

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00036/4

TITLE: Delaware Diamond State Health Plan

AWARDEE: Delaware Department of Health & Social Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Delaware’s Diamond State Health Plan (DSHP) section 1115(a) Medicaid Demonstration extension (hereinafter “Demonstration”). The parties to this agreement are the Delaware Department of Health & Social Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State’s obligations to CMS during the life of the Demonstration. The STCs are effective January 1, 2007 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration extension is approved through December 31, 2009.

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; Family Planning Expansion Program; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of State Deliverables for the Demonstration Extension Period.

Additionally, four attachments have been included to provide supplemental information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Diamond State Health Plan section 1115(a) Demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The initial Diamond State Health Plan Demonstration was approved in 1995 to enroll most Medicaid recipients into managed care organizations (MCOs) beginning January 1, 1996.

The State’s goal in implementing the Demonstration is to improve the health status of low-income Delawareans by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered; and
- Expanding coverage to additional low-income Delawareans with resources generated through managed care efficiencies.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall 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 award letter of which these STCs are part, shall apply to the Demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in the applicable law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy that occur after the approval date of this Demonstration, unless the provision being changed is explicitly waived in the award letter governing the Demonstration of which these STCs are part. For the current extension period of this Demonstration, this requirement shall also apply to all applicable regulation and policy issued by CMS with respect to the Deficit Reduction Act of 2005, signed into law on February 8, 2006, including but not limited to the documentation of citizenship requirements contained in section 1903(x) of the Social Security Act (the Act).
4. **Impact on Demonstration of Changes in Federal Law.** To the extent that a change in Federal law requires either a reduction or an increase in Federal financial participation (FFP) in expenditures under such the Demonstration, the State will 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 the implementation of the change. 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 shall not be required to submit title XIX State plan amendments for changes to Demonstration eligible populations covered solely through the Demonstration. If a population covered through the 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, family planning services covered under this Demonstration, 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. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.
7. **Amendment Process:** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not

be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:

- a) An explanation of the public process used by the State 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 expenditure cap. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current extension 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 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 shall be modified to incorporate the amendment provisions.
8. **Extension of the Demonstration.** If the State intends to extend the Demonstration beyond the period of approval granted under section 1115(a), the requirements in section 1115(e) may apply. During the 6 month period ending one year before the date the Demonstration would otherwise expire, the chief executive officer of the State may submit to the Secretary of the Department of Health and Human Services a written request to extend the Demonstration for up to 3 years. If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted. The extension of a Demonstration shall be on the same terms and conditions that applied to the Demonstration before it was extended. If an original condition of approval of a Demonstration was that it be budget neutral, the Secretary shall take such steps as may be necessary to ensure that in the extension of the Demonstration such condition continues.
9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.
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. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.
13. **Adequacy of Infrastructure.** The State will 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 and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 FR 49249 (September 27, 1994) when any program changes to the Demonstration, including but not limited to those referenced in paragraph 6 are proposed by the State.
15. **Compliance with Managed Care Regulations.** The State must comply with the managed care regulations at 42 CFR 438 et. seq., except as expressly identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR 438.6.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The DSHP Demonstration includes three distinct components. The Medicaid managed care program provides Medicaid State Plan benefits through comprehensive managed care delivery systems to most recipients eligible under the State plan. The Uninsured Adult expansion provides Medicaid benefits to adults with specified income and assets. The Family Planning expansion provides access to services to women whose income is at or below 200 percent of the FPL, and who lose any of the following: Medicaid eligibility 60 days postpartum; Medicaid benefits; or DSHP comprehensive benefits.

16. Eligibility.

Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived in the award letter for this Demonstration.

Those non-Medicaid eligible groups described below who are made eligible for the Demonstration by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this Demonstration.

The criteria for Diamond State Health Plan eligibility is as follows:

State Plan Mandatory Groups*	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Pregnant women	At or below 185 percent FPL	<u>If age 20 and under:</u> DSHP TANF Children <u>If age 21 and over:</u> DSHP TANF Adult
Infants less than one year old	At or below 185 percent FPL	DSHP TANF Children
Children ages 1 through 5 years	At or below 133 percent FPL	DSHP TANF Children
Children ages 6 through 21 years	At or below 100 percent FPL	DSHP TANF Children
Adults receiving Supplemental Security Income (SSI) payments or otherwise disabled	At or below 100 percent FPL	DSHP SSI Adults
Children receiving Supplemental Security Income (SSI) payments or otherwise disabled	At or below 100 percent FPL	DSHP SSI Children
State Plan Optional Groups**	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Pregnant women	Above 185 through 200 percent FPL	<u>If age 20 and under:</u> DSHP TANF Children <u>If age 21 and over:</u> DSHP TANF Adult
Infants less than one year old: Optional targeted low-income children	<ul style="list-style-type: none"> • Above 185 percent through 200 percent FPL • Meet the definition specified in section 2110(b)(1) of the Act. • The State receives title XXI funds for expenditures for these children. Title XIX funds are available under this Demonstration if the State exhausts its title XXI allotment. 	DSHP MCHP
TANF Adults	At or below 100 percent FPL	DSHP TANF Adult
Section 1931 Families	At or below 100 percent FPL	<u>If age 20 and under:</u> DSHP TANF Children <u>If age 21 and over:</u> DSHP TANF Adult

