. Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit. All expenditures for health care services for Demonstration participants, as defined in STC 30(d), are subject to the budget neutrality agreement.

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

a) **Tracking Expenditures.** In order to track expenditures, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number (11-W-00185/4) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.

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

c) **Pharmacy Rebates.** The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the Demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the Demonstration, and not on any other CMS-64.9 form (to avoid double counting). Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

d) **Use of Waiver Forms.** For each DY, three Waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter to report title XIX expenditures associated with the Demonstration. The expressions in quotations marks, for each Population below, are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

i. **Demonstration Population 1 "MA-Dual Eligible":** Medicare and Medicaid dual eligibles receiving hospice, home and community based services, or institutional care services.
ii. **Demonstration Population 2 "MA-Medicaid Instit.":** Medicaid only eligibles receiving hospice, home and community based services, or institutional care services.
iii. **Demonstration Population 3 "MA-Medicaid Only":** Medicaid only eligibles not receiving hospice, home and community based services, or institutional services.

e) **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

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

31. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

32. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

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

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

b) 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.

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

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

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

c) The State assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable Federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

35. State Certification of Funding Conditions. The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

a) Units of government, including governmentally-operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration;

b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures;

c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match;

d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally-operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments; and,

e) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover,

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

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

37. Program Integrity. The State must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the Demonstration.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

38. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined using an aggregate limit methodology, with budget neutrality expenditure targets set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. All data supplied by the State to CMS is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the CMS-64 Report from the MBES/CBES System.

39. Risk. Under an aggregate budget neutrality agreement, the State shall be at risk for changing economic conditions which impact both enrollment levels and enrollee expenditures.

40. Budget Neutrality Expenditure Limit. The cumulative budget neutrality expenditure limit of $9,402,053,590, which was in effect as of January 1, 2008, will remain in effect and unchanged for this Demonstration extension period (January 1, 2011 – December 31, 2015).

41. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the Demonstration.

42. Exceeding Budget Neutrality. If, at the end of this Demonstration period, the budget neutrality expenditure limit has been exceeded, the excess Federal funds must be returned to CMS.

XI. EVALUATION OF THE DEMONSTRATION

43. Submission of Draft Evaluation Design. The State shall submit to CMS for approval, within 120 days from the award of the Demonstration, a draft evaluation design. At a

minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the Demonstration. The evaluation design must also include a discussion of the goals, objectives, and effectiveness of data mining activities performed by the MFCU. The data mining component of the evaluation design must include but not be limited to the number and quality of cases opened, and the number of fraud-related convictions and recoveries.

The draft design must discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

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

45. Cooperation with Federal Evaluators. Should CMS conduct an evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor. The State must cooperate with CMS and the Health and Human Services Office of Inspector General, as applicable, in any review or evaluation of the Demonstration.

XII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	STC Reference
May 1, 2011	Draft Evaluation Design	Section XI, STC 43
Each April 1st	Annual Report	Section VIII, STC 25
60 days following the end of the quarter	Quarterly Progress Reports	Section VIII, STC 24
30 days following the end of each quarter	Quarterly Expenditure Reports	Section IX, STC 28

ATTACHMENT A

Under STC 24, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

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

NARRATIVE REPORT FORMAT

Title Line One – Florida MEDS-AD

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 6 (1/1/2011 – 12/31/2011)
Federal Fiscal Quarter: 2/2011 (1/1/2011 – 3/31/2011)

Introduction

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

Enrollment Information

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

Demonstration Populations (as hard coded in the Form CMS-64)	Total as of end of Current Quarter	Voluntary Disenrolled in Current Quarter	Involuntary Disenrolled in Current Quarter
Population 1 – MA-Dual Eligibles			
Population 2 – MA-Medicaid Instit			
Population 1 – Ma-Medicaid Only			

Outreach/Innovative Activities

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

Operational/Policy Developments/Issues

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

Consumer Issues

Provide 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 Activities

Identify any quality assurance/monitoring activity in the current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

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

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

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

Date Submitted to CMS