CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00039/5

TITLE: **Minnesota Prepaid Medical Assistance Project Plus (PMAP+)**

AWARDEE: **Minnesota Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Minnesota' s Prepaid Medical Assistance Project Plus section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the Minnesota Department of Human Services (DHS) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, extent of Federal involvement in the Demonstration, and the State's obligations to CMS during the life of the Demonstration. The STCs are effective July 1, 2011 unless otherwise specified. All previously approved STCs, Waivers, Expenditure Authorities and Not Applicables are superseded by the STCs set forth below. This Demonstration extension is approved through December 31, 2013.

The STCs have been arranged into the following subject areas:

- Preface
- Program Description and Objectives;
- General Program Requirements;
- Eligibility and Demonstration Scope;
- Benefits;
- MinnesotaCare Cost Sharing;
- Delivery System;
- Medical Education and Research Costs (MERC);
- General Reporting Requirements;
- General Financial Requirements Under Title XIX;
- Monitoring Budget Neutrality;
- Evaluation of the Demonstration; and
- Schedule of State Deliverables for the Demonstration Extension Period.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Minnesota's section 1115 PMAP+ demonstration was initially approved and implemented in July 1995. Minnesota was one of the early States to use health care reform waivers to cover uninsured populations. The PMAP+ demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both MinnesotaCare Program eligibles and Medicaid State plan groups. The goal of Minnesota's health care reform effort is to provide organized and coordinated health care that includes pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. The populations affected by this Demonstration not only includes mandatory State plan eligibles, but also expands coverage to those that would not traditionally qualify for Medicaid, such as higher income parents/caretakers.

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 title XIX State plan amendments for changes affecting 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 State Plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, 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 paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. 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 paragraph 15, 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 designs will be modified to incorporate the amendment provisions.

8. .**Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

a) Demonstration Summary and Objectives: The State must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.

b) Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

d) Quality: The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

e) Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating that the State has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

f) Interim Evaluation Report: The State must provide an evaluation report reflecting the hypotheses being tested and any results available.

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

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. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph nine, during the last 6 months of the Demonstration, the State may choose to not enroll individuals into the Demonstration who would not be eligible for Medicaid under the current Medicaid State plan. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. **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.

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

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS 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.

14. **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.

15. . **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements approved by CMS as an amendment to the State plan 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 amendment or extension of this Demonstration.

16.

17. FFP. Federal funds are not available for expenditures for this Demonstration until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY AND DEMONSTRATION SCOPE

16. **Eligibility.** Certain individuals are eligible under the PMAP+ Demonstration who either would not otherwise be eligible under the Medicaid State plan or elect not to participate in the State plan. These "demonstration eligibles" are described below:

b) Demonstration Eligibles are individuals who meet the eligibility standards as specified in the following chart. The first group is served through the State plan and the other groups are served through the MinnesotaCare program:

GROUPS MADE ELIGIBLE UNDER THE PMAP+ DEMONSTRATION				
Participating Groups	**Expenditure Authority Population**	**Eligibility Authority**	**Income Standards**	**Income Methodology (Net income test. Medicaid deeming rules apply)**
MA One Year Olds: Infants age 12-23 months	Population 1	Section 1115	At or below 275 % FPL	• Apply methods for MA infants
MinnesotaCare Pregnant Women	Population 2	Section 1115	At or below 275 % FPL	• Gross household income per paragraph 18 and no Medicaid deeming. • No disregards /deductions
MinnesotaCare Children < 21 Years)	Population 3 Population 4	Section 1115	At or below 200% FPL Above 200 and at or below 275% FPL	• Gross household income per paragraph 18 and no Medicaid deeming. See also paragraph 21. • No disregards /deductions •
MinnesotaCare Caretaker Adults (includes 3 subgroups)	Population 5	Section 1115	Subgroup 1 Up to 100% of FPL, or $57,500 of annual income, whichever is lower –funded by title XIX. Subgroup 2 Between 100 % and 200% of the FPL, or $57,500 of annual income, whichever is lower. This subgroup is funded by title XIX as described in paragraph 45(d) Subgroup 3 Between 200% and 275% of FPL, or $57,500 of annual whichever is lower funded by title XIX	• Gross household income per paragraph 18 and no Medicaid deeming. • No disregards /deductions

c) Medicaid State Plan Eligible Populations Affected by the Demonstration: In addition, under the PMAP+ demonstration certain Medicaid State Plan groups are

mandated into mandatory managed care, which include the following:

i. Medicare and Medicaid Dual eligibles under 65 years who are not using a disabled basis of eligibility;

ii. American Indians, as defined in 25 U.S.C. 1603(c);

iii. Disabled children under age 19 who are eligible for SSI under Title XVI who are not using a disabled basis of eligibility;

iv. Children under age 19 who are in State-subsidized foster care or other out of home placement;

v. Children under age 19 who are receiving Foster Care under Title IV-E;

vi. Children under age 19 who are receiving adoption assistance under Title IV-E;

vii. Children under 19 with special health care needs who are receiving services through family-centered, community-based coordinated care system that receives grants funds under Section 501(a)(1)(D) of Title V who are not using a disabled basis of eligibility.

17. **Definitions.** The State defines the following terms differently in the eligibility determination process for MinnesotaCare than under the Medicaid State plan.

a) **MinnesotaCare Family** means a parent or parents and their children (under 21 years of age); or guardians and their wards who are children; and grandparents, foster parents, and other caretaker relatives residing in the same household; and includes children temporarily absent from the household in settings such as schools, camps or visitation with noncustodial parents. "Parents" means the birth, adoptive or stepparent of a child. The definition of MinnesotaCare Family is used to determine which individuals' income must be counted as family income for purposes of determining eligibility for MinnesotaCare. The State receives FFP only for the groups listed in paragraph 17(a), with "MinnesotaCare Caretaker Adult" defined in (b) below.

b) **MinnesotaCare Caretaker Adult.** The term "caretaker adult" used in item 17 means parents and other caretaker relatives. Parent means the birth, adoptive or stepparent of a child. Caretaker relative has the same meaning as "caretaker relative" under Medicaid.

c) **MinnesotaCare Assets.** The term "assets" means all cash and other personal property, as well as any real property that a family owns that has monetary value. "Net asset" means the asset's fair market value minus any encumbrances including but not limited to, liens and mortgages.

i. The net asset values of all assets owned by adult applicants and enrollees, who are not pregnant, are considered MinnesotaCare Assets, except for those assets excluded under(ii) below.

ii. The value of assets that are not considered in determining eligibility for MinnesotaCare is the same as the value of assets that are not considered in determining eligibility for Medical Assistance, with the following exceptions:

iii.

(A) The value of worker's compensation settlements are not considered in determining assets for MinnesotaCare; and

iv.