State Plan Optional Groups**	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Adults receiving Supplemental Security Income (SSI) payments or otherwise disabled	101 through 133 percent FPL	DSHP SSI Adults
Children receiving Supplemental Security Income (SSI) payments or otherwise disabled	101 through 133 percent FPL	DSHP SSI Children
Demonstration Eligible Groups***	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Uninsured Adults Expansion	Aged 21 and older with incomes up to 100 percent FPL	DSHP Exp. Pop.
Family Planning Expansion	Women aged 15 through 50 who lose Medicaid eligibility or comprehensive benefits eligibility under DSHP, at or below 200 percent of the FPL.	FP Expansion

- * These mandated State Plan eligible beneficiaries are enrolled in the Demonstration for use of the managed care network and to generate savings for Expansion populations listed in the Demonstration Eligible Groups category.
- ** These optional State Plan eligible beneficiaries are enrolled in the Demonstration for the use of the managed care network and to generate savings for Expansion populations listed in the Demonstration Eligible Groups category.
- *** These DSHP eligible populations are expansions whose expenditures are paid for solely by savings generated by the Demonstration.

17. **Eligibility Exclusions.** The following persons are excluded from the DSHP managed care program.

Individuals enrolled in the 1915 (c) waiver programs
Individuals eligible for both Medicare and Medicaid
Individuals residing in an institution or nursing home (for more than 30 days)
Presumptively eligible pregnant women
Unqualified aliens, both documented and undocumented
Individuals enrolled in the Breast and Cervical Cancer Treatment Program

18. **Diamond State Health Plan Benefits.** Benefits provided through this Demonstration for the Medicaid managed care and family planning expansion programs are as follows:

- a) **Medicaid Managed Care.** Medicaid benefits are State plan benefits delivered through managed care organizations or managed care delivery systems, with the exception of certain services paid for by the State on a fee-for-service basis. All benefits that DSHP managed care enrollees may receive under this Demonstration are listed in Attachment A.

- b) **Family Planning Expansion.** Family planning services are limited to those services whose primary purpose is family planning and which are provided in a family planning setting. Procedures and services authorized under this program are outlined in Attachment B.

V. COST SHARING

19. Co-payments will be charged to all DSHP enrollees as follows:

Service	Co-payment
Pharmacy services	\$.50 per prescription

VI. DELIVERY SYSTEMS

20. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force.

Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

21. **Institutions for Mental Diseases (IMDs).** Expenditures for services rendered to Diamond State Health Plan enrollees between the ages of 21 and 64 who are patients in IMDs are not eligible for FFP.

VII. FAMILY PLANNING EXPANSION PROGRAM

22. **Family Planning Expansion Program.** Family planning services are provided to eligible recipients who lose Medicaid eligibility at 60 days postpartum, lose Medicaid benefits, or lose DSHP comprehensive benefits with a redetermination of eligibility, including income, at 12 months. In 2007, the income limit for the family planning expansion program and the annual redetermination income limit will change from the current maximum income level of 300 percent of the FPL to at or below 200 percent of the FPL.

- a. **Duplicate Payments.** The State must not use title XIX funds to pay for individuals enrolled in Medicare, Medicaid, SCHIP, any other Federally funded program (i.e., title X), or component of this section 1115 Demonstration who seek services under the family planning expansion program. The State shall only enroll or reenroll individuals into the family planning demonstration that are uninsured (defined as not having creditable coverage). The State will have up to one year from the date of the approval letter to disenroll currently enrolled insured individuals at their annual eligibility re-determination. During this one-year period, the State shall pursue third party liability reimbursement for any individual who has other insurance and ensure that Medicaid will

be the payer of last resort.

- b. **Primary Care Referral.** The State shall facilitate access to primary care services for enrollees in the family planning expansion program. The State shall submit to CMS a copy of the written materials that are distributed to the family planning expansion program participants as soon as they are available. The written materials must explain to the participants how they can access primary care services. In addition, the State must evaluate the impact of providing referrals for primary care services. This component of the evaluation must be highlighted in the evaluation design that will be submitted to CMS as specified in paragraph 49(b) of this document.
- c. **Eligibility Redeterminations.** The State will ensure that redeterminations of eligibility for this component of the Demonstration are conducted, at a minimum, once every 12 months.
 - i. **Process.** The State shall submit for CMS approval its process for eligibility redeterminations within 30 days from the date of the award letter. The process for eligibility redeterminations shall not be passive in nature, but will require that an action be taken by the family planning expansion program recipient in order to continue eligibility for this program. The State may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.
 - ii. **Integrity.** No later than 30 days from the date of the award letter, the State will provide to CMS for approval, an appropriate methodology for ensuring the integrity of annual eligibility determinations of individuals covered under the family planning expansion program. The State will use this methodology to conduct reviews of the eligibility determination process on an annual basis. As part of the submission, the State will also develop an eligibility determination error rate methodology. If annual reviews of the eligibility determination process suggest error rates beyond a State established threshold, the State will develop a corrective action plan for CMS approval.
 - iii. **Family Planning Expansion Income Limit.** The State shall change its income eligibility criteria from 300 percent of the FPL to at or below 200 percent of the FPL. In order to implement this change, the State may either immediately institute this eligibility criteria, or may opt to use the new criteria at the time of annual eligibility redetermination. This program eligibility income limit change for all Family Planning Expansion eligibles must be completely transitioned no later than 12 months from implementation.

