CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00342/4

TITLE: Georgia Pathways to Coverage

AWARDEE: Georgia Department of Community Health

Title XIX Costs Not Otherwise Matchable Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Georgia for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from October 15, 2020 – September 30, 2025, unless otherwise specified, be regarded as expenditures under the state's title XIX plan. The demonstration will be implemented effective July 1, 2021.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Georgia to operate the above-identified section 1115(a) demonstration.

1. **Low Income Adults.** Expenditures to provide medical assistance to individuals ages 19 – 64 with income up to 95 percent (effectively 100 percent with the 5 percent income disregard) of the federal poverty level (FPL), who are not otherwise eligible for Medicaid, as described in the STCs.

2. **Mandatory Employer-Sponsored Insurance.** Expenditures to the extent necessary to provide premium assistance and assistance for associated cost sharing to subsidize the employee's share of the costs of insurance premiums for employer-sponsored health insurance, as described in the STCs.

Title XIX Requirements Not Applicable to the Demonstration Eligible Populations

All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly identified as not applicable to these expenditure authorities shall apply to the demonstration for the period of this demonstration.

1. **Eligibility and Reasonable Promptness** **Section 1902(a)(8) and 1902(a)(10)(A)**

   To the extent necessary to enable the state to require qualifying hours and activities and premium payments as a condition of eligibility as described in the STCs.

   To the extent necessary to enable the state to begin Medicaid coverage on the first day of the month following receipt of a beneficiary's initial premium payment and verification of compliance with the qualifying hours and activities requirement as described in the STCs.

2. Methods of Administration **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable the state to not provide non-emergency medical transportation services (NEMT), except for individuals eligible for early periodic screening, diagnostic and treatment (EPSDT) services as described in the STCs.

3. Provision of Medical Assistance **Section 1902(a)(8)**

To the extent necessary to suspend and terminate eligibility for individuals who fail to comply with the qualifying hours and activities requirement as described in the STCs.

4. Amount, Duration, Scope of Services and Comparability **Sections 1902(a)(10)(B) and 1902(a)(17)**

To the extent necessary to enable the state to allow beneficiaries to receive benefits provided through an ESI plan without wrap-around benefits.

5. Premiums **Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**

To the extent necessary to enable the state to require monthly premium payments, as described in the STCs.

6. Comparability **Sections 1902(a)(10)(B) and 1902(a)(17)**

To the extent necessary to enable the state to vary premium and cost sharing requirements for different beneficiaries based on income and other factors as described in the STCs.

7. Retroactive Eligibility **Section 1902(a)(34)**

To permit the state not to provide retroactive eligibility to individuals in the demonstration.

8. Hospital Presumptive Eligibility **Section 1902(a)(47)(B)**

To permit the state not to provide hospital presumptive eligibility to individuals in the demonstration.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00342/4

TITLE: Georgia Pathways to Coverage

AWARDEE: Georgia Department of Community Health

I. PREFACE

The following are the STCs for the "Georgia Pathways to Coverage" section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Georgia Department of Community Health (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the state expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. The Georgia Pathways to Coverage demonstration will operate statewide and is approved for a 5-year period from October 15, 2020 – September 30, 2025. The state will implement the demonstration effective July 1, 2021.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

With this approval, Georgia's Pathways to Coverage demonstration will provide Medicaid coverage to individuals ages 19 through 64 who have household incomes up to 95 percent of the federal poverty level (FPL) (effectively 100 percent with the 5 percent income disregard) who are not otherwise eligible for Medicaid coverage and who meet the eligibility criteria and requirements.

As a condition of eligibility, individuals must complete a minimum of 80 hours of qualifying activities monthly unless they require a reasonable accommodation due to a disability or experience a circumstance that gives rise to good cause for non-compliance after enrollment. Applicants and beneficiaries may satisfy the qualifying hours and activities requirement through a variety of qualifying activities described in these STCs. Certain applicants will also be required to make a premium payment within 90 days of the eligibility determination before Medicaid coverage will begin, unless they meet the criteria for an exemption from the premium payment requirement as described in these STCs.

The monitoring and evaluation sections in the STCs specify that CMS has the authority to require the state to submit a corrective action plan if monitoring or evaluation data indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid. The STCs further specify that any such corrective action plan, submitted by the state, could include a temporary suspension of implementation of demonstration programs in circumstances where data indicate substantial, sustained, directional change, inconsistent with state targets (such as substantial, sustained trends indicating increased difficulty accessing services by those attempting to opt-in). These updates will aid the state in measuring and tracking the demonstration's impact on Georgians affected by it, and give CMS additional tools to protect applicants and beneficiaries, if necessary. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** 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 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in federal law, regulation, and written policy, not expressly

waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

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

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as well as a modified allotment neutrality worksheet as necessary, as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
   b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, 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, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPA) 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 appropriate state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plans governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, 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 either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based expenditures, will be available for changes to the

demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
   a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
   b. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;
   c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include 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 detail 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;
   d. An up-to-date CHIP allotment worksheet, if necessary; and
   e. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs, must submit a transition and phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:
   a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct

tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan, the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR part 431 subpart E. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw expenditure authorities and end the demonstration at any time it determines that continuing the expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must 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 an administrative hearing to challenge CMS' determination prior to the effective date. If expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and

enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

    The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. **Federal Financial Participation (FFP).** No federal matching for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid programs – including procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

16. **Eligibility.** Only adults ages 19 through 64 with income up to 95 percent of the FPL (effectively 100 percent with the 5 percent income disregard) are eligible to opt into Medicaid coverage under the Georgia Pathways to Coverage demonstration by meeting the requirements specified in these STCs. Individuals must also meet non-financial eligibility requirements (e.g., residency, citizenship or satisfactory immigration status) and other

eligibility requirements as described in these STCs. This demonstration eligible population is not otherwise eligible for Medicaid through the state plan and can only be covered under Medicaid through this demonstration.