(B) Applicant or enrollee bank accounts that contain personal income or are used to pay personal expenses are not considered capital or operating assets of a trade or business, and will not be considered under the $200,000 exclusion for capital or operating assets of a trade or business.

v.

iii. Adult applicants and enrollees who are not pregnant, who are not citizens, and whose sponsor has signed an affidavit of support must count their sponsor's assets when determining eligibility.

d) **MinnesotaCare Gross Annual Family Income.** The term "MinnesotaCare Gross Annual Family Income" means the total non-excluded income of all family members for an annual period, determined in accordance with items (i) through (v) below:

i. Selfemployment income is calculated in accordance with sub items (A) and (B) below.

(A) The adjusted gross income reported on the applicant or enrollee's Federal income tax form for the previous year is summed with the depreciation, carryover loss, and net operating loss amounts. In the case of self-employed farmers, adjusted gross income from the applicant or enrollee's Federal income tax form for the previous year is used.

(B) If the applicant or enrollee reports that income has changed since the period of their last tax return, income may be calculated using documentation such as business records or quarterly tax reports.

ii. Earned income is calculated in accordance with sub-items (A) and (B).

(A) The income of wage earners, including all wages, salaries, commissions, and other benefits received as monetary compensation from employers before any deduction, disregard, or exclusion, is calculated using the following rules:

(1) Unless the conditions specified in (2) apply, income from the last 30 days is used and projected to a 12-month period.

(2) If the wage earner is employed on a seasonal basis or receives income too infrequently or irregularly to be calculated under sub-item (1), total income for the past 12 months is used.

(3) The earned income of full-time and part-time students under age 19 is not counted as income.

(4) Federal or State tax rebates are not counted as income or assets.

(B) When an applicant or enrollee reports that earned income has changed from the amount calculated in subitem (A), the new amount is projected forward for 12 months.

iii. Unearned income is calculated in accordance with subitems (A) and (B).

(A) The following unearned income received in the preceding tax year, with any reported changes, is projected to reflect a 12 month period:

(1) Supplemental security income under title XVI of the Social Security Act;

(2) Social security benefits;

(3) Veterans' administration benefits;

(4) Railroad retirement benefits;

(5) Unemployment benefits;

(6) Workers' compensation benefits;

(7) Child support;

(8) Spousal maintenance or support payments; and

(9) Income from any other source, including interest, dividends, and rent.

(B) When an applicant or enrollee reports that unearned income has changed from the amount calculated in subitem (1), the current amount is projected forward for 12 months.

(C) Lump sums are only counted as income for people who are self-employed if claimed as income on the tax return.

iv. Noncitizen applicants and enrollees whose sponsor signed an affidavit of support, as defined under United States Code, Title 8, Section 1183a, will be deemed to include their sponsor's income as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law Number 104-193 as "gross family income" to the same extent sponsor deeming applies in the Medical Assistance program.

v. If the caretaker relative, foster parent or legal guardian applies separately for the children, only the children's income is counted. If the caretaker relative, foster parent or legal guardian applies with the children, the adult's income is counted in determining gross family income. If the caretaker relative, foster parent or legal guardian applies separately for their own coverage, only the adult's income is counted.

vi. Payments made to victims under the Catastrophic Survivor Compensation Fund are not counted as income in determining gross family income.

e) **Medical Assistance (MA).** The terms "Medical Assistance" and "Medicaid" both shall refer to the coverage and benefits provided to individuals who are eligible under Minnesota's Medicaid State plan.

f) **Federal Poverty Level (FPL).** The terms "Federal Poverty Level" and "FPL" refer to the Federal Poverty Guidelines published annually by the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation

19. **MinnesotaCare Eligibility Criteria.** An applicant or enrollee must meet the following eligibility requirements in order to enroll in MinnesotaCare:

a) Is a member of the family as defined in paragraph 18(a).

b) Does not currently have other health coverage, nor had other health coverage during the 4 months immediately preceding the date MinnesotaCare coverage is to begin. An

applicant or enrollee who is entitled to Medicare Part A, or enrolled in Medicare Part B coverage, is considered to have health coverage for this purpose. An applicant, or enrollee, who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare. Items (i) through (iv) below are not considered to be health coverage under this section.

i. Medical Assistance,

ii. Cost effective health insurance that was paid for by Medical Assistance, unless the insurance was continued after Medical Assistance determined the health insurance no longer to be cost effective, or after the individual's Medical Assistance case was closed.

iii. General Assistance Medical Care (GAMC);

iv. Civilian Health and Medical Program of the Uniformed Services, Tri Care (formerly CHAMPUS).

c) Does not have current access to employer-subsidized health coverage, as defined by the State.

d) Does not have lost employer-sponsored coverage due to:

i. the employer terminating coverage during the 18 months immediately preceding the date MinnesotaCare coverage would begin, except that this provision does not apply to a family or individual who was enrolled in MinnesotaCare within 6 months or less of reapplication, and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit; or

ii. the employee failing to take up coverage offered by the employer during an open enrollment period within the preceding 18 months.

e) Meet non-financial eligibility factors under the Medicaid State plan (e.g., State residence; citizenship and identity documentation; non-citizenship eligibility; assignment of rights to medical benefits; cooperation with establishing paternity, obtaining medical support, and identifying third party liability; and provision or application for social security number).

f) Have MinnesotaCare Gross Family Income that does not exceed 275 percent of the FPL. In addition to not exceeding 275 percent of the FPL, MinnesotaCare caretaker adults must also not have family income that exceeds $57,500.

g) For adults, except for pregnant women, not have MinnesotaCare Assets that exceed the following limits:

i. A household of one person must not own more than $10,000 in total MinnesotaCare Assets;

ii. A household of two or more persons must not own more than $20,000 in total MinnesotaCare Assets; and

iii. An eligible individual or family may accrue interest on their assets, but the total must be reduced to the maximum at the time of an eligibility redetermination.

h) Comply with the family enrollment requirements as follows:

i. Parents who enroll in MinnesotaCare must enroll any eligible children in MinnesotaCare or Medical Assistance.

ii. Unless other insurance is available, children may be enrolled in MinnesotaCare even if their parents do not enroll.

iii. If one parent in a household enrolls in MinnesotaCare, both parents in the household must enroll in MinnesotaCare or Medical Assistance unless other insurance is available.

iv. If one child in a family is enrolled in MinnesotaCare, all children in the family must be enrolled in MinnesotaCare or Medical Assistance unless other insurance is available.

v. If one spouse in a household is enrolled in MinnesotaCare, the other spouse in the household must enroll in MinnesotaCare or Medical Assistance unless other insurance is available.

vi. Except as provided in item ii above, families cannot enroll only some uninsured members in MinnesotaCare.

vii. In families that include a caretaker relative, foster parent or legal guardian, the caretaker relative, foster parent or legal guardian may apply as a family or may apply separately for the children.

i) Not be a resident of a correctional or detention facility.

j) Pay monthly premiums, as defined in Section VII.

