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

NUMBER: 11-W-00180/0 (Title XIX Medicaid funding)

TITLE: Washington Medicaid Reform Waiver

AWARDEE: State of Washington Department of Social and Health Services

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I. PREFACE

The following are Special Terms and Conditions (Special Terms and Conditions) for the Washington State's section 1115 demonstration program, entitled Washington Medicaid Reform Waiver, Project No. 11-W-00180/0. The Special Terms and Conditions have been arranged into the following subject areas: General Requirements and Agreements, General Reporting Requirements, Legislation, Assurances, and Operational Protocol.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services (CMS) Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter.

The state agrees that it will comply with all applicable Federal statutes relating to nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

II. GENERAL PROGRAM REQUIREMENTS AND AGREEMENTS

1. **Extension or Phase-out Plan.** No later than 18 months prior to the expiration of the demonstration, the State must notify CMS whether it plans to request an extension of the demonstration. Requests for extensions will be due no later than 1 year prior to the expiration of the demonstration. If the State does not intend to request an extension, it must submit to CMS a phase-out plan no later than 1 year prior to the expiration of the demonstration. The phase-out plan is subject to CMS review and approval.

2. **Evaluation.** The State shall submit to CMS for approval within 90 days from the award of the demonstration a draft design of an evaluation design . At a minimum, the report shall include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the demonstration) that are being tested. The report will discuss the outcome measures that will be used in evaluating the impact of the demonstration during this extension period, particularly among the target population. It will discuss the data sources and sampling methodology for assessing these outcomes. The evaluation design must include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those other initiatives occurring in the State. The report will identify whether the State will implement the evaluation, or select an outside contractor for the evaluation. CMS will provide comments on the report within 30 days of receipt, and the State will submit a final report within 30 days of receipt of CMS comments.

   The State will implement the evaluation design, and submit to CMS a draft evaluation report 120 days prior to the expiration of this demonstration. CMS will provide comments within 60 days of receipt of the report. The State shall submit the final report prior to the expiration date of this demonstration.

3. **CMS Right to Suspend or Preclude Demonstration Implementation.** The CMS may suspend or preclude Federal Financial Participation (FFP) for State demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.

4. **State Right to Terminate or Suspend Demonstration.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. If the State chooses to terminate this demonstration before the expiration date, it will notify CMS in writing at least 30 days prior to terminating services to participants. If CMS or the State terminates the demonstration, the State will, at least 30 days prior to terminating services, notify the participants of the services of the action it intends to take, notify them of the effective date of the action, and how the action will affect the participants.

5. **CMS Right to Terminate or Suspend Demonstration Operation.** During demonstration operation, CMS may suspend or terminate FFP for this project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination. The effective date of such action shall not be fewer than 45 days from the date of notice. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the State materially failed to comply. The CMS reserves the right to withhold waivers and authority for pending FFP for costs not otherwise matchable or to withdraw waivers or authority for costs not otherwise matchable at any time, if it determines, after good faith consultation with the State, that granting or continuing the waivers or authority for costs not otherwise matchable would no longer be in the public interest. If the waiver or authority for costs not otherwise matchable is withdrawn, CMS will be liable only for normal closeout costs.

III. GENERAL REPORTING REQUIREMENTS

1. **Monthly Progress Calls.** Before and for 6 months after implementation, CMS and the State will hold monthly calls to discuss demonstration progress. After 6 months of operation, CMS and the State will determine the appropriate frequency of progress calls.

2. **Quarterly and Annual Progress Reports.** The State will submit quarterly progress reports that are due no later than 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include and overview of the past year as well as the last quarter, and will serve as the annual progress report. These reports must include information on operational and policy issues appropriate to the State's program design and provide progress on the evaluation. The report must also include information on any issues that arise in conjunction with the demonstration.