17. **Demonstration Enrollment.** Eligibility under this demonstration is prospective only. At the point of application, individuals must report and provide documentation for meeting the qualifying hours and activities requirement for the month prior to application unless the individual self-attests to having a disability in their Medicaid application, in which case they would be considered for a reasonable accommodation. Applicants and beneficiaries can report compliance with the qualifying hours and activities requirement for the month prior to application by self-attestation, accompanied by the submission of supporting documentation online or in-person. Eligible individuals will receive an approval notice and an initial premium packet and must also pay their initial monthly premium (if applicable) as set forth in STC 25 and select a managed care organization (MCO) or be auto-assigned before they are enrolled in the Medicaid program.

18. **Effective Date of Coverage.** The state is not obligated to provide retroactive eligibility in accordance with section 1902(a)(34) for beneficiaries eligible for or enrolled in Medicaid under the Pathways to Coverage demonstration.
    a. Beneficiaries with household income from 0 up to 50 percent of the FPL do not have an initial and monthly premium payment requirement and their Medicaid coverage will begin the first day of the month following the state's eligibility determination.
    b. Beneficiaries with income at 50 percent up to 95 percent (effectively 100 percent with the 5 percent income disregard) of the FPL are required to make an initial and ongoing sliding scale monthly premium payments based on their household income as described in STC 25. Individuals will have ninety (90) days following their initial eligibility determination to make their first premium payment. Failure to make a payment during the ninety (90) day payment period will result in closure of the beneficiary's application as specified in STC 28. Individuals may reapply at any time. For individuals who make an initial premium payment, Medicaid coverage will begin the first day of the month following the initial premium payment. Beneficiaries must continue to make ongoing monthly premium payments as described in STCs 25-28, for continued Medicaid coverage.

V. BENEFITS

19. **Georgia Pathways to Coverage Program Benefits.** Beneficiaries enrolled in the demonstration will receive Medicaid state plan benefits with the exception of non-emergency medical transportation (NEMT). Beneficiaries ages 19 and 20 who receive Medicaid benefits under the demonstration will receive early and periodic screening, diagnostic, and treatment (EPSDT) services.

20. **Employer Sponsored Insurance.** Beneficiaries who are eligible for Medicaid under the demonstration and who are eligible for employer sponsored insurance (ESI) will be required to enroll in the state's Health Insurance Premium Payment Program (HIPP), if it is cost effective to the state. Beneficiaries enrolled in ESI will have a benefit package limited to the

services covered by their ESI and will not receive wrap-around services. Once eligible, the HIPP will provide reimbursement for monthly premium and cost sharing expenses.

a. ESI Cost Effectiveness. During the eligibility determination process, the state will determine if the employer-sponsored plan is cost-effective using a methodology that considers the amount paid under the MCO capitation rate versus what it would pay to cover the cost of premiums and associated cost-sharing under the demonstration. If the state determines the ESI plan is no longer cost-effective, the beneficiary will no longer be required to enroll in an ESI plan, and may receive Medicaid coverage under the demonstration, if still eligible.
b. ESI Cost Sharing. Beneficiaries intending to obtain care from an ESI provider that does not participate with Medicaid will need to:
    i. Submit a bill, invoice or other documentation to the state Medicaid third party liability (TPL) vendor agency demonstrating the member's liability no less than thirty (30) calendar days before payment is due. The state will pay the beneficiary prospectively for the beneficiary's cost sharing obligation when the required information is submitted timely.
    ii. The state may, at its discretion, pay cost sharing obligations prospectively if the member submits a bill or invoice less than thirty (30) calendar days before payment is due.
    iii. The beneficiary may file for a reimbursement of a copayment made at the point of service if they are unable to submit documentation prior to the appointment for an advanced payment.
c. ESI Disenrollment. Beneficiaries who voluntarily disenroll from ESI coverage while such coverage is available and cost-effective to the state will no longer be eligible for Medicaid coverage through the demonstration and may reapply at any time. Beneficiaries who lose ESI coverage or such ESI coverage is no longer cost effective to the state, may receive Medicaid coverage under the demonstration, if still eligible.

VI. MEMBER REWARDS ACCOUNTS

21. Member Rewards Account. All beneficiaries enrolled in Medicaid under the demonstration (except beneficiaries receiving premium assistance through the HIPP) will be provided with a Member Rewards Account (MRA). The MRA is an educational tool used to "deduct" beneficiary copayments, reflect accrued premium payment amounts (if applicable), and deposit incentives that have a dollar-value equivalent for completing healthy behavior activities as described in STC 22. Points in the MRA are non-monetary credits, that are converted to dollars for purposes of payment and when deducted for copayments and other allowable expenses. Any deduction does not result in actual charges to the beneficiary. If there are insufficient funds in the MRA to pay a copayment or other allowable expense, copayments will continue to be deducted, and any future premium payments or healthy incentive points will be applied to the negative balance. Beneficiaries will not be responsible for any copayments or other allowable expenses due to a negative MRA balance. Beneficiaries will have access to view their balance, including copayment deductions, premium credits, and healthy behavior credits consistent with the requirements in 42 CFR 435.918, and will also receive account statements that will include information about the amount used, the amount paid out of the MRA, and the remaining balance

22. **Healthy Behavior Incentives.** The state will provide dollar-value equivalent incentive points for healthy behavior activities, including but not limited to, attending smoking cessation classes, annual well visits, or complying with a diabetes prevention or management program. Once the balance of the MRA reaches a fifty (50) dollar-value equivalent, beneficiaries may use the MRA to access items and services not covered under Georgia's Medicaid state plan, such as dental services, glasses, contacts and over the counter drugs.

VII. COST SHARING

23. **Cost Sharing for Participants in the Demonstration.** All demonstration eligible beneficiaries, (except beneficiaries enrolled in HIPP) will be required to pay copayments for certain services consistent with Medicaid cost sharing rules. The copayments are described in Table 1 below and are consistent with copayments in the state plan, with the exception of a copayment for non-emergency use of the emergency department, as described in STC 24. Beneficiary copayments will not be collected at the point of service and will be retroactively deducted from the MRA based on encounter data. If there are insufficient funds in the MRA, copayments will continue to be deducted without any out of pocket expense to the beneficiary, as described in STC 21. Any future beneficiary premium payments (if applicable) or healthy incentive points earned will be applied to offset the negative balance, without any out of pocket expense to the beneficiary.