20. **Special Eligibility Rules for Individuals who Receive a COBRA Premium Subsidy from the State**

Individuals and their qualified family members who are eligible for the 65 percent COBRA continuation premium subsidy for health care coverage under the American Recovery and Reinvestment Act of 2009 may also be eligible for a state premium subsidy. Any individual who receives a state premium subsidy under this provision is exempt from the insurance barrier described in paragraph 19(b) if the individual or the individual's qualified beneficiaries apply for MinnesotaCare after the individual no longer receives COBRA continuation coverage.

21. **Special Eligibility Rules For Children in MinnesotaCare.**

a) A child who: (1) has been continuously enrolled in the Children's Health Program, and subsequently in MinnesotaCare, and is not a resident of a correctional or detention facility; or (2) whose gross annual family income at or below 200 percent of FPL, is eligible for MinnesotaCare without regard to the insurance barriers described in paragraph 19(b), (c) and (d), so as long as continuous enrollment is maintained from the child's initial eligibility and the child meets both (i) and (ii) below:

i. The child meets the requirements under paragraph 19(a), (f) and (h).

ii. The child is not otherwise insured for the covered health services. A child is not otherwise insured for covered health services when subitems (A), (B), or (C) apply:

(A) The child lacks coverage in two or more of the following areas: basic hospital coverage; medical/surgical coverage; major medical coverage; dental coverage; vision coverage.

(B) The child's coverage requires a deductible of $100 or more per person per year.

(C) A child with a particular diagnosis lacks coverage because the child has

exceeded the maximum coverage for that diagnosis or the policy of coverage excludes that diagnosis.

b) MinnesotaCare children in families with income equal to or below 275 percent of FPL who fail to submit renewal forms and related documentation necessary for verification of continued eligibility in a timely manner shall remain eligible. The commissioner shall use any means available to verify family income. If the commissioner determines that there has been a change in income and that a premium payment is required to maintain enrollment, the commissioner shall notify the family of the new premium payment, its due date, and that the children will be disenrolled if the premium payment is not received by the due date. If the new premium payment is not received by the due date, the children will be disenrolled effective the first day of the calendar month following the calendar month for which the premium is due.

c) Any child residing in foster care or a juvenile residential correctional facility on the child's 18th birthday is, upon completion of an initial application for MinnesotaCare, automatically eligible for MinnesotaCare without regard to the income limits, insurance barriers, family enrollment requirements, and premium payments described in paragraphs 19 and 34. MinnesotaCare coverage begins the first day of the month following the date of termination from foster care or release from a juvenile residential correctional facility. Individuals must be contacted annually to ensure that they continue to reside in the state and are interested in continuing MinnesotaCare coverage. The first period of renewal begins the month the enrollee turns 21 years of age.

22. **Relationship Between MinnesotaCare and MA.** The following terms govern the relationship between MinnesotaCare and MA.

a) In order to assist applicants for MinnesotaCare in making an informed choice between MA and MinnesotaCare, application forms for MinnesotaCare must meet the following criteria.

i. Application Form With Affirmative Selection. The application forms for MA and MinnesotaCare must feature a set of check boxes, or other means, for the applicant to indicate whether he or she is applying for MinnesotaCare or both MinnesotaCare and MA. The application form may allow applicants to select more than one option. At the time of application, Minnesota must provide comparative information on MinnesotaCare and MA that describes the eligibility criteria, benefits (including retroactive eligibility), cost sharing (including monthly premium requirements), managed care, other information on the two programs needed to make an informed choice, and instructions on how to obtain assistance in making that choice. The signature page of the form must contain an affirmation that the applicant has reviewed the available options and has exercised an informed choice.

ii. An eligibility determination for MA must be done for every application for which a choice of MA is indicated. Individuals found to be MA eligible must be enrolled in MA. If a choice of MA is not indicated on the application form, the individual is not considered an applicant for MA, and no MA eligibility determination is required. If no selection of program is made by the applicant, the State will perform MA determination first, then MinnesotaCare.

iii.

iv. Minnesota must notify CMS 60-days in advance if the State intends to make changes to the MinnesotaCare application form. The application form must be submitted along with a description of the changes made.

b) The State will initiate a process to facilitate MA eligibility determination requests for

MinnesotaCare enrollees whose cases close for failure to pay the premium when potential MA eligibility is indicated. This process will assure up to 3 months of retroactive eligibility with no gap in coverage for those who are MA eligible. A notice informing recipients that they may be eligible for MA without a premium will be sent when cases close due to failure to pay the premium where potential MA eligibility is indicated. The notice will include an acceptance form and a stamped, return addressed envelope with which to indicate an interest in an MA eligibility determination.

c) Individuals enrolled in MinnesotaCare may at any time request and receive a determination of their eligibility for MA. An enrollee who makes such an application and is determined eligible for MA must be disenrolled from MinnesotaCare, with MinnesotaCare coverage terminating the last day of the calendar month in which Department of Human Services (DHS) receives notice of the enrollee's MA eligibility. Those determined eligible for MA may receive up to 3 months of MA retroactive eligibility prior to the date of their MA application.

d) MinnesotaCare premiums paid by an enrollee may be used as medical expenses to meet an income spend down for MA.

e.) The State must ensure that no duplicate claims are paid for enrollees who disenroll from MinnesotaCare and enroll into MA during the 3 months of retroactive coverage provided under MA that overlaps with MinnesotaCare coverage.

23. **Special Rules Pertaining to MA Eligibility**. Under the demonstration waiver, eligibility for the MA Program is consistent with Minnesota's State plan except as provided for in this section.

a) **Coverage for Pregnant Women**. Rather than requiring multiple eligibility determinations for qualified pregnant women and all other categorically needy pregnant women, MA eligibility for pregnant women is determined using an income standard of 275 percent of the FPL. Eligibility for all pregnant women enrolled in MA is determined with no asset test and continues until the end of the month in which 60 days post-partum occurs. Medical verification of pregnancy must be provided no later than 30 days after enrollment as a pregnant woman. Coverage for pregnant women consists of the full MA benefit set for a qualified pregnant woman in accordance with section 1902(a)(10)(A)(i)(III) of the Act.

b) **12-Month Eligibility Period for Certain Medically Needy Medicaid Eligibles.** Minnesota may provide 12 months of eligibility to individuals who qualify for Medical Assistance as medically needy, provided they have only unvarying, unearned income (UUI) or only income from sources excluded from consideration by law. Minnesota must continue to use a 6-month budget period for determining medically needy eligibility under the Medicaid State Plan. UUI is defined as income from a source other than employment or self-employment that can reasonably be anticipated to be the same amount every month and for which changes, such as periodic cost-of-living increases, can be anticipated. Examples of UUI include Social Security Disability Insurance, Reemployment Insurance (Unemployment Compensation), veterans' disability payments, and private pensions. Examples of income excluded from consideration by law include federally excluded payments such as certain tribal payments, German war reparations, Women, Infants and Children Program benefits, and earnings of a minor household member who is a full-time student. Cases with spenddowns must be reviewed every 6 months to ensure the recipient has sufficient medical expenses to meet the spenddown.