3. **Final Report.** At the end of the demonstration, a draft final report must be submitted to CMS for comments. The CMS' comments shall be taken into consideration by the State for

incorporation into the final report. The CMS's document *Author's Guidelines: Grants and Contracts Final Reports* is available to the State upon request. The final report is due no later than 180 days after the termination of the project. The final report will incorporate the final evaluation report, or it will be provided at the same time as a stand-alone document.

IV. LEGISLATION

1. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. If the law, regulation, or policy statement cannot be linked specifically with program elements of the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

2. **Changes in Federal Law Affecting Medicaid.** The State will, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt state section 1115 demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

   If the new law cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology to CMS for complying with the change in law. If the methodology were consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

3. **Amending the Demonstration.** Washington will request modifications to the demonstration by submitting revisions to the protocol for CMS approval. These modifications will include technical changes in policy and procedures. Substantive changes to the demonstration design (i.e., family planning expansion, and the inclusion of institutionalized individuals within the waiver population) will require submission of a formal amendment to the proposal and advance CMS approval. The State will work with CMS in amending the waiver application in the later stages of the demonstration program.

V. COST SHARING

1. **Demonstration Population.** Premium amounts for demonstration population eligibles (Categorically Needy optional Children) are set forth in the State's July 18, 2003 proposal, but may be changed by the State, with CMS prior approval, through an amendment to the State's Operational Protocol (as described in section VII of these Special Terms and Conditions). Prior to implementing any exemption for American Indian and Alaska Native children from premiums, as requested in the demonstration application, the following steps must be completed. Washington must submit to CMS an explanation of how such an exemption is consistent with the strict scrutiny test applicable for race, color or national origin classifications under title VI of the Civil Rights Act of 1964. Washington's explanation will be subject to review and approval by the appropriate components of the Department of Health and Human Services. Such an exemption may be implemented only if the explanation is accepted by the Department.

VI. ASSURANCES

Acceptance of the Special Terms and Conditions of Approval constitutes the State's assurance of the following:

1. **Preparation and Approval of the Operational Protocol.** Prior to service delivery under the demonstration, an Operational Protocol document, which represents all policies and operating procedures applicable to the demonstration, will be prepared by the State and approved by CMS. The State acknowledges that CMS reserves the right not to approve an Operational Protocol in the event that it does not comply with the Special Terms and Conditions of Approval, and that approval of changes in premium levels is discretionary with CMS. *Requirements and required contents of the Operational Protocol are outlined in Section VII of these Special Terms and Conditions.*

2. **Adequacy of Infrastructure.** Adequate resources for implementation, monitoring activities, and compliance with the Special Terms and Conditions of the demonstration will be provided by the State.

3. **Evaluation and Monitoring Design.** The State will conduct formative and possible outcome evaluations of the impact of the demonstration on participants and eligibles. The State acknowledges the importance to CMS of formative evaluation to the operation, quality improvement and possible modification to innovative demonstration initiatives.

4. **Budget Neutrality.** The cost of services provided during the demonstration will be no more than 100 percent of the cost to provide Medicaid services without the demonstration.

5. **Public Notice and Consultation.** The State will comply with the public notice requirements issued via September 27, 1994 edition of the *Federal Register*, Vol. 59, No. 186 dated September 29, 1994, and Centers for Medicare & Medicaid Services (CMS) requirements regarding Native American tribal consultation.

VII. OPERATIONAL PROTOCOL

1. **Operational Protocol Timelines and Requirements.** The Operational Protocol will be submitted to CMS no later than 60 days prior to program implementation. The CMS will respond within 30 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the Special Terms and Conditions, those issue being necessary to approve the Operational Protocol. FFP is not available for Medicaid Assistance Payments prior to CMS approval of the Operational Protocol. The FFP is available for post-approval project development and implementation, and compliance with Special Terms and Conditions. Subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures will be submitted for review by CMS. The State will submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

2. **Required Contents of Operational Protocol:**

   a) **Organization and Structural Administration.** A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform. Include details such as a timeline of demonstration implementation tasks prior to and post implementation, including steps, estimated time of completion, and who will be responsible for items.