Table 1. Copayment Amounts

Service	Copay
Inpatient Hospitalization	$12.50 for entire stay
Outpatient Hospital Visit	$3.00 per visit
Non-emergency use of the emergency department	$30.00 per visit
Primary Care	$0.00
Specialist	$2.00
Durable Medical Equipment (DME)	$3.00 $1.00 for rentals and supplies
Pharmacy – Copayment varies based on the cost to the state.	$10.00 or less: $0.50 $10.01 to $25.00: $1.00 $25.01 to $50.00: $2.00 $50.01 or more: $3.00

24. **Non-Emergent Use of the Emergency Department.** A beneficiary's MRA will be reduced by thirty (30) dollars of non-monetary credits for each non-emergent visit to the emergency department. This deduction will be waived for any beneficiary who contacts their MCO's 24-hour nurse hotline prior to utilizing the emergency department. The beneficiary must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA, of the Act and have a medical professional determine that it is not an emergency using the prudent layperson standard—before their MRA balance can be reduced. Notwithstanding the fact that the MRA deduction is not cost sharing, the state must ensure that hospitals comply with the requirements described in 42

CFR 447.54(d)(2) related to educating beneficiaries about appropriate alternative settings before the state deducts the amount from the MRA. Emergency services are not subject to cost sharing per 42 CFR 447.56(a)(2).

25. **Premiums.** All beneficiaries, except beneficiaries described in Table 2 and beneficiaries exempt from premiums as described in 42 CFR 447.56, will be required to make initial and ongoing premium payments based on household income as described in Table 3 below. Premiums rates will not exceed two percent of the beneficiary's household income. Premium payments will be reflected in the beneficiary's MRA and a premium surcharge will apply to beneficiaries who use tobacco as described in STC 26(a).

Table 2. Populations Exempt from Premium Payments
Beneficiaries with employer-sponsored insurance enrolled in HIPP.
Beneficiaries enrolled in vocational education programs of highly sought-after trades through the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant programs. Beneficiaries are also exempt from premiums for two months after graduation.
Beneficiaries with income less than 50 percent of the FPL.

26. **Eligibility.** Beneficiaries must meet the eligibility requirements specified in these STCs and pay the first monthly premium (unless they are exempt from premium payments) in order for Medicaid coverage to begin. Individuals will have ninety (90) days following the initial eligibility determination to make their first premium payment, if applicable. Failure to make the initial payment within ninety (90) days will result in closure of the individual's case. Individuals required to pay premiums will not be enrolled in Medicaid until the initial premium payment has been made. Table 3 provides the monthly premium and tobacco surcharge amounts based on income. The state will determine the beneficiary's monthly premium amount based on the beneficiary's modified adjusted gross income.
    a. Tobacco Surcharge. Beneficiaries enrolled in Medicaid through this demonstration who self-attest as a tobacco user will be assessed a tobacco surcharge as indicated in Table 3 below. This surcharge is a separate deduction from the beneficiary's MRA and is not assessed with the monthly premium payment. If a beneficiary completes a smoking cessation program and attests to no longer using tobacco, the surcharge will be lifted. Smoking cessation programs are covered by Medicaid if the state's conditions of coverage for smoking and tobacco cessation are met. The tobacco surcharge is appealable for beneficiaries who believe they are not subject to the surcharge. The tobacco surcharge is not appealable for beneficiaries who attest to using tobacco but do not participate in a smoking cessation, or other qualified health improvement activity.

Table 3. Premium and Tobacco Surcharge Amounts		
Income	**Monthly Single Premium**	**Tobacco Surcharge**
From 50 percent up to 85 percent FPL	$7.00	$3.00
From 85% and up to 95 percent FPL (effectively 100 percent	$11.00	$5.00

with the 5 percent income disregard)		

27. **Premium Notices.** The state must notify applicants of the premium payment requirement at the time of their eligibility determination. Applicants will receive an initial premium packet with information about premium payment due dates; how to report changes in income; the time period over which income is calculated (e.g., monthly income); the deadline for reporting a change in circumstances; the consequences of non-payment (including the date of termination for failure to pay) and the consequences of failing to report changes in circumstance that could affect eligibility. Applicants will also be informed that once the premium payment is made the beneficiary may only change MCOs for cause, except during the beneficiary's annual enrollment opportunity. If a beneficiary misses a monthly premium payment deadline, they will receive a reminder notice outlining the missed payment, the deadline for the late payment, and the consequences of non-payment, including the date of suspension or disenrollment for failure to pay. The state will provide beneficiaries with advance notice of any adverse action prior to the date of action, consistent with 42 CFR 435.917 and 42 CFR part 431 subpart E.

28. **Missed Premium Payments.** Beneficiaries who miss one or two subsequent premium payments after making the initial premium payment will be granted a maximum of two grace period months in a benefit year. Beneficiaries will be given the following opportunities to avoid suspension and disenrollment and to prospectively reinstate coverage as described below:
    a. Grace Period. Beneficiaries who miss a premium payment will be given a two-month grace period and coverage will continue. There is a maximum of two grace period months in a benefit year. Payments made during the grace period will be applied to the following month. All missed premiums during a beneficiary's grace period will be forgiven at redetermination and the beneficiary's grace period will reset for the new certification year.
    b. Suspension. Beneficiaries who miss a total of three premium payments in a benefit year will have coverage suspended for up to ninety (90) days if they fail to make a payment before the next due date, except for beneficiaries who are in a grace period at the time of redetermination as described in STC 28(c). Beneficiaries will have ninety (90) days from the date of suspension to submit a payment in order to prospectively reinstate coverage. Beneficiaries who fail to make a payment within ninety (90) days of the suspension date will be disenrolled from Medicaid and will need to reapply for coverage.
    c. Redetermination. If at any time, including at redetermination, the state is made aware of a change in the beneficiary's income during the current enrollment period, the state will evaluate whether the beneficiary's premium amount should be adjusted. Outstanding premium payments from the prior benefit year will be forgiven.

29. **Beneficiary and State Contributions: State Assurances.** Prior to the implementation of the premium requirement as a condition of eligibility at the time of application and for continued eligibility, the state shall make the general assurance that it is in compliance with protections for beneficiaries related to STC 28, and will:

a. Permit the state or the MCO to attempt to collect the unpaid premiums from the beneficiary, but the state or the MCO will not report the premium amount owed to credit reporting agencies, place a lien on a beneficiary's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the beneficiary's earnings for enrollees at any income level. The state will not "sell" the obligation for collection by a third-party. Further, while the amount is collectible by the state, re-enrollment is not conditioned upon repayment.
b. Monitor that beneficiaries do not incur household cost sharing and premiums that, when combined, exceed five (5) percent of the aggregate household income, in accordance with 42 CFR 447.56(f), without regard to MCO enrollment of members in the household. Once a household reaches the cap, the state assures that no further copayments can be charged to beneficiaries, and the premium amount will be reduced for the remainder of the quarter to retain access to the My Rewards Account.
c. Charge copayment amounts, if applicable, that do not exceed Medicaid cost sharing permitted by federal law and regulation and the terms of this demonstration.
d. Ensure that the state, or its designee, does not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing are considered an administrative expense by the state.
e. Ensure that all payments from the beneficiary, or on behalf of the beneficiary, are accurately credited toward unpaid premiums in a timely manner, and provide the beneficiary an opportunity to review and seek correction of the payment history.
f. Ensure that the state has a process to refund any premiums paid for a month in which the beneficiary is ineligible for Medicaid services for that month.
g. Ensure that a beneficiary will not be charged a higher premium the following month due to nonpayment or underpayment of a premium in the previous month(s), except that amounts outstanding and due from the previous month/s may be reflected separately on subsequent invoices.
h. Ensure the state notifies beneficiaries whose eligibility has been suspended for failure to meet the qualifying hours and activities requirement, and provide written notice to prevent overpayment of premiums.
i. Conduct outreach and education to beneficiaries to ensure that they understand the program policies regarding qualifying hours and activities, good cause, premiums and associated consequences for nonpayment. Beneficiaries must be informed of how premium payments should be made; the potential impact of a change in income on premium payments owed; the consequences of failure to report a change in income or circumstances that affect eligibility; the time period over which income is calculated (e.g., monthly income); the deadline for reporting changes in circumstances; and how to reenroll if disenrolled for non-payment of premiums.
j. Provide all applicants timely determinations of eligibility in accordance with 42 CFR 435.912.
k. Provide all applicants and beneficiaries with timely and adequate written notices of any decision affecting their eligibility, including an approval, denial, termination, or suspension of eligibility, or a denial or change in benefits and services pursuant to 42 CFR 435.917 and consistent with 42 CFR 435.905(b) and 431.206-214.

l. The state must send a notice at least 10 days in advance of the date of action (as defined at 42 CFR 431.201 pursuant to 42 CFR 431.211-214.
m. Provide all applicants and beneficiaries with fair hearing rights consistent with 42 CFR part 431, subpart E.
n. Ensure program information is available, and accessible in accordance with 42 CFR 435.901 and 435.905.
o. Provide beneficiaries written notice of requirements to qualify for reactivation of Medicaid coverage following suspension or disenrollment due to non-payment of premiums described in STC 33.
p. Provide notice (consistent with 42 CFR 435.917 and 431.206-214) in advance of any adverse action, including information about the suspension period with an explanation of what the status means, including but not limited to: the right to appeal; the right to apply for Medicaid on a basis not affected by this status; what the suspension status means with respect to the ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange); what to do if circumstances change such that they may be eligible for coverage in another Medicaid category; as well as any implications with respect to whether they have minimum essential coverage.
q. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable accommodations related to premium payments.
r. Maintain a system that identifies, confirms, and provides reasonable accommodations related to the obligation to pay premiums to beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Patient Protection and Affordable Care Act.
s. Ensure the state will monitor the demonstration and, using information available to the state, work to identify any disparate impact on certain beneficiaries, based on characteristics including gender, sexual orientation, race or ethnicity.

VIII. DELIVERY SYSTEM

30. Overview. The Georgia Pathways to Coverage demonstration will use the current statewide managed care delivery system for all covered individuals under the authority of the Georgia Managed Care Organization (MCO) Program authorized in the state plan. Only eligible beneficiaries participating in ESI are exempt from mandatory managed care enrollment.

31. Managed Care Organization. Beneficiaries will be enrolled to receive services through one of the MCOs under contract with the state. The MCOs are subject to the federal laws and regulations as specified in 42 CFR Part 438, unless otherwise specified. Beneficiaries will be given the opportunity to select an MCO at the time of application or select to be auto-assigned.

IX. QUALIFYING HOURS AND ACTIVITIES REQUIREMENT

32. Overview. As a requirement for eligibility, applicants must complete a minimum of 80 hours of qualifying activities, as described in STC 33 before Medicaid coverage will begin. As a condition of maintaining Medicaid eligibility, beneficiaries will be required to continue

meeting the qualifying hours and activities requirement and report compliance, as specified in STC 34, unless they require a reasonable accommodation due to a disability as described in STC 37, or experience a circumstance that gives rise to good cause for non-compliance after enrollment, as described in STC 36.

33. **Qualifying Activities.** Beneficiaries may satisfy their qualifying hours and activities requirement through participation in one or more of the following activities:
    a. Subsidized or unsubsidized public or private sector employment, including self-employment and employment as an independent contractor;
    b. On-the-job-training in the public or private sector;
    c. Participation in job readiness activities directly related to the preparation for employment, including habilitation and rehabilitation activities and GED programs;
    d. Community service with public or non-profit organizations participating in projects that serve the community;
    e. Vocational Educational Training limited to 12 months in a beneficiary's lifetime, unless a beneficiary is enrolled in vocational education for a highly sought-after trade through the Technical College System of Georgia High Demand Career Initiative (in this instance, vocational education training may count as a qualifying activity for the duration of the vocational education program);
    f. Enrollment in an institution of higher education, (qualifying activity hours earned will vary based on course load); and
    g. Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program, as long as the beneficiary has been determined eligible for GVRA services based upon a documented disability and remains in compliance with the terms of the GVRA program.

34. **Hour Requirements and Reporting.** All applicants must be in compliance with the 80 hour qualifying activities and income eligibility requirements for the month prior to the application to be enrolled. Applications of individuals not in compliance with the qualifying hours and activities requirement at the time of application will be denied if the individual is not eligible for any other category of assistance. The individual may reapply at any time. Applicants and beneficiaries who report a disability at the point of application, or after initial eligibility, and who are not eligible for any other category of assistance based on their disability, may request a reasonable accommodation to assist with meeting the qualifying hours and activities as described in STC 37. An individual whose application is denied will receive information regarding other resources or activities to assist in meeting the hours and activities requirements and may reapply at any time. Beneficiaries must report their qualifying hours and activities monthly, except as specified below. Beneficiaries who report their qualifying hours and activities, and demonstrate that they meet these requirements, for six (6) consecutive months will be exempt from the monthly reporting requirement for the remainder of the beneficiary's 12-month benefit year. The state will perform periodic and random audits to verify documentation and compliance with qualifying hours and activities. Beneficiaries who no longer have to report compliance monthly are still required to report changes in circumstance such as income, employment or other qualifying activities that impact eligibility.

35. **Non-Compliance.** Applicants who do not comply with the qualifying hours and activities requirement as described in STCs 32-34, and who do not have a reasonable accommodation due to a disability reported at the time of application as described in STC 37, will have their application denied if they do not qualify for any other category of assistance. Beneficiaries who are enrolled in the demonstration and fail to meet the qualifying hours and activities requirement, and who do not have a reasonable accommodation due to a disability, or do not have a circumstance that gives rise to good cause, will have their eligibility suspended.
    a. Suspension Effective Date. Beneficiaries who fail to comply with the qualifying hours and activities requirement as described in STCs 32-34 and who do not have a circumstance that gives rise to good cause, will have eligibility suspended on the first day of the month following notification to the beneficiary of his or her non-compliance, consistent with the requirements in 42 CFR 431.211 and will have ninety (90) days from the notice of suspension to meet the qualifying hours and activities requirement for the suspension to be lifted.
    b. Reinstatement Following Non-Compliance. Beneficiaries may have coverage prospectively reinstated after a suspension if the beneficiary provides verification of compliance with the qualifying hours and activities requirement for one month. Coverage will be prospectively reinstated in the month immediately following the month in which a beneficiary meets the qualifying hours and activities requirements.
    c. Disenrollment and Re-enrollment Following Non-Compliance. Beneficiaries who do not meet the qualifying hours and activities requirements within the ninety (90) day suspension period will be disenrolled and can reapply for coverage at any time.

36. **Good Cause.** The state will consider a beneficiary who has been compliant with the qualifying hours and activities requirement for good cause if the beneficiary demonstrates a need for the good cause as a result for failing to meet or report the qualifying hours and activities requirement for that month. Beneficiaries may request a good cause from the qualifying hours and activities requirement up to a maximum of 120 hours during a 12 month benefit year. The circumstances constituting good cause must have occurred during the month for which the beneficiary is seeking a good cause exception. The circumstances that may give rise to good cause include, but are not limited to, the following verified circumstances:
    a. The beneficiary or an immediate family member experiences a hospitalization or a serious illness and as a result, is unable to fulfill the qualifying hours and activities;
    b. The beneficiary experiences a short-term injury or illness and as a result, is unable to fulfill the qualifying hours and activities;
    c. The beneficiary experiences the birth, adoption, or death, of an immediate family member;
    d. The beneficiary accepts a foster child placement, including those in kinship care;
    e. The beneficiary experiences a natural or human-caused disaster (including a public health emergency declared by the state in the county the person resides) and as a result, is unable to meet the requirements;
    f. The beneficiary has a family emergency or other life event (e.g., divorce, civil legal matter, or is a victim of domestic violence) and as a result, is unable to fulfill the hours and activities requirements;

g. The beneficiary is temporarily homeless and as a result, is unable to fulfill the hours and activities requirements;
h. The beneficiary is quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, or exposure to COVID-19, or because of a closure of the place(s) where the beneficiary was meeting the hours requirement related to COVID-19 and as a result, is unable to fulfill the hours and activities requirement; or
i. Other good cause reason(s) as defined and approved by the state.

37. Reasonable Accommodations. The state must provide reasonable accommodations to individuals with disabilities protected by the ADA, Section 504 of the Rehabilitation Act and Section 1557 of the Patient Protection and Affordable Care Act, who are unable to meet the qualifying hours and activities requirement either at the time of application, or after enrollment in the demonstration.

a. Reasonable accommodations may include:
    i. Modified activities hours when a beneficiary or applicant is unable to participate due to the otherwise-required number of hours if agreed upon by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity;
    ii. Other accommodations that have been agreed upon by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity;
    iii. Alternative mechanisms to report compliance; and
    iv. Support services necessary to participate; including, referrals to state programs currently providing rehabilitation services for individuals with disabilities
b. The state must also provide reasonable accommodations and protections for program procedures, including but not limited to: understanding notices and program rules related to the qualifying hours and activities requirement; documenting qualifying hours and activities; assistance with demonstrating eligibility; circumstances that give rise to good cause; appealing disenrollments; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable accommodations.
c. Disability Reported at Application. If an individual has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the qualifying hours and activities requirement for reasons related to that disability at the time of application, the state will determine if the individual is eligible for another eligibility category. If the individual is not eligible for another eligibility category, the beneficiary will be referred to a state rehabilitation services program for individuals with disabilities. If the individual accepts the referral and meets the program requirements set by the referral agency within (90) days, the individual will be determined eligible for the demonstration.
d. Disability Reported After Enrollment. If beneficiary becomes unable to meet the qualifying hours and activities requirement after enrollment due to a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act, or due to having to care for a family member with a disability defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act, the state will:

i. Modify the number of hours of required for participation if agreed upon by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity;
ii. Provide other accommodations that have been agreed to by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity, alternative mechanisms to report compliance; and/or
iii. Provide support services, including referrals to state programs currently providing rehabilitation services for individuals with disabilities.

e. Beneficiary Compliance with Reasonable Accommodation. If a beneficiary participates in a qualifying program that provides rehabilitation services and meets the activities requirements determined by the program, the beneficiary will continue to receive Medicaid enrollment under the demonstration.
f. Beneficiary Non-Compliance with Reasonable Accommodation. Beneficiaries who are offered a reasonable accommodation and are unwilling to comply with the qualifying hours and activities requirement with the reasonable accommodation provided by the state, their employer, supervisor, or representative of the organization that provides the qualifying activity, will be reevaluated by the state to determine eligibility for another Medicaid eligibility. If the beneficiary declines the states proposed accommodation, the beneficiary's Medicaid coverage will be terminated, subject to the beneficiary's appeal rights.

38. Qualifying Hours and Activities: State Assurances. Prior to implementing the qualifying hours and activities requirement as a condition of eligibility at the time of application and for continued eligibility after enrollment, the state shall:

a. Ensure that there are processes and procedures in place to stop or recoup payments to an MCO when a beneficiary is suspended for failure to comply with program requirements and to trigger payment when eligibility is reinstated.
b. Ensure, to the maximum extent practicable, that there are processes and procedures in place to seek data from other sources, including SNAP and TANF, regarding a beneficiary's potential satisfaction of the qualifying hours and activities requirement and systems to permit beneficiaries to efficiently report qualifying hours and activities or demonstrate circumstances that give rise to good cause, in accordance with 42 CFR 435.907(a), 435.916(c), and 435.945, and to permit the state to monitor compliance.
c. Ensure that activities that may be used to satisfy qualifying hours and activities requirement are available during a range of times and through a variety of means (e.g., online, mail, in person, by telephone) at no cost to the beneficiary.
d. Ensure that beneficiaries have been screened and determined ineligible for all other bases of Medicaid eligibility prior to disenrollment or denial of eligibility and reviewed for eligibility for insurance affordability programs in accordance with 42 CFR 435.916(f).
e. Maintain system capabilities to operationalize both the suspension of eligibility and the prospective reinstatement of eligibility once the qualifying hours and activities requirement is met as described in STC 36.
f. Provide outreach and education to inform new applicants about the qualifying hours and activities requirement and how the requirement must be satisfied beginning at the time of

application.

g. Ensure that there are timely and adequate beneficiary notices provided in writing consistent with 42 CFR 435.917(a), 435.905(b), and 431.206-214, including but not limited to:
    i. The specific number of qualifying hours per month that a beneficiary is required to complete, and when and how the beneficiary must report participation or request a good cause exception;
    ii. A list of the specific qualifying activities that must be used to satisfy the qualifying hours and activities requirement and a list of the specific activities that beneficiaries can engage in;
    iii. Information about resources that help connect beneficiaries to opportunities for activities that would meet the qualifying activities and information about the community supports that are available to assist beneficiaries in meeting their qualifying hours and activities;
    iv. Information about how qualifying hours will be counted and documented;
    v. Information about what gives rise to a suspension of eligibility, what suspension of eligibility would mean for the beneficiary, including how it could affect redetermination, and how to avoid suspension, including how to apply for good cause exception and what kinds of circumstances might give rise to good cause;
    vi. If a beneficiary has sought to demonstrate good cause, that the good cause has been approved or denied with an explanation of the basis for the decision and how to appeal a denial;
    vii. If a beneficiary is not in compliance, that the beneficiary is out of compliance, and, if applicable, how the beneficiary can resume compliance in the month immediately following in order to avoid suspension of eligibility;
    viii. If a beneficiary is suspended, information on how to appeal that decision and/or how to demonstrate compliance so that coverage can be reinstated or reapply for Medicaid benefits if the beneficiary has been disenrolled; and
    ix. The right of individuals with disabilities to establish reasonable accommodations of their qualifying hours and activities with examples of the reasonable accommodations in those requirements to which individuals may be entitled, including, assistance with documenting participation, referrals for vocational rehabilitation services or accommodations through a state program, good cause exceptions if after initial eligibility an individual becomes unable to participate for a disability-related reason, and if applicable, reductions in hours of required participation if an individual is unable to participate in the otherwise required numbers of hours.

h. Provide full fair hearing rights as required under 42 CFR part 431 subpart E prior to suspension or dis-enrollment, and observe all requirements for due process for beneficiaries whose eligibility will be suspended, denied, or terminated for failing to meet the qualifying hours and activities requirements, including allowing beneficiaries the opportunity to raise additional issues in a hearing, including whether the beneficiary should be subject to the suspension or disenrollment, and provide additional documentation through the appeals process.

i. Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the

state, consistent with all applicable Medicaid requirements.

j. Develop and implement an outreach strategy to inform applicants and beneficiaries about the qualifying hours and activities requirement, how to report compliance with or request good cause exceptions from the qualifying hours and activities requirements and how to report changes in circumstances. Notices provided at enrollment, and suspension will provide information on resources available to beneficiaries who may require assistance reporting compliance with qualifying activates, requesting good cause exceptions, or reporting changes in circumstances.
k. Establish beneficiary protections, including assuring to the maximum extent practicable, that beneficiaries do not have to duplicate requirements, if applicable, to maintain access to all public assistance programs that require employment or another form of qualifying hours and activities.
l. Make good faith efforts to connect beneficiaries to existing community supports that are available to assist beneficiaries in meeting their qualifying hours and activities, including available non-Medicaid assistance with transportation, child care, language access services and other supports.
m. Ensure the state assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with a lack of public transportation to determine whether there should be further good cause exceptions from the qualifying hours and activities requirement and/or additional mitigation strategies, so that the qualifying hours and activities requirement will not be unreasonably burdensome for applicants and beneficiaries to meet.
n. Develop and maintain an ongoing partnership with the Georgia Department of Community Health and other state entities such as the Georgia Department of Labor, the Department of Behavioral Health and Developmental Disabilities, and the Georgia Vocational Rehabilitation Agency, to assist recipients with identifying and accessing opportunities for workforce training, complying with qualifying hours and activities, and moving toward independence and self-sufficiency.
o. Provide each beneficiary who has been disenrolled from Medicaid with information on how to access primary care and preventative care services at low or no cost to the beneficiary. This material will include information about free health clinics and community health centers including clinics that provide behavioral health and substance use disorder services. Georgia shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries who have lost coverage.
p. Make the general assurance that the state is in compliance with protections for beneficiaries related to STC 37 and:
    i. Make good faith efforts to connect beneficiaries with disabilities as defined above with services and supports necessary to enable them to meet their qualifying hours and activities;
    ii. Maintain a system that provides reasonable accommodations related to meeting the qualifying hours and activities to beneficiaries with disabilities as defined above;
    iii. Ensure the state will assess whether people with disabilities have limited job or other opportunities for reasons related to their disabilities. If these barriers exist

for people with disabilities, the state will consider further good cause exceptions from the qualifying hours and activities requirement;

iv. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable accommodations related to meeting the qualifying hours and activities requirements; and

v. Ensure the state will monitor the demonstration and, using information available to the state, work to identify any disparate impact on certain beneficiaries based on characteristics including gender, sexual orientation, race or ethnicity.

X. GENERAL REPORTING REQUIREMENTS

39. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

40. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

41. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:
    a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
    b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
    c. Submit deliverables to the appropriate system as directed by CMS.

42. **Implementation Plan.** The state must submit a draft Implementation Plan to CMS for review and comment no later than ninety (90) calendar days after the start date of the demonstration approval period. The state must submit a revised Implementation Plan within sixty (60) calendar days after receipt of CMS' comments. The Implementation Plan must cover at least the key policies being tested under this demonstration, including qualifying hours and activities requirements, premiums, and the non-applicability of retroactive eligibility. Additionally, the state may be expected to provide additional details not captured in the STCs regarding implementation of the other demonstration policies, such as incentives for healthy behaviors, copayments for the non-emergent use of the emergency department, and the non-applicability of hospital presumptive eligibility, retroactive eligibility and NEMT. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment D. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the Implementation Plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

43. **Monitoring Protocol.** The state must submit to CMS a draft Monitoring Protocol no later than one hundred and fifty (150) calendar days after the start date of the demonstration approval period. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS' comments. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment E.

    At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS's templates. Any proposed deviations from CMS's templates should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state

will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as broadly described in STC 47 below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to qualifying hours and activities requirements, premiums and cost-sharing, incentives for healthy behaviors, and the non-applicability of retroactive eligibility. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates as described in STC 47 below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

44. **Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each demonstration year (DY). The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.
    a. Operational Updates. The operational updates will focus on progress towards meeting the milestones identified in CMS's framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
    b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's annual goals and overall targets as will be identified in the approved Monitoring Protocol, and will cover key policies under this demonstration, including but not limited to qualifying hours and activities, premiums, including tobacco surcharge, incentives for healthy behaviors, and the non-applicability of retroactive eligibility. The state is also expected to provide monitoring data on demonstration policies around ESI cost-effectiveness and cost sharing, and—if appropriate—the non-applicability of hospital presumptive eligibility. The performance metrics will also reflect all other components of the state's demonstration**.** For example,

these metrics will cover enrollment, disenrollment or suspension by specific demographics and reason, participation in the qualifying hours and activities requirement, access to care, and health outcomes. Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances, and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the CMS framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

45. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring data indicate substantial sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services, or unpaid medical bills). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

46. Close Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the Close-Out report.
c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after

receipt of CMS' comments.

e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 39.

47. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

48. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

XI. GENERAL FINANCIAL REQUIREMENTS

49. Allowable Expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

50. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on 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. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section XII: Monitoring Budget Neutrality.
    a. Administrative costs, including those associated with the administration of the demonstration;
    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
    c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

52. **Sources of Non-Federal Share.** The state certifies that its match for the non-federal share of funds for this section 1115 demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.
    a. The state acknowledges that CMS has authority to 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 acknowledges that any amendments that impact the financial status of this section 1115 demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

53. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:
    a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
    b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, 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 expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE

is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). 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 (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

54. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

55. Medicaid Expenditure Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The following table provides a master list of MEGs defined for this demonstration.

Table 4: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Low Income Adults	Hypo 1	X		X	See Expenditure Authority #1

56. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER,

identified by the demonstration project number assigned by CMS 11-W-00342/4. Separate reports must be submitted by MEG (identified by Waiver Name) and DY (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the DY will be offset against expenditures incurred in the DY for determination of the state's compliance with the budget neutrality limits.
c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.
d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the table below, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita, and as also indicated in the table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 5: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Low Income Adults	Refer to STC 16	*N/A*	Low Income Adults	Date of service *OR* Other	MAP	Y	October 15, 2020	September 30, 2025

57. Demonstration Years. The DY for this demonstration are defined in the table below.

Table 6: Demonstration Years		
Demonstration Year 1	October 15, 2020 to September 30, 2021	12 months
Demonstration Year 2	October 15, 2021 to September 30, 2022	12 months
Demonstration Year 3	October 15, 2022 to September 30, 2023	12 months
Demonstration Year 4	October 15, 2023 to September 30, 2024	12 months
Demonstration Year 5	October 15, 2024 to September 30, 2025	12 months

58. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member month's data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in section XI. CMS will provide technical assistance, upon request.[1]

[1] 42 CFR 431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration

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

60. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit 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 section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. 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. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement 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 STC. The state agrees that if mandated changes in the federal law require state legislation. The changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. If, after review and/or audit, the data supplied by the state to set the budget neutrality expenditure limit are if found to be inaccurate. The state certifies that the data it provided are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief.

XII. MONITORING BUDGET NEUTRALITY

61. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist

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approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

62. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the for all demonstration populations, 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 the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

63. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which projected fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

64. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of

CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

65. **Hypothetical Budget Neutrality Test 1.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 8: Hypothetical Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR *[define]*	TREND	DY 1	DY 2	DY 3	DY 4	DY 5
Low Income Adults	PC	Both	$556.98	4.5 %	$608.24	$625.74	$632.49	$658.08	$684.41

66. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. 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 by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, 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 mutually agreed to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

67. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from October 15, 2020 – September 30, 2025. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

68. **Mid-Course Correction.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and

approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 9: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
	Cumulative Target Definition	**Percentage**
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit	0.0 percent

XIII. EVALUATION OF THE DEMONSTRATION

69. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirement that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 39.

70. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

71. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after the start date of the demonstration approval period.

Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

a. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing CE Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.
b. All applicable evaluation design guidance, including guidance about qualifying hours and activities requirements, premiums, the non-applicability of NEMT, copayment for non-emergent use of emergency department, the non-applicability of retroactive eligibility, and the overall demonstration sustainability.

72. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment C to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval.

73. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS's measure sets for eligibility and coverage (including qualifying hours and activities requirements), Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF). Hypotheses for qualifying hours and activities requirements must relate to (but are not limited to) the following outcomes: employment levels, income, transitions to commercial health insurance, and health status. Hypotheses for premiums and beneficiary account payments must relate to (but are not limited to) the following outcomes: beneficiary familiarity with premiums as a feature of commercial coverage, efficient use of health services (applicable to states with beneficiary accounts only), and likelihood of enrollment and enrollment continuity. Evaluation of premiums must also account for the effectiveness of the tobacco surcharge policy. Hypotheses for suspension for non-compliance must relate to (but are not limited to) the following outcomes: beneficiary compliance with demonstration requirements,

enrollment continuity, and health status (as a result of greater enrollment continuity). Hypotheses for the non-applicability of retroactive eligibility and hospital presumptive eligibility must relate to (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, enrollment when people are healthy, and health status (as a result of greater enrollment continuity). Hypotheses for the non-applicability of NEMT must relate to (but is not limited to) the following outcomes: number of provider visits per 1,000 beneficiaries—overall and by provider type, unmet needs for medical transportation, and missed appointments. Hypotheses for copayment for non-emergent use of emergency department (ED) must relate to (but are not limited to) the following outcomes: number of ED visits per 1,000 beneficiaries for emergent as well as non-emergent conditions, number of visits per 1,000 beneficiaries to primary care, urgent care clinic, and retail clinic, and average ED waiting time. The state's evaluation must also address ESI cost-effectiveness and cost-sharing. In addition, the state must investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs. Finally, the state must use results of hypothesis tests and cost analyses to assess demonstration effects on Medicaid program sustainability.

74. **Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

75. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.
    a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted, should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
    d. The state must submit the final Interim Evaluation Report 60 calendar days after

receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

76. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

77. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services or unpaid medical bills). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

78. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

79. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

80. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS

may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

Attachment A:
Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Technical assistance resources for constructing comparison groups, identifying causal inferences, phasing implementation to support evaluation, and designing and administering beneficiary surveys are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html.

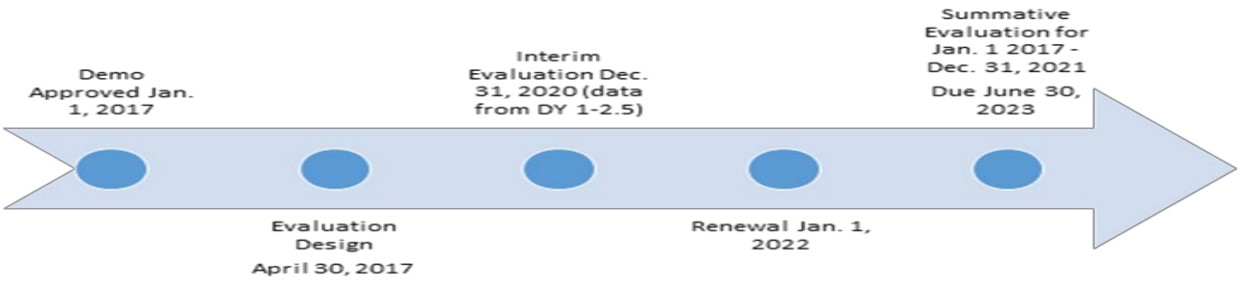
Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.
The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

a. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

b. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

c. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

d. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes;

e. Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

a. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

b. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended

outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

c. Identify the state's hypotheses about the outcomes of the demonstration:

   i. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   ii. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

a. *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
b. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
c. *Evaluation Period* – Describe the time periods for which data will be included.
d. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

   i. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
   ii. Qualitative analysis methods may be used, and must be described in detail.

a. Benchmarking and comparisons to national and state standards should be used, where appropriate.
b. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
c. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
d. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

e. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources. If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).
f. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
    i. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
    ii. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
    iii. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
    iv. The application of sensitivity analyses, as appropriate, should be considered.
g. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

a. **Special Methodological Considerations** – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:
When the demonstration is:
1) Long-standing, non-complex, unchanged, or
2) Has previously been rigorously evaluated and found to be successful, or
3) Could now be considered standard Medicaid policy (CMS published regulations or guidance)

When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
1) Operating smoothly without administrative changes; and
2) No or minimal appeals and grievances; and

3) No state issues with CMS-64 reporting or budget neutrality; and
4) No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

a. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include a "No Conflict of Interest" statement signed by the independent evaluator.

b. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

c. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B:
Preparing the Evaluation Report

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

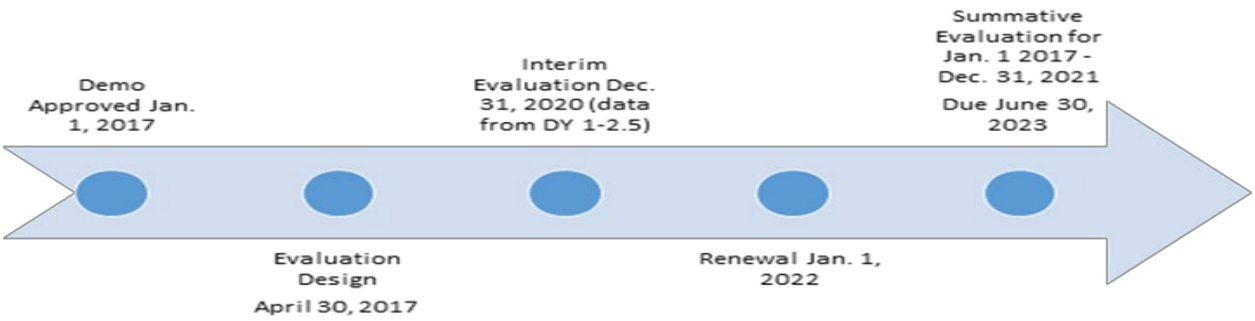
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;

B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines
There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports
The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the

data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2) *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period* – Describe the time periods for which data will be collected
4) *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic Methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make

judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1) What lessons were learned as a result of the demonstration?

2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment(s)

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C:
Evaluation Design (reserved)

Attachment D:
Implementation Plan (reserved)

Attachment E:
Monitoring Protocol (reserved)