24. **MinnesotaCare Application and Enrollment Process.** The following requirements apply to the application and enrollment process for MinnesotaCare.

a) Applicants must be allowed to apply directly to DHS, or to a local county agency (if the county elects to participate in eligibility determinations for MinnesotaCare). Applicants may also submit applications through appropriate referral sources. Appropriate referral sources include, but are not limited to: eligible provider offices; local social service agencies; school district offices; public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches; community health offices; WIC program sites. Referral sources that accept applications from applicants must send applications to DHS within 5 working days after receipt. Referral sources may not make MinnesotaCare eligibility determinations; only local county agencies and DHS may make these determinations. A family member who is age 18 or over, or an authorized representative, may apply on an applicant's behalf.

b) Applicants may be required to provide all information necessary to determine eligibility for MinnesotaCare and potential eligibility for Medical Assistance, including subitems i to vii:

i. Social security number;

ii. Household composition;

iii. Availability of other health coverage, including access to employer-subsidized health coverage;

iv. Gross annual family income;

v. Documentation of immigration status for applicants and enrollees who are not United States citizens;

vi. Assets of applicant caretaker adults, foster parents, and legal guardians;

vii. Any additional information needed by DHS to determine or verify eligibility

c) An applicant must be enrolled in MinnesotaCare on the date the following are completed: (1) A complete application is received by DHS and the applicant is determined eligible; and (2) the initial premium payment is received by DHS.

d) Coverage begins the first day of the calendar month following the date of enrollment, except:

i. Coverage for newborns is automatic and begins immediately from the moment of birth if the mother is enrolled;

ii. Coverage for eligible adoptive children of a family enrolled in MinnesotaCare begins on the first day of the month of placement for the purpose of adoption;

iii. Coverage for other new members of an enrolled family begins the first day of the month following the month in which the change is reported;

iv. Coverage of enrollees who are hospitalized on the first day of the month following enrollment begins the day following the date of discharge from the hospital.

e) **Retroactive Coverage.** Applicants may pay for MinnesotaCare coverage for health care services received prior to the usual coverage start date described in (c)and (d)

above. Retroactive coverage begins the first day of the calendar month for which the enrollee requests and pays for up to 3 months of retroactive coverage, after meeting the following requirements:

i. Must be a former MA or GAMC enrollee;

ii. Must apply for MinnesotaCare within 30 days following termination of MA or GAMC;

iii. Must return all requested MinnesotaCare verifications within 30 days of written request for verifications;

iv. Must be eligible for ongoing MinnesotaCare;

v. Must pay the initial MinnesotaCare premium within 30 days of the initial premium billing; and

vi. Must pay the optional premium for the retroactive months within 30 days of the optional premium billing.

25. **Disenrollment from MinnesotaCare.** The MinnesotaCare enrollees may be disenrolled from MinnesotaCare for the following reasons:

a) Enrollees may be disenrolled from MinnesotaCare who fail to pay the required premium when due, unless the enrollee is pregnant or is a child under age 2. A dishonored check is considered failure to pay the premium and the agency may demand a guaranteed form of payment to replace a dishonored check. Nonpayment of the premium results in disenrollment from the plan effective for the first day of the calendar month for which the premium was due.

Enrollees who are disenrolled for nonpayment of premiums who pay all past due premiums as well as current premiums within 20 days shall be reenrolled retroactive to the first day of disenrollment.

b) If an enrollee who is pregnant fails to pay the premium, Minnesota Care coverage continues until the last day of the month in which 60 days post-partum occurs.

c) If the premium is not paid for an enrollee who is a child under age 2, MinnesotaCare coverage continues to the last day of the month following the month in which the child becomes 2 years of age.

d) MinnesotaCare enrollees who are members of the military and their families may voluntarily disenroll for good cause when one or more family members are called to active duty. The 4-month waiting period is eliminated.

26. **MinnesotaCare Redetermination Period.** Eligibility for MinnesotaCare must be re-determined at least every 12 months. Enrollees may be required to provide the information needed to redetermine eligibility in advance of the date in which their eligibility would otherwise expire. The redetermination period begins the first day of the month after the month in which the application is approved. Minnesota may change the redetermination period to any length of time between 6 and 12 months by notifying CMS by letter in advance of the change. Furthermore, each Quarterly Progress Report must include a statement of the current length of the enrollment period for MinnesotaCare. Enrollees may be required to report to the State any changes that affect their MinnesotaCare eligibility, such as changes in income, access to employer-sponsored insurance, changes in household composition, and changes in assets.

27. **Re-Enrollment In MinnesotaCare**

27. **Re-Enrollment in MinnesotaCare.**

a) An enrollee who voluntarily terminates coverage from the program, or who is disenrolled for failure to pay the required premium, may be barred from reenrolling in MinnesotaCare until 4 calendar months after the date coverage terminates unless the person demonstrates good cause for voluntary termination or nonpayment and pays the unpaid premium for any month in which coverage is to be provided and is otherwise eligible for MinnesotaCare.

b) The 4-month penalty under (a) above may not be applied to individuals described in paragraph 26, items (b), (c), and (d).

c) Good cause for nonpayment does not exist if a person chooses to pay other family expenses instead of the MinnesotaCare premium.

d) Good cause for nonpayment and voluntary termination means, generally, circumstances that excuse an enrollee's failure to pay the required premium when due or voluntarily terminating coverage, including (but not limited to) circumstances such as:

i. Because of serious physical or mental incapacity or illness, the enrollee fails to pay the premium;

ii. The enrollee voluntarily disenrolls under the mistaken belief that other health coverage is available; and

iii. The enrollee does not receive a regular source of income for which the enrollee has relied on to pay the required premium.

e) The State may determine whether good cause exists based on the weight of the corroborative evidence submitted by the person to demonstrate good cause.

f) MinnesotaCare enrollees who are members of the military and their families, who voluntarily disenroll when one or more family members are called to active duty, may reenroll during or following that member's tour of active duty. Income and asset increases reported at the time of reenrollment are disregarded until the renewal date.

V. BENEFITS

29. **Benefits Package: MinnesotaCare Children and Pregnant Women, and MA One Year Olds.** The benefit offered to MinnesotaCare Children, MinnesotaCare Pregnant Women, and MA One Year Olds is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid State Plan, including all services that meet the definition of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) found in section 1905(r) of the Act.

30. **Benefits Package: MinnesotaCare Caretaker Adults.** The benefit offered to MinnesotaCare Caretaker Adults (except pregnant women) is identical to the benefit offered to categorically eligible individuals under Minnesota's Medicaid State Plan, except that the services listed in (a) through (h) below are excluded, and inpatient hospital services are limited for certain participants as described in (i) below.

a) Services included in an individual's education plan;

b) Private duty nursing;

c) Orthodontic services;

d) Non-emergency medical transportation services;

e) Personal Care Services;

f) Targeted case management services (except Mental Health targeted case management which is a covered service for MinnesotaCare caretaker adults to the degree that it is covered in the Medicaid State plan);

g) Nursing facility services; and

h) ICF/MR services.

i) Inpatient Hospital Limit: MinnesotaCare Caretaker Adults (except pregnant women) with income above 215 percent of the FPL are subject to a $10,000 annual limit on inpatient hospitalization.

31. 32. **Covered Access Services**. MinnesotaCare covers sign and spoken language interpreters who assist an enrollee in obtaining MinnesotaCare eligibility and covered services.

VI. MINNESOTACARE COST SHARING.

33**. Cost Sharing in Medicaid.** The cost sharing requirements for Medicaid eligibles under the Medicaid State plan must conform to the requirements set forth in the State plan. The cost sharing requirements for MA One Year Olds must be identical to the requirements specified for Medicaid eligible infants, as specified in the Medicaid State plan.

34.**MinnesotaCare Cost Sharing.** In general, cost sharing requirements imposed on MinnesotaCare enrollees may be no more than what would be required of the corresponding categorically needy populations under the Minnesota Medicaid State plan. The State may require cost sharing by MinnesotaCare enrollees that exceeds Medicaid State plan amounts as follows:

a) **MinnesotaCare Sliding Scale Premium Schedule.** Minnesota may establish a sliding scale premium schedule (Premium Schedule) for individuals participating in MinnesotaCare that generally exceeds the amounts that can be charged in premiums under title XIX. The State must publish the sliding scale premium schedule on a public Web site, and include a copy with the Annual Report required under paragraph 43. (As of the date of this approval, the current sliding scale premium schedule is posted to the following Web site: http://www.dhs.state.mn.us.) The State may update and revise the sliding scale premium schedule at the start of each Demonstration Year (DY) and attach a copy of the updated schedule to the Quarterly Progress Report for the quarter ending in March. The sliding scale premium schedule must meet the following requirements:

i. The Maximum Premium is the highest total premium that a family can be required to pay, with the exception that children in families with MinnesotaCare Gross Family Income, at or below 200 percent FPL, may be charged no monthly premium as described in paragraph 34(b). The Maximum Premium Table below provides an upper limit on the Maximum Premium amounts that can be charged to various types of families. The upper limits are expressed as a percentage of the family's MinnesotaCare Gross Family Income. Each cell in the table gives the highest income level (expressed as a percentage of FPL) to which a given upper limit applies. (For example, for a one-person family with MinnesotaCare Gross Family Income less than or equal to 54 percent of FPL, the Maximum Premium can be no more than 1.5

or equal to 54 percent of FPL, the Maximum Premium can be no more than 1.5 percent of their MinnesotaCare Gross Family Income. For a family of the same size with MinnesotaCare Gross Family Income above 54 percent up to 82 percent, the Maximum Premium can be no more than 1.8 percent of MinnesotaCare Gross Family Income.)

Maximum Premium Table

Upper Limit	Maximum Income Level as Expressed by Family Size				
	1 Person Family	2 Person Family	3 Person Family	4 Person Family	5 Or More
1.5%	54%	51%	49%	48%	46%
1.8%	82%	79%	77%	76%	74%
2.3%	110%	107%	105%	104%	103%
3.1%	137%	135%	134%	133%	132%
3.8%	165%	163%	162%	161%	160%
4.8%	193%	191%	190%	190%	189%
5.9%	220%	219%	219%	218%	218%
7.4%	248%	247%	247%	247%	247%
8.8%	275%	275%	275%	275%	275%

ii. The Premium Schedule amount for a one person family with one person enrolled in MinnesotaCare may not exceed the Maximum Premium for that family type.

iii. The following are the rules governing Premium Schedule amounts for two person families. When two individuals are enrolled in MinnesotaCare, the Premium Schedule amount may not exceed the Maximum Premium, as defined in (i) above; when one individual is enrolled in MinnesotaCare, the premium will be one-half of the two-person premium.

iv. The following are the rules governing Premium Schedule amounts for families with three or more persons. When three or more individuals are enrolled in MinnesotaCare, the Premium Schedule amount may not exceed the Maximum Premium; when two individuals are enrolled in MinnesotaCare, the premium will be two-thirds of the three-or-more-person premium; with one individual enrolled in MinnesotaCare, the premium will be one-third of the three-or-more-person premium.

v. Notwithstanding the limits described above, the percentage of gross income charged for a family of five may be applied to families of more than five with the same monthly income.

vi. Notwithstanding the limits described above, the Premium Schedule amounts may be a minimum of $4 for each person enrolled in MinnesotaCare.

vii. The State may round all Premium Schedule amounts to the nearest whole dollar.

b) **Application of Premium Requirements.** The following rules govern the application of premium cost sharing.

i. MinnesotaCare Children with MinnesotaCare Gross Family Income, at or below 200 percent of FPL, may be charged no premiums.

ii. In addition to (i) above, and after excluding the children described in (i), a family may be charged premiums for their remaining MinnesotaCare eligible family members (children with MinnesotaCare Gross Family Income above 200 percent

of FPL through 275 percent of FPL, Pregnant Women and Caretaker Adults) based on the sliding scale described in (a) above. The excluded children do not count as family members for the purpose of determining the correct premium schedule amount for the remaining family members.

iii An Indian who is eligible to receive or has received an item or service furnished by the Indian Health Services, an Indian Tribe or Tribal Organization or an Indian Urban Organization (I/T/U), or through referral under contract health services is exempt from premiums and similar charges..

iv. MinnesotaCare enrollees who fail to pay their monthly premiums may be disenrolled from MinnesotaCare, subject to the limitations described in paragraph 26.

v. Members of the military and their families who meet the eligibility requirements for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's active tour of duty may be allowed to participate in MinnesotaCare without premiums for a period of up to 12 months, effective the first day of the month following the month in which eligibility was approved.

35. **Co-Payments.**
Items or services furnished to an Indian directly by Indian Health Services, an Indian Tribe or Tribal Organization or an Indian Urban Organization (I/T/U), or through referral under contract health services are exempt from copayments, coinsurance, deductibles, or similar charge.

All other MinnesotaCare Caretaker Adults may be charged co-payments that exceed the amounts allowed in the Minnesota Medicaid State Plan, as follows:

a) Up to $3 per non-preventive visit to a physician or other primary care provider;

b) Up to $3.50 per visit for non-emergency use of a hospital emergency department;

c) Up to $3 per prescription;

d) Up to $25 for eyeglasses; and

e) Co-payments totaling $30 or more paid by a pregnant woman after the date the pregnancy is diagnosed must be refunded.

The following table summarizes the MinnesotaCare cost sharing provisions.

Population	Premiums	Deductibles	Co-Payments
MinnesotaCare Children (at or below 200% FPL)	No premium	None	No more than State plan
MinnesotaCare children (above 200% and at or below 275% FPL)	Monthly premiums based on a sliding scale based on income and family size	None	No more than State plan
MinnesotaCare Pregnant Women (at or below 275% FPL)	Monthly premiums based on a sliding scale based on income and family size	None	No more than State plan
MinnesotaCare Caretaker Adults (at or below 275% FPL)	Monthly premiums based on a sliding scale based on income and family size	None	• $3 per visit for non-preventive visit • $3.50 per visit for non-emergency use of the emergency

			room • $3 for prescription drugs • $25 for eyeglasses

VII. DELIVERY SYSTEM

36. **Pre-Paid Managed Care Delivery Systems.** All Medicaid eligible individuals described in paragraph 17(b) and MA One Year Olds may be required to participate in the PMAP pre-paid managed care delivery system, on the same basis as other Medicaid eligibles whose participation in managed care was mandated under section 1932 of the Act. MinnesotaCare eligibles may be required to participate in the PMAP managed care delivery system or in a separate prepaid managed care delivery system specifically for MinnesotaCare. All Medicaid and MinnesotaCare managed care arrangements are subject to the Federal regulations found at 42 CFR 438.

37. **American Indians**. CMS acknowledges that, in consultation with tribal governments, DHS has developed an approach to Medicaid purchasing for American Indian recipients that is different from the remainder of the Medicaid program. These approaches address issues related to tribal sovereignty, the application of Federal provisions that prevent Indian Health Services (IHS) facilities from entering into contract with managed care organizations (MCOs), and other issues that have posed obstacles to enrolling American Indian/Alaska Native Medicaid recipients into PMAP. Minnesota will continue to abide by the terms of these agreements, as stipulated below.

a) American Indian Medicaid recipients, whether residing on or off a reservation, will have direct access to out-of-network services at IHS, 93-638 (IHS/638) facilities, or Urban Indian Organizations. DHS will purchase these out-of-network services on a fee-for-service basis using payment rates negotiated between IHS and CMS, except when a 93-638 facility elects to receive the standard Medicaid rate. Physicians at IHS and 93-638 facilities will be able to refer recipients to specialists within the MCO network. Enrollees may not be required to see their MCO primary care provider prior to accessing the referral specialist.

b) The State will consult with tribal governments before approving marketing materials that target American Indians recipients. Certificates of Coverage (COC) will include a description of how American Indian enrollees may direct access IHS/638 providers and how they may obtain referral services. The State will consult with tribal government prior to approving the COC. MCOs will provide trainings and orientation material s to tribal governments upon request, and will make training and orientation available to interested tribal governments. Tribal governments may assist the State in presenting or developing materials describing various MCO options to their members. If a tribal government revises any MCO materials, the MCO may review them. No MCO materials will be distributed until there is agreement between the MCO and Tribal government on any revisions.

c) MCOs may not require any prior approval or impose any condition for an American Indian to access services at IHS/638 facilities. A physician in an IHS/638 facility may refer an American Indian recipient to an MCO participating provider for services covered by Medicaid and the MCO may not require the recipient to see a primary care provider within the MCO's network prior to referral. The participating provider may determine that services are not medically necessary.

VIII. MEDICAL EDUCATION AND RESEARCH COSTS (MERC)

38. **Medical Education and Research Costs (MERC).** Through expenditure

authoritygranted under this Demonstration, total computable payments for the medical education cost component for Medicaid services provided through Medicaid capitated managed care entities that are paid directly to medical education institutions (or to medical care providers) through the MERC Trust Fund are eligible for FFP.

a) Each Demonstration Year, payments made under this provision are limited to the amount claimed for FFP under this demonstration as MERC expenditures for SFY 2009. This aggregate limit applies to all graduate medical education (GME) payments authorized under this Demonstration. This amount represents GME expenditures for managed care enrollees as determined by the State under the authority of 42 CFR 438.6(c)(5). The State must provide documentation to CMS detailing the amounts paid out under the SFY 2009 MERC funding cycle that are eligible to receive FFP no later than October 31,2009 . This amount will constitute the limit for MERC funding for the demonstration in lieu of the limit expressed at 42 CFR §438.6(c)(5)(v). Minnesota may carve out and pay GME providers through the MERC fund for only those managed care products or portions thereof for which there was a carve-out in the calendar year 2008 contracts. Those products are: Minnesota Senior Care, Minnesota Senior Care Plus, Special Needs Basic Care, the portion of the Families and Children contract for individuals enrolled in Medical Assistance, and the portion of the Minnesota Senior Health Options contract for individual who are not enrolled in Medicare.

b) Because the State is directing managed care GME from the MCOs to the MERC, the State may not include GME as a component of capitation rates or as a direct payment under the State plan for managed care enrollees while this expenditure authority exist, with the exception of those managed care products for which no carve-out existed in calendar year 2008, which includes the MinnesotaCare Program, the Minnesota Disability Health Options Program, and those capitation payments for dual eligibles enrolled in the Minnesota Senior Health Options Program. The State may also continue to make a GME adjustment to capitation rates paid to Metropolitan Health Plan in order to recognize higher than average GME costs associated with enrollees utilizing Hennepin County Medical Center according to 42 CFR 438.6(c)(5), not to exceed $6,800,000 in annual total computable payments. The adjustment to the Metropolitan Health Plan rates is in addition to the MERC adjustment and is not subject to the MERC limit. Nothing in this provision exempts Minnesota from any of the requirements of 42 CFR 438.6(c) with respect to Medicaid managed care rate setting and actuarial soundness.

c) The amounts described in (a) may be distributed as follows:

   i. Up to $2,157,000 may be paid to the University of Minnesota Board of Regents, to be used for the education and training of primary care physicians in rural areas, and efforts to increase the number of medical school graduates choosing careers in primary care;

   ii. Up to $1,035,360 may be paid to Hennepin County Medical Center for graduate clinical medical education;

   iii. Up to $1,121,640 may be used to fund payments to teaching institutions and clinical training sites for projects that increase dental access for under-served populations and promote innovative clinical training of dental professionals;

   iv. Up to $17,400,000 may be paid to the University of Minnesota Academic Health Center for purposes of clinical GME;

   v. Amounts in excess of those distributed under (i) through (iv) above, up to the

prescribed limit, may be paid to eligible training sites, based on a formula that incorporates a two-part public program factor described in (vi) below.

vi. The two part public program factor is calculated as follows: (1) public program revenue for each training site eligible for the carve-out funding; and (2) a supplemental public program factor, which is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The distribution to training sites whose public program revenues accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental public program factor.

vii. Training sites that received no public program revenues are ineligible for payments from the PMAP funding transferred to the trust fund.

d) FFP is available for total computable amounts paid from the MERC Trust Fund to recipient entities, within the limits described in this paragraph and the expenditure authorities. The Minnesota Department of Health, which operates the MERC Trust Fund, must certify the total computable payments made from the MERC Trust fund to eligible entities in order for the State to receive FFP.

e) The State shall provide information to CMS regarding any modifications to the existing source of non-Federal share for any GME expenditures claimed under PMAP+. This information shall be provided to CMS, and is subject to CMS approval, prior to CMS providing FFP at the applicable Federal matching rate for any valid PMAP+ expenditures.

f) As part of the Annual Report required under paragraph 43 the State must include a report on GME activities in the most recently completed DY, that must include (at a minimum):

i. A list of the sponsoring institutions and training sites receiving payments from the MERC Trust Fund under these provisions, the amount paid to each sponsoring institution/training site, the subparagraph of (c) above under which each payment was made, and the source of the non-Federal share for each payment (i.e., each payment from the MERC Trust Fund must be identified with a corresponding transfer into the fund to account for the non-Federal share). A blanket statement can be used if the source of the non-Federal share is the same for all or most of the payments. Sponsoring institutions are the entities that receive payments from the MERC Trust Fund under (c)(i) through (c)(iv) above. The amounts paid to sponsoring institutions, and by training sites under (c)(v), are the basis for Minnesota's claim of FFP.

ii. A description of the process used by the University of Minnesota Board of Regents to allocate funds they received from the MERC Trust Fund, a list of sub-grantees receiving these funds, and the amount each sub-grantee received;

iii. With respect to payments made under (c)(iii) above: (A) a description of the public process used to determine which potential sponsoring institutions will receive grants and the amount of each grant, and (B) if any of the sponsoring institutions made sub-grants, a list of the sub-grantees and the amount each received; and

iv. With respect to payments made under (c)(v) above: a description of the public process used to determine which potential training site will receive grants and the amount of each grant.

IX. GENERAL REPORTING REQUIREMENTS

39. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX of the Social Security Act in Section X of the STCs.

40. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality as outlined in Section X. The State must submit any corrected budget neutrality data upon request.

42. **Bi –Monthly Calls.** The State must participate in monitoring calls with CMS. 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, the benefit package, audits, lawsuits, financial reporting related to 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. CMS will 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 will jointly develop the agenda for the calls.

43. **Quarterly Progress Reports.** The State must submit progress reports no later than 60 days following the end of each calendar 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:

a) An updated budget neutrality monitoring spreadsheet;

b) Events occurring during the quarter, or anticipated to occur in the near future, that will effect 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; changes to the Minnesota Health Care Program application; pertinent legislative activity; and other operational issues relevant to the Demonstration.

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

d) Quarterly enrollment reports that include the member months for each demonstration population; and

e) Evaluation activities and any interim findings.

44. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, any interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy, and administrative difficulties and solutions in the operation of the Demonstration. The State must submit the draft annual report no later than 120 days after the close of each DY. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

a. The annual report must include certain information regarding the managed care plans the State contracts with to provider PMAP+ services. This information will include:

i) A description of the managed care contract bidding process

i) A description of the managed care contract bidding process

ii) The number of contract submissions, the names of the plans, and a summary of the financial information submitted by each bidder.

iii) Annual managed care plan audit report summary.

iv) A description of any corrective action plans required of the managed care plans.

v) A summary of any complaints received by the State from the public regarding the managed care contracting and oversight process.

46. Transition Plan. On or before July 1, 2012, the State is required to prepare and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including 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 plan must contain the required elements and milestones described in paragraphs 36a-e outline below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

a) Seamless Transitions. Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

i. Determine eligibility under all January 1, 2014, 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.

ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

b) Access to Care and Provider Payments and System Development or Remediation. As necessary to meet the State's priorities, the State should assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. Additionally, the Transition Plan for the Demonstration is expected to expedite

the State's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation.

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

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

e) **Implementation.**

i. By July 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

47. **Quarterly Expenditure Reports: CMS 64.** 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 XI.

48. **Reporting Expenditures Under the Demonstration: CMS-64.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

a) **Tracking Expenditures.** In order to track expenditures under this demonstration, Minnesota 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 of the State Medicaid Manual (SMM). All Demonstration expenditures subject to the budget neutrality expenditure limit will be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). DY 1 is defined as the year beginning July 1, 1995, and ending June 30, 1996, and DY 2 and subsequent DYs are defined accordingly. All other Medical Assistance payments that are not subject to the budget neutrality expenditure limit for PMAP+, and are not part of any other title XIX waiver program, should be reported on Forms CMS-64.9 Base and/or 64.9P Base as instructed in the SMM.

Base as instructed in the SMM.

b) For monitoring purposes, cost settlements associated with expenditures subject to the budget neutrality expenditure limit may be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements not so associated, the adjustments must be reported on lines 9 or 10C, as instructed in the SMM.

c) For each DY, beginning in waiver year 8, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted reporting expenditures for the demonstration populations, by eligibility group. Payments made to provide health care services to the eligibility groups listed below are the expenditures subject to the budget neutrality expenditure limit. The State must complete separate pages for the following eligibility groups:

i. **Minnesota Care Children < 21 Years** (waiver name: "MC Children<21"),

ii. **MA Children Age One** (waiver name: "MA Children Age 1"),

iii. **MinnesotaCare Pregnant Women** (waiver name: "PREGNANT WOMEN"),

iv. **MinnesotaCare Caretaker Adults** (waiver name: "ADULT CARETAKERS").

v.

d) For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in Section IV, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

d) **Premiums and Pharmacy Rebates.** Premiums that are collected by the State from enrollees whose expenditures are subject to budget neutrality must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. Pharmacy rebates are reported on Form CMS-64.9 base, Service Category Line 7. Neither premium collections nor pharmacy rebates figure into the calculation of net expenditures subject to the budget neutrality test.

e) **Payments for Health Plan Performance.** The State makes annual payments to recognize health plan performance of contractual targets during the previous calendar year. Such payments should be allocated on the CMS-64 waiver pages to reflect the amounts attributable to waiver group and waiver year in the following manner. First, determine the percentage distribution of each calendar year's payment amount by waiver year and waiver group. Then apply those same proportions to the payment totals for the same calendar year.

f) **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 such administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using "MA Demo" as the waiver name.

g) **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made

within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

49. **Reporting Member-Months: Quarterly Progress Report.** For the purpose of calculating the budget neutrality expenditure limit, the State will provide to CMS on a quarterly basis the actual number of eligible member/months for each of the four eligibility groups (EGs) defined in (b) below. The enrollment data will be submitted to the CMS Project Officer 60 days after the end of each quarter as part of the quarterly progress report. To permit full recognition of "in-process" eligibility, reported counts of member months shall be subject to minor revisions as needed.

a) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

b) Member months must be provided for the following categories of enrollees, which correspond to categories that appear in the eligibility table in paragraph 17 (Eligibility):

i. **MinnesotaCare Children < 21 years**

ii. **MA One Year Olds**

iii. **MinnesotaCare Pregnant Woman**

iv. **MinnesotaCare Caretaker Adults**

50. **Standard Medicaid Funding Process: CMS-37.** The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will 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.

51. **Medical Education and Research Costs (MERC).** Claims eligible for FFP, based on payments from the MERC Trust Fund as described in paragraph 38**,** must be reported on separate Forms CMS-64.9 Waiver and 64.9 Waiver, on line 18E, using waiver name, "MERC 1115." These expenditures are not subject to the budget neutrality expenditure limit.

52. **Extent of Federal Financial Participation for the Demonstration.** CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Section X.

a) Administrative cost, including those associated with the administration of the PMAP+ Demonstration;

b) Net expenditures of the Medicaid program that are paid in accordance with the approved State Plan and waivers granted for the purpose of implementing PMAP+ ; and

c) Net expenditures that are paid in accordance with the approved expenditure authorities granted for the purpose of implementing PMAP+.

53. **Sources of Non-Federal Share**. The State certifies that the source of the non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with Title XIX of the Social Security 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) The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program

(c) Additionally, the State shall provide information to CMS regarding any modifications to the existing source of non-Federal share for expenditures claimed under PMAP+. This information shall be provided to CMS, and is subject to CMS approval, prior to CMS providing FFP at the applicable Federal matching rate for any valid PMAP+ expenditures.

(d) 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 and/or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid and Demonstration 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 or the Demonstration and in which there is no connection to Medicaid or Demonstration payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

54. **State Certification of Funding Conditions**. The State certifies 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 used as the non-Federal share of Title XIX payments.

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 must certify to the State the total computable amount of 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 in accordance with Title XIX of the Social Security Act and implementing regulations. 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. Additionally, all transfers must occur prior to the specific payments under the demonstration which the transfers are designated to fund. 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 or Demonstration 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 or the Demonstration and in which there is no connection to Medicaid or Demonstration payments, are not considered returning and/or redirecting a Medicaid or Demonstration payment.

e) Nothing in these STCs concerning certification of public expenditures relieves the State of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

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

56. 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.

XI. MONITORING BUDGET NEUTRALITY

557. **Limit on Title XIX Funding.** The State will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on expenditures for the eligibility groups listed in paragraph 45(c) during the demonstration period. This limit will be determined using a per capita cost method. In this way, the State will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid eligibles, CMS assures that the State demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

58. **Projecting Service Expenditures.** Each DY estimate of Medicaid service expenditures will be calculated as the product of the projected per member/per month (PMPM) cost times the actual number of eligible member months for the eligibility groups listed in paragraph 45(c) as reported to CMS by the State under the guidelines set forth in Section X, paragraph 45. The budget neutrality expenditure limit for the eligibility groups listed in paragraph 45(c) is the sum of these annual limits for all DYs.

59. **Calculation of the Budget Neutrality Expenditure Limit.** The following are the PMPM costs for the calculation of the budget neutrality expenditure limit for the demonstration enrollees in the eligibility groups listed in paragraph 45(c) under this extension period. ***The demonstration year is July 1 through June 30.***

Eligibility Group	Trend Rate	DY 17 SFY 2012 PMPM	DY 18 SFY 2013 PMPM	DY 19 SFY 2014 PMPM
MinnesotaCare Children	4.9 %	$280.00	$293.72	$308.11
MA Children Age One	4.9 %	$324.42	$340.32	$357.00
MinnesotaCare Pregnant Women	5.3%	$861.51	$907.17	$955.25
MinnesotaCare Caretaker Adults	5.3 %	$557.64	$587.19	$618.31

*** Historical PMPM limits for DY 1 (1996) through DY 16 (2011) are provided in Attachment A.**

60. **Application of the Budget Neutrality Test.** The budget neutrality limit for the eligibility groups listed in paragraph 45(c) shall consist of a comparison between the Federal share of the budget neutrality expenditure limit for the demonstration and the amount of FFP that the State has received for expenditures subject to that limit.

a) The Federal share of the budget neutrality expenditure limit for the eligibility groups listed in paragraph 45(c) is equal to the budget neutrality limit for the demonstration multiplied by the Composite Federal Share.

b) The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C, by total computable expenditures as reported for the same period on the same schedule. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative method based on mutual agreement.

61. **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 cumulative expenditures exceed the calculated budget neutrality expenditure limit by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan for CMS for approval

Demonstration Year	Cumulative Expenditure Limit Definition	Percentage
Year 1 through 17	Budget Neutrality expenditure cap plus	1.0 percent
Year 1 through 18	Combined budget neutrality expenditure cap plus	0.5 percent
Year 1 through 19	Combined budget neutrality expenditure caps plus	0 percent

62. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period, the budget neutrality expenditure limit for the demonstration 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.

XII. EVALUATION OF THE DEMONSTRATION

1. 63.**Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS' approval of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II of these STCs, as well as the specific hypotheses that are being tested, including those indicators that focus specifically on the target populations and the public health outcomes generated from the use of Demonstration funds. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It 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 must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

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

3. **65. Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design described in paragraph 54 within 60 days of receipt, and the State must submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the Demonstration. CMS must 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.

4. **66. 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 as requested.

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE TERM OF THIS DEMONSTRATION EXTENSION

Date	Deliverable
Per paragraph 58	Submit Draft Evaluation Design
Per paragraph 8	Submit to CMS Demonstration Extension Application per the

	timeframe requirements in paragraph 8 and Interim Evaluation Report for the current extension period
Quarterly	**Deliverables**
	Requirements for Quarterly Report, paragraph 42
	Enrollment Reports, paragraph 42
	Expenditure Reports, paragraph 44
Annual	**Deliverables**
	Submit Draft Annual Reports, paragraph 43

ATTACHMENT A
HISTORICAL PMPM FOR THE PMAP + SECTION 1115 DEMONSTRATION

DY	SFY	Pregnant Women	MinnesotaCare Children	MA Children	Caretak Adults
1	1996	$532.85	$77.28	$480.34	$0
2	1997	$550.96	$84.84	$516.00	$0
3	1998	$780.63	$93.34	$534.46	$0
4	1999	$808.73	$98.57	$563.86 - 1st 6 m $198.10 - 2nd 6 m	$135.46
5	2000	$855.64	$105.82	$212.68	$143.32
6	2001	$905.26	$113.61	$228.33	$151.63
7	2002	$957.78	$121.97	$245.14	$160.42
8	2003	$455.17	$152.97	$177.25	$294.62
9	2004	$491.58	$164.23	$190.30	$318.19
10	2005	$530.91	$176.32	$204.30	$343.64
11	2006	$573.38	$189.30	$219.34	$371.13
12	2007	$619.25	$203.23	$235.48	$400.82
13	2008	$668.79	$218.19	$252.81	$432.89
14	2009	$715.28	$233.35	$270.38	$462.98
15	2010	$764.99	$249.56	$289.17	$495.16
16	2011	$818.15	$266.91	$309.27	$529.57