   b) **Reporting Items.** A description of the content and frequency of each of reporting items as listed in Attachment A of this document.

   c) **Premiums.** A description of the calculation and collection of applicable premiums. Include the following:

      - Premium amounts,
      - How they were calculated;
      - How they will be reported to CMS (refer to items 2.d. and 6. of Attachment A of this document); and,
      - The process through which enrollees and providers will be informed of enrollee financial obligations.

   d) **Premium Protections.** A description of the enrollee protections in place regarding State disenrollment of enrollees due to non-compliance with premium requirements for demonstration participation, and how enrollees will be informed. For example:

      - The grace period during which enrollees may make applicable premium payments without termination from the program;

- How the State will notify the enrollee that he or she has failed to make the required payment and may face termination from the program if the payment is not made;
- How the individual will be assured the right to appeal any adverse actions for failure to pay premiums; and,
- The process in place to re-enroll the individual in the demonstration if payment of the required premium is paid.

e) **Outreach/Marketing/Education.** A description of the State's outreach, marketing, education, staff training strategy/schedule. Include in the description:
- Information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers, or contracted parties);
- Types of media to be used;
- Specific geographical areas to be targeted;
- Locations where such information will be disseminated;
- Staff training scheduled, schedules for State forums or seminars to educate the public; and,
- The availability of bilingual materials/interpretation services and services for individuals with special needs. Include a description of how eligibles will be informed of cost sharing responsibilities and the training provided to State staff regarding educating beneficiaries on the universe of XIX program options available to them.

f) **Eligibility/Enrollment.** A detailed description of the population of individuals eligible for the demonstration (and eligibility exclusions). Describe the processes for the following, and include the State agency responsible for each of the processes:
- Eligibility determination;
- Annual redetermination;
- Intake, enrollment, and disenrollment; and,

g) **Quality.** Describe the State's overall quality assurance monitoring plan. The plan should include, at a minimum, the following:
- A discussion of how the State will monitor operations of the program (personnel and systems);
- The system in place to trigger and alert State staff to issues that need attention;
- All quality indicators to be employed to monitor service delivery under the demonstration and the methodology for measuring such indicators;
- The system to be put in place so that feedback from quality monitoring will be incorporated into the program;
- Quality monitoring surveys, and the monitoring and corrective action plans to be triggered by the surveys;
- Fraud control provisions and monitoring; and,
- Monitoring for the effects of any undue burden on categorically needy optional families due to the premiums imposed through this demonstration.

h) **Grievances and Appeals.** If the grievances and appeals policies differ from non-demonstration Medicaid, then provide a description of the grievance and appeal policies that will be in place in the demonstration and how the process will be monitored.

i) **Evaluation Design.** The State will provide a more detailed description of the State's evaluation design included in its approved proposal, including:

1. A discussion of the demonstration hypotheses that will be tested;
2. Outcome measures that will be included to evaluate the impact of the demonstration;
3. What data will be utilized;
4. The methods of data collection;
5. How the effects of the demonstration will be isolated from those other initiatives occurring in the State;
6. Any other information pertinent to the State's evaluative or formative research via the demonstration operations;
7. The number of individuals whose eligibility is terminated for nonpayment of required premiums; and,
8. How the premium structure will be monitored against undue burden on participants/eligibles.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits that are established in accordance with Attachment B (Monitoring Budget Neutrality).

2. a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap 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 demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.b.

   b. For each demonstration year, a separate Form CMS-64.9 WAIVER and/or 64.9P WAIVER will be submitted reporting expenditures for individuals enrolled in the demonstration. The sum of the quarterly expenditures for all demonstration years will represent the expenditures subject to the budget neutrality cap (as defined in 2.c.). The procedures for the reporting to these expenditures will be described in the Operational Protocol.

   c. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of individuals who are enrolled in the demonstration. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and will be reported on Form CMS 64.9 WAIVER and/or 64.9P WAIVER.

   d. Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the demonstration will be reported to CMS on the CMS-64 Summary Sheet on Line 9.D., in order to assure Medicaid is properly credited with premium collections.

e. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs will be identified on the Forms CMS-64.10 WAIVER and/or 64.10P WAIVER.