VIII. GENERAL REPORTING REQUIREMENTS

- 23. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in Section IX.

24. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. seq. except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.
25. **Reporting Requirements Related to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section X.
26. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, family planning issues, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. 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.
27. **Quarterly Reports:** The State must submit progress reports in the format specified in Attachment C no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:
- a) An updated budget neutrality monitoring spreadsheet;
 - b) 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; grievances; quality of care; access; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; and other operational issues;
 - c) Action plans for addressing any policy and administrative issues identified;
 - d) The number of individuals enrolled in the family planning expansion program as well as the number of participants; and
 - e) Evaluation activities and interim findings.
28. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the Demonstration. The State must submit the draft annual report no later than April 1 after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.
29. **Title XXI Reporting.** The State will provide CMS with the following:

- a) An updated SCHIP Allotment Neutrality worksheet. This document shall be submitted within 30 days of the award letter, but no later than January 31, 2007.
- b) An enrollment report by Demonstration population showing end of quarter actual and unduplicated ever enrolled figures. The enrollment data for the title XXI population will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter.

30. Reporting Requirements Related to the Family Planning Expansion.

- a) In each annual report described in paragraph 28, the State shall report the average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth through age 1-year. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)
- b) In each annual report described in paragraph 28, the State shall report the number of actual births that occur to family planning expansion demonstration participants. (Participants include all individuals who obtain one or more covered medical family planning services through the family planning expansion program each year.)
- c) The State will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates no later than June 30, 2007. For purposes of this section, “fertility rate” means birth rate. These rates must:
 - i. Reflect fertility rates during Base Year 2000 for women, age 15-50 years, with family incomes between at or below 200 percent FPL and ineligible for Medicaid except for pregnancy;
 - ii. Be adjusted for age, using age bands, for all potential Demonstration participants; and
 - iii. Include births paid for by Medicaid.
- d) At the end of each Demonstration year (DY), a DY fertility rate will be determined by summing the age-specific rates using the age distribution of the Demonstration participants during that DY to weight the age-specific fertility rates, unless the State demonstrates that the age distribution is consistent with the prior DY(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates.

The base-year fertility rate and the Demonstration year fertility rate will be used to calculate a measure of births averted through the Demonstration using the following formula:

$$\text{Births Averted} = (\text{base-year fertility rate}) - (\text{fertility rate of Demonstration participants during DY}) \times (\text{number of Demonstration participants during DY})$$

The intent of the family planning expansion program is to avert unintended pregnancies in order to offset the cost of family planning services for Demonstration participants.

IX. GENERAL FINANCIAL REQUIREMENTS

31. **Quarterly Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS 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.
32. **Reporting Expenditures Under the Demonstration.** In order to track expenditures under this Demonstration, Delaware must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act 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). Expenditures for optional targeted low income children claimed under the authority of title XXI shall be reported each quarter on forms CMS-64.21U and/or CMS 64.21UP.
- a) For the family planning expansion component of the Demonstration, the State should report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:
 - i. Allowable family planning expenditures eligible for reimbursement at the State's Federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.
 - ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.
 - b) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.
 - c) Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.
 - d) Expenditures for Demonstration services not listed in Attachment A must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 Waiver or 64.9P Waiver.
 - e) The State will make corrections to Form CMS-64.9 for any Demonstration expenditures reported incorrectly for all quarters in which the Demonstration was in effect. These corrections must be input no later than January 1, 2008. This corrective action must include the following:

- i. A transfer of all expenditures for Demonstration services not listed in Attachment A from the waiver sheets to the base sheets using the appropriate prior period adjustment reporting method; and
 - ii. A transfer of all drug rebate collections from the waiver sheets to the base sheets using the appropriate prior period adjustment reporting method.
- f) For each Demonstration year, seven (7) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following Demonstration populations. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in brackets. Expenditures should be allocated to these forms based on the guidance found below.

- i. **Demonstration Population 1:** TANF Children less than 21
[DSHP TANF Children]
- ii. **Demonstration Population 2:** TANF Adults aged 21 and over
[DSHP TANF Adult]
- iii. **Demonstration Population 3:** Disabled Children less than 21
[DSHP SSI Children]
- iv. **Demonstration Population 4:** Aged and Disabled Adults 21 and older
[DSHP SSI Adults]
- v. **Demonstration Population 5:** Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL: optional targeted low income children. See section (g) below for specific reporting guidelines. [DSHP MCHP]
- vi. **Demonstration Population 6:** Uninsured Adults up to 100 percent FPL
[DSHP Exp. Pop.]
- vii. **Demonstration Population 7:** Family Planning Expansion
[FP Expansion]

g) Specific Reporting Requirements for Demonstration Population 5.

- i. The State is eligible to receive title XXI funds for expenditures for these children, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or 64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual.
- ii. Title XIX funds are available under this Demonstration if the State exhausts its title XXI allotment once timely notification as described in subparagraph (iii) has been provided.

- iii. If the State exhausts its title XXI allotment prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this Demonstration Population must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver. To initiate this:
 - 1) The State shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for this Demonstration population;
 - 2) The State shall submit:
 - a) An updated budget neutrality assessment that includes a data analysis which identifies the specific “with waiver” impact of the proposed change on the current budget neutrality expenditure cap. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current extension 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 result of the proposed change which isolates (by Eligibility Group) the impact of the change;
 - b) An updated SCHIP allotment neutrality worksheet.
- iv. The expenditures attributable to this Demonstration population will count toward the budget neutrality expenditure cap calculated under Section X, paragraph 45, using the per member per month (PMPM) amounts for TANF Children described in Section X, paragraph 45(a)(ii), and will be considered expenditures subject to the budget neutrality cap as defined in paragraph 33, so that the State is not at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

33. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Medicaid expenditures related to the Demonstration benefit package described in Attachment A provided to individuals who are enrolled in this Demonstration as described in paragraph 32(f)(i-vii), subject to the limitation specified in paragraph 32(g). All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.
34. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
35. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining

budget neutrality.

36. Reporting Member Months. The following describes the reporting of member months for Demonstration populations:

- a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 31, the actual number of eligible member months for the Demonstration Populations defined in paragraph 32(f)(i-vii). The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

- b) The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.
- c) For the purposes of this Demonstration, the term “Demonstration eligibles” excludes unqualified aliens and refers to the Demonstration Populations described in paragraph 32 (f)(i-vii).

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

38. 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 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 of the Medicaid program that are paid in accordance with the approved Medicaid State plan.

- c) Net medical assistance expenditures made under section 1115 Demonstration authority under the DSHP.

39. Extent of Federal Financial Participation for Family Planning Expansion Program. CMS shall provide FFP for CMS-approved services (including prescriptions) provided to women under the family planning expansion program at the following rates and as described in Attachment B:

- a) For procedures or services clearly provided or performed for the primary purpose of family planning (contraceptives and sterilizations) and which are provided in a family planning setting, FFP will be available at the 90 percent Federal matching rate. Procedure codes for office visits, laboratory tests, and certain other procedures must carry a diagnosis that specifically identifies them as a family planning service.
- b) Family planning-related services reimbursable at the Federal Medical Assistance Percentage (FMAP) rate are defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a “family planning-related” problem was identified/diagnosed during a routine/periodic family planning visit. Services/surgery, which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center or a hospital for family planning-related services, are not considered family planning-related services and are not covered under the Demonstration.
- c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for sexually transmitted infections as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. Subsequent treatment would be paid for at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, no FFP will be available.
- d) CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.
- e) Delaware will provide to CMS an updated list of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding Systems (HCPCS) codes covered under the Demonstration on January 31 of each Demonstration year. The revised code list should reflect only changes due to updates in the services and should only include services for which the State has already received approval.
- f) Changes to services listed in Attachment B will require an amendment to the Demonstration in accordance with Section III, paragraph 7 of these STCs.

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

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

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

- a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.
- b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.
- d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

X. MONITORING BUDGET NEUTRALITY

43. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative

budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

44. **Risk.** Delaware shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles. Because CMS provides FFP for all Demonstration eligibles, Delaware shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Delaware at risk for the per capita costs for current eligibles, CMS assures that the federal Demonstration expenditures do not exceed the level of expenditures do not exceed the level of expenditures had there been no Demonstration.
45. **Demonstration Populations Used to Calculate the Budget Neutrality Expenditure Cap.** The following describes the method for calculating the budget neutrality expenditure cap for the Demonstration:
- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each EG described as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 36 for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (ii) below. Historical PMPM costs used to calculate the budget neutrality expenditure cap are provided in Attachment D.
 - ii. The PMPM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this Demonstration are specified below. In addition, the PMPM cost for each EG in Demonstration year 12 has been increased by the appropriate growth rate included in the 2007 Presidents' Budget for DYs 13 and 14, as outlined below.

Eligibility Group	Growth Rate	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM
DSHP TANF Children	5.84%	\$280.38	\$296.75	\$314.08
DSHP TANF Adult	5.16%	\$481.68	\$506.54	\$532.67
DSHP SSI Children	5.42%	\$1,651.56	\$1,741.07	\$1,835.44
DSHP SSI Adults	5.42%	\$1,690.19	\$1,781.79	\$1,878.37
DSHP MCHP *	5.84%	\$280.38	\$296.75	\$314.08

* When title XXI funds are exhausted, the PMPM for this population will be used to calculate the budget neutrality expenditure cap and expenditures will be reported as expenditures subject to the budget neutrality cap in accordance with Section IX, paragraph 32(g).

iii. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (ii) above.

b) The overall budget neutrality expenditure cap for the Demonstration is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a)(iii). The Federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations described in paragraph 32(f) during the Demonstration period reported in accordance with Section IX, paragraph 32.

46. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

<u>Demonstration Year</u>	<u>Cumulative Expenditure Cap Definition</u>	<u>Percentage</u>
Year 12	Budget neutrality expenditure cap plus	1 percent
Years 12 and 13	Combined budget neutrality expenditure caps plus	0.5 percent
Years 13 through 14	Combined budget neutrality expenditure caps plus	0 percent

In addition, the State may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the Demonstration will exceed the cap during this extension.

47. **Expenditure Containment Initiatives.** In order to ensure that the Demonstration remains budget neutral during the extension period, the State shall consider implementing new initiatives and/or strategies. Possible areas of consideration may include, but are not limited to, pharmacy utilization, MCO rates, behavioral health, expansion program waiting lists, or service limitations.

The State will inform CMS of the cost-containment initiatives that it considers implementing and its progress through the quarterly and annual reports required under paragraphs 27 and 28, respectively.

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

XI. EVALUATION OF THE DEMONSTRATION

49. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a) and (b), the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding both components. The State must submit to CMS for approval a draft evaluation design no later than April 1, 2007. The evaluation must outline and address evaluation questions for both of the following components:

- a) **The Diamond State Health Plan.** At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must 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.
- b) **Family Planning Expansion.** The draft design must include a discussion of the goals, objectives and evaluation questions specific to this component of the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the family planning expansion program, particularly among the target family planning population, during the period of approval. It must 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 family planning expansion program shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. The report should also include an integrated presentation and discussion of the specific evaluation questions (including those that focus specifically on the target population for the family planning program) that are being tested. At a minimum, the following data elements will be included in the measurement methodology:

Measure	Number	Percentage Change
Enrollment		
Averted Births		
Family Planning Patients Receiving a Clinical Referral for Primary Care	(estimate may be based on a sample)	

50. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft designs within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 49, within 60 days of receipt of CMS comments. The State must implement the evaluation designs and report its progress on each in the quarterly reports. The State must submit to CMS a draft evaluation report 120 days prior to the expiration of the Demonstration. CMS shall provide comments within 60 days of receipt of the report. The State must submit the final report prior to the expiration date of the Demonstration.

51. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration, the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS.

XII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date -	Deliverable	STC Reference
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Specific		
2/1/2007	Submit Process for Eligibility Redeterminations for Family Planning Expansion Program	Section VII, paragraph 22
2/1/2007	Submit Methodology for Monitoring Family Planning Annual Determinations	Section VII, paragraph 22
4/1/2007	Submit Draft Evaluation Plan, including Evaluation Designs for the Diamond State Health Plan and Family Planning Expansion	Section XI, paragraph 49
6/30/2007	Submit Base-year Fertility Rates for Family Planning Expansion Program	Section VIII, paragraph 30
1/1/2008	Complete CMS-64 expenditure corrections	Section IX, paragraph 32
7/1/2008	Written Notice to CMS of Intent to Continue Demonstration	Section III, paragraph 8
7/31/2008	Submit Draft Evaluation Report, which includes preliminary analysis and recommendations related to the Diamond State Health Plan and Family Planning Expansion	Section XI, paragraph 50
1/1/2009	Submit Demonstration Application 1115(e)	Section III, paragraph 8
12/31/2009	Submit Final Evaluation Report	Section XI, paragraph 50

	Deliverable	STC Reference
Annual	By January 31 – Updated Family Planning Code List	Section, IX , paragraph 39
	By April 1 st - Draft Annual Report	Section VIII, paragraph 28
Each Quarter		
	Quarterly Operational Reports	Section VIII, paragraph 27
	Quarterly Enrollment Reports	Section VIII, paragraph 29
	CMS-64 Reports	Section IX, paragraph 31
	Eligible Member Months	Section IX, paragraph 36

ATTACHMENT A

DSHP Benefits

Inpatient and outpatient hospital services including ambulatory surgical centers
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services, including non-invasive and invasive imaging
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies for eligible women aged 15-50
Physicians services including nurse practitioners and nurse midwife services
Dental services (for individuals under age 21 only)
Physical and occupational therapy
Speech, hearing and language therapy
Prescription drugs and medical supplies
Durable medical equipment including prosthetic and orthotic devices, hearing aids and prescription shoes
Nursing facility services (30 days only)
Case management services
Hospice care services
Inpatient behavioral health services (mental health and chemical dependence services, 30 days only for adults age 21 and over)
Outpatient behavioral health services (mental health and chemical dependence services limited to 30 visits for children and 20 for adults)
Emergency medical services including emergency transportation
Renal dialysis
Private duty nursing

*Non-emergency transportation is covered as an administrative expenditure.

ATTACHMENT B

Family Planning Code List

Amendments to this Attachment may be made consistent with Section III, paragraph 7. The following procedure codes are considered family planning services as noted below:

Procedure Code	Description	90% FFP	90% FFP w/V25 or FP Dx	FMAP
00851	Tubal ligation / transection	✓		
11975	Insertion, implantable contraceptive capsules	✓		
11976	Removal, implantable contraceptive capsules		✓	
11977	Removal w/ reinsertion, implantable contraceptive capsules	✓		
57170	Diaphragm or cervical cap fitting w/ instructions	✓		
58300	Insertion of intrauterine device (IUD)	✓		
58301	Removal of intrauterine device (IUD)		✓	
58600	Ligation or transection of fallopian tubes	✓		
58611	Ligation or transection of fallopian tubes	✓		
58615	Occlusion of fallopian tubes by device	✓		
58670	Laparoscopy, surgical; w/fulguration of oviducts (w/ or w/out transection)	✓		
58671	Laparoscopy, surgical; w/occlusion of oviducts by device (eg: band, clip, etc.)	✓		
81000	Urinalysis, by dipstick or reagent for bilirubin, glucose, hemoglobin, etc.		✓	
81002	non-automated without microscopy		✓	
81003	automated, without microscopy		✓	
81005	Urinalysis; qualitative or semiquantitative, except immunoassays		✓	
81007	bacteriuria screen, except by culture or dipstick		✓	
81015	microscopic only		✓	
81020	two or three glass test		✓	
81025	Urine pregnancy test, by visual color comparison methods		✓	
85013	Blood count; spun microhematocrit		✓	
85014	Blood count; other than spun microhematocrit		✓	
85018	Blood count; hemoglobin		✓	
86255	Fluorescent antibody; screen, each antibody		✓	
86592	Syphilis test; qualitative (g., VDRL, RPR, ART)		✓	
85693	Syphilis test; quantitative		✓	
86631	Antibody; Chlamydia		✓	
86632	Antibody; Chlamydia, IgM		✓	
86689	Antibody; HTLV or HIV antibody, confirmatory test (e.g., Western Blot)		✓	
86694	Antibody; herpes simplex, non-specific type test		✓	
86695	Antibody, herpes simplex, type 1		✓	
86701	Antibody; HIV-1		✓	
86702	Antibody; HIV-2		✓	

ATTACHMENT B

Family Planning Code List

Procedure Code	Description	90% FFP	90% FFP w/V25 or FP Dx	FMAP
86703	Antibody; HIV-1 and HIV-2, single assay		✓	
86781	Antibody; Treponema Pallidum, confirmatory test (e.g., FTA-abs)		✓	
87081	Culture, bacterial, screening only, for single organisms		✓	
87110	Culture, chlamydia		✓	
87206	Smear, primary source, w/ interpretation; fluorescent &/or fast stain		✓	
87207	Smear, primary source, w/ interpretation; special stain (e.g., malaria, herpes)		✓	
88141	Cytopathology, cervical or vaginal (any reporting system) physician interp.		✓	
88142	Cytopathology, cervical or vaginal (any reporting system) thin prep		✓	
88143	with manual screening and rescreening under physician supervision		✓	
88147	Cytopathology smears, cervical or vaginal; screening in automated system		✓	
88148	Screening by automated system with manual rescreening - phys. supervis.		✓	
88150	Cytopathology, slides, cervical or vaginal; manual screening - phys. supervis.		✓	
88155	Cytopathology, slides, cervical or vaginal; definitive hormonal evaluation		✓	
88164	Cytopathology, slides, cervical or vaginal; (Bethesda System)		✓	
88165	with manual screening and rescreening - phys supervis.		✓	
88166	with manual screening and computer-assisted rescreening - phys supervis.		✓	
88167	with manual screening and computer-assisted rescreening - cell selection		✓	
88302	Level II Surgical Pathology		✓	
99201	New Patient - Office or other outpatient visit		✓	
99202	New Patient - Office or other outpatient visit		✓	
99203	New Patient - Office or other outpatient visit		✓	
99204	New Patient - Office or other outpatient visit		✓	
99205	New Patient - Office or other outpatient visit		✓	
99211	Established Patient - Office or other outpatient visit		✓	
99212	Established Patient - Office or other outpatient visit		✓	
99213	Established Patient - Office or other outpatient visit		✓	
99214	Established Patient - Office or other outpatient visit		✓	
99215	Established Patient - Office or other outpatient visit		✓	
J0120	Injection, tetracycline, up to 250 mg			✓
J0290	Injection, ampicillin sodium, 500 mg			✓
J0295	Injection, ampicillin sodium / sulbactam sodium, per 1.5 g			✓
J0530	Injection, penicillin G benzathine and penicillin G procaine, up to 600,000 units			✓
J0540	Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units			✓
J0550	Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units			✓
J0560	Injection, penicillin G benzathine, up to 600,000 units			✓
J0570	Injection, penicillin G benzathine, up to 1,200,000 units			✓
J0580	Injection, penicillin G benzathine, up to 2,400,000 units			✓

ATTACHMENT B

Family Planning Code List

Procedure Code	Description	90% FFP	90% FFP w/V25 or FP Dx	FMAP
J0690	Injection, cefazolin sodium, 500 mg			✓
J0694	Injection, cefoxitin sodium, 1 g			✓
J0696	Injection, ceftriaxone sodium, per 250 mg			✓
J0697	Injection, sterile cefuroximr sodium, per 750 mg			✓
J0698	Cefotaxime sodium, per g			✓
J0710	Injection, cephalirin sodium, up to 1 g			✓
J0715	Injection, ceftizoxime sodium, per 500 mg			✓
J0720	Injection, chloramphenicol sodium succinate, up to 1 g			✓
J0743	Injection, cilastatin sodium imipenem, per 250 mg			✓
J0770	Injection, colistimethate sodium, up to 150 mg			✓
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg	✓		
J1364	Injection, erythromycin lactobionate, per 500 mg			✓
J1580	Injection, garamycin, gentamicin, up to 80 mg			✓
J1840	Injection, kanamycin sulfate, up to 500 mg			✓
J1850	Injection, kanamycin sulfate, up to 75 mg			✓
J1890	Injection, cephalothin sodium, up to 1 g			✓
J2010	Injection, lincomycin HCl, up to 300 mg			✓
J2460	Injection, oxytetracycline HCl, up to 50 mg			✓
J2510	Injection, penicillin G procaine, aqueous, up to 600,000 units			✓
J2540	Injection, penicillin G potassium, up to 600,000 units			✓
J2700	Injection, oxacillin sodium, up to 250 mg			✓
J3000	Injection, streptomycin, up to 1 g			✓
J3260	Injection, tobramycin sulfate, up to 80 mg			✓
J3320	Injection, spectinomycin dihydrochloride, up to 2 g			✓
J3370	Injection, vancomycin HCl, 500 mg			✓
S0610	Annual GYN - new patient		✓	
S0612	Annual GYN - established patient		✓	

ATTACHMENT C

Quarterly Report Content and Format

Under Section VIII, paragraph 27, 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 – Diamond State Health Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 12 (1/1/2007 – 12/31/2007)

Federal Fiscal Quarter: 1/2007 (1/07 - 3/07)

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.)

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

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

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 1: TANF Children less than 21 [DSHP TANF Children]		
Population 2: TANF Adults aged 21and over [DSHP TANF Adult]		
Population 3: Disabled Children less than 21 [DSHP SSI Children]		
Population 4: Aged and Disabled Adults 21and older [DSHP SSI Adults]		
Population 5: Infants less than one year of age with income levels above 185 percent FPL through 200 percent FPL: optional targeted low income children. [DSHP MCHP]		

ATTACHMENT C

Quarterly Report Content and Format

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	Disenrolled in Current Quarter
Population 6: Uninsured Adults up to 100% FPL [DSHP Exp. Pop.]		
Population 7: Family Planning Expansion [FP Expansion]		

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.

Expenditure Containment Initiatives

Identify all current activities, by program and or demonstration population. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting

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

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
DSHP TANF Children				
DSHP TANF Adult				
DSHP SSI Children				
DSHP SSI Adults				
DSHP MCHP (Title XIX match)				

B. For Informational Purposes Only

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
DSHP MCHP (Title XXI match)				
DSHP Exp. Pop.				
FP Expansion				

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

ATTACHMENT C

Quarterly Report Content and Format

prevent other occurrences. Also discuss feedback received from the MCRP and other consumer groups.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Family Planning Expansion Program

Identify all significant program developments/issues/problems that have occurred in the current quarter, including the required data and information under Section VII, paragraph 19, including enrollment data requested that is not represented in the formatted tables.

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

ATTACHMENT D

Historical Budget Neutrality Data

The table below lists the calculated per-member per-month (PMPM) figures for the Diamond State Health Plan by eligibility group and service, as well as the negotiated trend rates for each of the demonstration years preceding this extension. At this renewal of the demonstration, the service categories listed below (pharmacy, behavioral health, and managed care) have been collapsed into one PMPM per eligibility group.

Note: During DSHP's last extension under the authority of section 1115(f), demonstration year eight was converted from the Federal fiscal year to a calendar year. Therefore, an additional three months (noted below as Oct – Dec. 2003) was added to the extension period in order to put the demonstration on a calendar year basis.

DY	Time Period	Service Category	TANF Children		TANF Adults		SSI Children		SSI Adults	
			Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM
1	FFY 1996	Pharmacy	25.3%	\$ 9.66	32%	\$ 29.08	21%	\$ 51.51	27.4%	\$ 58.95
		Behavioral Health	29.8%	\$ 31.64	29.8%	\$ 1.15	29.8%	\$ 85.17	29.8%	\$ 119.28
		Managed Care	6.79%	\$ 92.60	6.17%	\$ 215.39	6.85%	\$ 647.08	6.85%	\$ 523.85
2	FFY 1997	Pharmacy	6.79%	\$ 10.31	6.17%	\$ 30.87	6.85%	\$ 55.04	6.85%	\$ 169.84
		Behavioral Health	6.79%	\$ 33.79	6.17%	\$ 1.22	6.85%	\$ 85.17	6.85%	\$ 119.28
		Managed Care	6.79%	\$ 98.89	6.17%	\$ 228.67	6.85%	\$ 691.41	6.85%	\$ 559.74
3	FFY 1998	Pharmacy	6.79%	\$ 11.01	6.17%	\$ 32.78	6.85%	\$ 58.81	6.85%	\$ 181.47
		Behavioral Health	6.79%	\$ 36.08	6.17%	\$ 1.29	6.85%	\$ 97.23	6.85%	\$ 136.19
		Managed Care	6.79%	\$ 105.60	6.17%	\$ 242.78	6.85%	\$ 738.77	6.85%	\$ 598.08
4	FFY 1999	Pharmacy	6.79%	\$ 11.76	6.17%	\$ 34.80	6.85%	\$ 62.83	6.85%	\$ 193.90
		Behavioral Health	6.79%	\$ 38.53	6.17%	\$ 1.37	6.85%	\$ 103.89	6.85%	\$ 145.51
		Managed Care	6.79%	\$ 112.77	6.17%	\$ 257.76	6.85%	\$ 789.37	6.85%	\$ 639.05
5	FFY 2000	Pharmacy	6.79%	\$ 12.56	6.17%	\$ 36.95	6.85%	\$ 67.14	6.85%	\$ 207.18
		Behavioral Health	6.79%	\$ 41.15	6.17%	\$ 1.46	6.85%	\$ 111.01	6.85%	\$ 155.48
		Managed Care	6.79%	\$ 120.43	6.17%	\$ 273.67	6.85%	\$ 843.45	6.85%	\$ 682.82
6	FFY 2001	Pharmacy	6.79%	\$ 13.41	6.17%	\$ 39.23	6.85%	\$ 71.74	6.85%	\$ 221.37
		Behavioral Health	6.79%	\$ 43.94	6.17%	\$ 1.55	6.85%	\$ 118.62	6.85%	\$ 166.13
		Managed Care	6.79%	\$ 128.61	6.17%	\$ 290.55	6.85%	\$ 901.22	6.85%	\$ 729.59
7	FFY 2002	Pharmacy	6.79%	\$ 14.32	6.17%	\$ 41.65	6.85%	\$ 76.65	6.85%	\$ 236.54
		Behavioral Health	6.79%	\$ 46.93	6.17%	\$ 1.64	6.85%	\$ 126.74	6.85%	\$ 177.51
		Managed Care	6.79%	\$ 137.34	6.17%	\$ 308.48	6.85%	\$ 962.95	6.85%	\$ 779.57
8	FFY 2003	Pharmacy	6.79%	\$ 15.29	6.17%	\$ 44.22	6.85%	\$ 81.90	6.85%	\$ 236.54
		Behavioral Health	6.79%	\$ 50.11	6.17%	\$ 1.74	6.85%	\$ 135.42	6.85%	\$ 189.67
		Managed Care	6.79%	\$ 146.67	6.17%	\$ 327.51	6.85%	\$ 1,028.92	6.85%	\$ 832.97
	Oct – Dec. 2003	Pharmacy	6.79%	\$ 15.54	6.17%	\$ 44.89	6.85%	\$ 83.27	6.85%	\$ 256.96
		Behavioral Health	6.79%	\$ 50.94	6.17%	\$ 1.77	6.85%	\$ 137.68	6.85%	\$ 192.84
		Managed Care	6.79%	\$ 149.10	6.17%	\$ 332.45	6.85%	\$ 1,046.10	6.85%	\$ 846.88

ATTACHMENT D

Historical Budget Neutrality Data

DY	Time Period	Service Category	TANF Children		TANF Adults		SSI Children		SSI Adults	
			Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM
9	CY 2004	<i>Pharmacy</i>	6.79%	\$ 16.60	6.17%	\$ 47.66	6.85%	\$ 88.97	6.85%	\$ 74.56
		<i>Behavioral Health</i>	6.79%	\$ 54.40	6.17%	\$ 1.88	6.85%	\$ 147.11	6.85%	\$ 206.05
		<i>Managed Care</i>	6.79%	\$ 159.22	6.17%	\$ 352.96	6.85%	\$ 1,117.76	6.85%	\$ 904.89
10	CY 2005	<i>Pharmacy</i>	6.79%	\$ 17.73	6.17%	\$ 50.60	6.85%	\$ 95.07	6.85%	\$ 93.37
		<i>Behavioral Health</i>	6.79%	\$ 58.09	6.17%	\$ 1.99	6.85%	\$ 157.19	6.85%	\$ 220.16
		<i>Managed Care</i>	6.79%	\$ 170.03	6.17%	\$ 374.74	6.85%	\$ 1,194.33	6.85%	\$ 966.88
11	CY 2006	<i>Pharmacy</i>	6.79%	\$ 18.93	6.17%	\$ 53.72	6.85%	\$ 101.58	6.85%	\$ 13.47
		<i>Behavioral Health</i>	6.79%	\$ 62.04	6.17%	\$ 2.11	6.85%	\$ 167.96	6.85%	\$ 235.25
		<i>Managed Care</i>	6.79%	\$ 181.58	6.17%	\$ 397.86	6.85%	\$ 1,276.14	6.85%	\$ 1,033.11