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

g. The procedures related to this reporting process, report contents, and frequency must be discussed by the State in the Operational Protocol (see Section VII).

3. a. For the purpose of calculating the budget neutrality expenditure cap referenced in Attachment B, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined below. This information should be provided to CMS in conjunction with the quarterly progress report referred to in Special Term and Condition III-2. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section VII).

b. The term, "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 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.

c. The term "demonstration eligibles" refers to categorically needy optional children: 1) under age 1 whose family income exceeds 185 percent FPL; 2) Age 1 through 5 whose family income exceeds 133 percent FPL; and, 3) Age 6 through 18 whose family income exceeds 100 percent FPL.

4. The standard Medicaid funding process will be used during the demonstration. Washington must estimate total matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable/federal share) subject to the budget neutrality cap must be separately reported by quarter for each federal fiscal year on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in Attachment B. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

5. CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits referenced in Attachment B:

   a. Administrative costs, including those associated with the administration of the demonstration.
   b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.
   c. Net medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration.

6. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

ATTACHMENT B
MONITORING BUDGET NETURALITY

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, Washington 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 Washington at risk for changing economic conditions. However, by placing Washington at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

Base Year Expenditures

The base year expenditure and per capita amounts, and demonstration years trended per capita amounts must be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments; if necessary adjustments must be made. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act.

The base year is federal fiscal year 2002 and constitutes historical expenditure and utilization data provided by Washington for demonstration eligibles. Base year expenditure and enrollment data (calculated in member months) were used to calculate base year per capita costs for current eligibles under this demonstration. The base year cost is $102.16.

Base year expenditures and trended per capita amounts were not included for Medicaid State Plan amendments submitted after the established base year. All State Plan amendments submitted before or during the base year must be reflected in the base year data finalized with CMS.

Projecting Service Expenditures

Each demonstration year (DY) budget estimate of Medicaid service expenditures will be calculated as the product of the monthly per person cost times the actual number of eligible/member months trended annually as reported to CMS by the State under the guidelines set forth in Attachment A number 3.a. If the Demonstration Years do not align with the established base year, Demonstration Year budget limits must be calculated by pro-rating the agreed-upon annual trend rate for the appropriate number of months.

Using the trend rates to produce Demonstration Year PMPM cost estimates

Since the beginning and the end of the demonstration do not coincide with the base year, the following methodology was used to produce DY PMPM cost limits. Using a monthly equivalent growth rate, the appropriate number of monthly trend factors was used to convert base year PMPM costs to PMPM costs for the first DY. The formula for the monthly equivalent rate of 7.2 percent is $(1.072)^{1/12} = 1.005811$ or .5811 percent. To convert the FFY 2002 base year cost to DY1 per capita cost (a period of 29 months) the following formula was applied: $102.16 \times [(1.05811)^{29}] = \$120.85$. The first DY 1 begins February 1, 2004 through January 31, 2005. After the first DY, the annual trend factor of 7.2 percent will be used to trend forward from one year to the next.

The per capita budget ceiling for each demonstration year for trend rate for Demonstration Population Eligibles (Categorically Needy optional Children) is listed below.

Demonstration Year	Per Member Per Month (PMPM)	Annual Trend Rate
2004	$120.85	7.2%
2005	$129.55	7.2%
2006	$138.88	7.2%
2007	$148.87	7.2%
2008	$159.59	7.2%

How the limit will be applied

The limit calculated above from the trended service expenditures will apply to actual expenditures for demonstration services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for beneficiaries and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

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

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

Expenditure Review

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

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent