

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



May 9, 2018

Dawn Stehle
Deputy Director for Health and Medicaid Director
Division of Health and Medicaid Services
Arkansas Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

Dear Ms. Stehle:

The Centers for Medicare & Medicaid Services (CMS) is approving Arkansas' request to extend its section 1115 demonstration project, entitled, "Arkansas TEFRA-like Section 1115 Demonstration" (Project No. 11-W-00163). CMS' approval of this demonstration extension is granted under the authority of section 1115(a) of the Social Security Act (the "Act") and is effective as of the date of this letter through December 31, 2022.

The Arkansas TEFRA-like Section 1115 Demonstration provides services to disabled children who meet the criteria for the optional Medicaid category commonly referred to as the "Katie Beckett Option" that was enacted into Medicaid law under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) (P.L. 97-248). The "TEFRA population" (also known as "Katie Beckett children") are children age 18 or younger with long-term disabilities, mental illness, or complex medical needs, in families with income that is too high to qualify for Medicaid, who could become Medicaid eligible if receiving extended care in an institutional setting. The TEFRA Medicaid eligibility option allows these disabled children to become Medicaid eligible based on their own income and resources in order to receive medical services in (less-costly) home-settings instead of in an institution. Arkansas uses section 1115 authority to provide coverage to TEFRA-eligible children but with a condition of coverage that monthly premiums are assessed for families with income above 150 percent of the Federal Poverty Level. However, a family's total annual cost-sharing is capped at five percent of the family's annual gross income.

All Medicaid title XIX requirements as expressed in law, regulation and policy statement not expressly waived or identified as not applicable in these approval documents shall apply to this demonstration. Arkansas' authority to deviate from Medicaid requirements is limited to the specific authorities described in the enclosed approval documents and to the purpose(s) indicated.

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility, and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstration is likely to assist with promoting the objectives of Medicaid. Consistent with federal transparency requirements, CMS also considers all public comments received during both the state and federal public input periods when evaluating whether the demonstration project as a whole will likely assist in promoting the objectives of Medicaid.

Arkansas and CMS did not receive any public comments during the state and federal public comment periods. However, several hundred comments noted in a Beneficiary Satisfaction Survey accompanying the state's extension application were reviewed. The commenters overwhelmingly were in support of the TEFRA-like demonstration and expressed gratitude for the services provided by this demonstration as being critical to being able to care for their children with special healthcare needs in the home instead of an institution. However, many of these same commenters, as well as others, expressed concerns about inefficient initial application and renewal processes, lack of timely notice and timeframe for families to submit annual renewal paperwork, lack of knowledgeable TEFRA-specific state workers/customer service representatives or long telephonic customer service wait times, and insufficient information and communication from the state regarding available TEFRA services, participating providers, and family requests for reconsideration of the monthly premium amount due to changes in income.

After review of all the materials submitted by the state, including the comments from the state's TEFRA Beneficiary Satisfaction Survey report, CMS has determined that Arkansas' TEFRA-like demonstration should be extended because it is likely to assist with promoting the objectives of title XIX of the Act by improving access to high-quality, person-centered services that produce positive health outcomes for individuals. Despite the concerns raised, Arkansas has achieved its stated objectives and successful demonstration outcomes such as access to care following TEFRA enrollment improving from 75 percent to more than 90 percent; more than 95 percent of surveyed TEFRA parents report a "high level of satisfaction" with obtaining physician services needed for their children; and the proportion of TEFRA beneficiaries who experienced a lockout period remained low at 3.94 percent instead of the projected 5 percent. CMS has determined based on the state's evaluation outcomes, that the issues raised during the state's public input period did not preclude the state from meeting its intended goals and objectives for the demonstration and for title XIX. However, to mitigate these concerns, CMS has included provisions in the enclosed set of STCs to require Arkansas to monitor and report to CMS its progress on remediating these issues until resolved as agreed upon by CMS and the state. Provisions also include requiring the state to solicit input on its progress from all interested stakeholders during the federally-required annual post-award public forum to be held by the state, with a summary report to be included in the state's annual monitoring report.

CMS' approval of this demonstration is also conditioned upon compliance with these STCs and associated expenditure and non-applicable authorities that define the nature, character, and extent of anticipated federal involvement in this demonstration project. This award is subject to the state's written acknowledgement of the award and acceptance of the enclosed STCs and associated expenditure and non-applicable authorities within 30 days of the date of this letter.

Your CMS project officer for this demonstration is Mr. Emmett Ruff, who can be contacted to answer any questions concerning the implementation of this demonstration at 410-786-4252 or at Emmett.Ruff@cms.hhs.gov. Official communications regarding program matters and correspondence concerning the demonstration should be submitted to him at the following address:

Emmett Ruff
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mailstop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communications regarding demonstration program matters should be sent simultaneously to Mr. Ruff and to Mr. Bill Brooks, Associate Regional Administrator (ARA) for the Division of Medicaid and Children's Health Operations, in our Dallas Regional Office. Mr. Brooks' contact information is as follows:

Centers for Medicare & Medicaid Services
1301 Young Street
Room 714
Dallas, TX 75202
E-mail: Bill.Brooks@cms.hhs.gov

If you have questions regarding this correspondence, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid & CHIP Services, at (410) 786-9686.

Sincerely,

/s/

Tim Hill
Acting Director

Enclosures

cc: Bill Brooks, ARA, CMS Dallas Region
Stacey Shuman, State Lead, CMS Dallas Region

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY LIST**

NUMBER: 11-W-00163/6

TITLE: Arkansas TEFRA-like Section 1115 Demonstration

AWARDEE: Arkansas Department of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Arkansas for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authority and the provisions specified as "not applicable" enable Arkansas to operate its demonstration effective as of the date of the associated CMS approval letter through December 31, 2022:

- Expenditures for a targeted application process for services provided to children age 18 or younger, who require an institutional level of care, and meet the criteria for a child eligible for Medicaid under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) (promulgated in section 1902(e)(3) of the Act). This optional coverage group is also known as the "Katie Beckett" coverage option.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Cost Sharing

**Section 1902(a)(14)
insofar as it incorporates
Section 1916**

To enable Arkansas to charge a sliding scale monthly premium to custodial parent/guardian(s) of eligible children with annual family income above 150 percent of the federal poverty level and to implement periods of enrollee ineligibility for failure to pay applicable monthly premiums.

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

NUMBER: 11-W-00163/6

TITLE: Arkansas TEFRA-like Demonstration

AWARDEE: Arkansas Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Arkansas TEFRA-like section 1115(a) Medicaid demonstration extension (hereinafter “demonstration”). The parties to this agreement are the Arkansas Department of Health and Human Services (state) and the Centers for Medicare & Medicaid Services (CMS). These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. This demonstration extension is approved through December 31, 2022. All previously approved STCs are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

- I.** Preface
 - II.** Program Description and Objectives
 - III.** General Program Requirements
 - IV.** Eligibility, Benefits, and Enrollment
 - V.** Cost Sharing
 - VI.** Delivery Systems;
 - VII.** General Reporting Requirements
 - VIII.** General Financial Requirements
 - IX.** Monitoring Budget Neutrality for the Demonstration
 - X.** Evaluation of the Demonstration
 - XI.** Schedule of State Deliverables
- Attachment A: Template for Annual Monitoring Reports
Attachment B: Evaluation Design Plan (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Arkansas TEFRA-like demonstration was initially approved October 17, 2002 and implemented on January 1, 2003. The demonstration provides services to disabled children eligible for Medicaid under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA (also known as the Katie Beckett Option after the child whose plight inspired Congress to enact this option into Medicaid law) is an optional Medicaid category of coverage that was developed to allow children with disabilities, whose family has income that is too high to qualify for Medicaid, to gain Medicaid eligibility based on the income and resources of the child. These TEFRA children receive medical care in home-based settings rather than in institutions (which was a requirement for these children to become Medicaid eligible before

enactment of the "Katie Beckett waiver" under the Tax Equity and Fiscal Responsibility Act (TEFRA)).

Prior to 2002, Arkansas opted to cover these children under the optional TEFRA coverage category under the Medicaid State Plan. While this Medicaid State Plan coverage allowed children with disabilities to remain in their homes, it ultimately placed an unsustainable financial burden on the state. To address the financial viability of the program while maintaining coverage of this population of children with disabilities, the state chose to transition coverage of the "TEFRA population" from the Medicaid State Plan to a section 1115 demonstration program, under which the state can charge premiums for the TEFRA child's coverage based on family income and implement a lock-out period for nonpayment of premiums. Accordingly, Arkansas has been providing coverage to the TEFRA population of children under section 1115 authority consistently since January 1, 2003 pursuant to several extensions approved by CMS.

On October 18, 2017, Arkansas submitted a request to extend the demonstration for a three-year period with no program changes. CMS is approving this extension request for a period of five years, through December 31, 2022, as agreed upon with the state, in accordance with guidance outlined in the November 6, 2017 Center for Medicaid & CHIP Services (CMCS) Informational Bulletin on Section 1115 Demonstration Process Improvements. These STCs, accompanying the CMS approval letter, permit section 1115 demonstration authority for the Arkansas TEFRA-like Demonstration through December 31, 2022.

The waiver and expenditure authorities granted by this demonstration meets the objective of Medicaid to improve access to high-quality, person-centered services that produce positive health outcomes for individuals because it permits Arkansas to continue to provide coverage to children with long-term disabilities, mental illness, or complex medical needs in home-settings instead of more costly institutions.

Arkansas will continue to test the below hypotheses and goals for this demonstration, which CMS and Arkansas expects will also continue to promote Medicaid program objectives by:

- Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population;
- Ensuring demonstration enrollees have access to timely and appropriate preventive care;
- Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and satisfaction in the quality of care received; and,
- Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low.

III. GENERAL PROGRAM REQUIREMENTS

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

of 1975.

- 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (which are a part of these terms and conditions), must apply to the demonstration.
- 3. Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
 - b) If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. Changes Subject to the Amendment Process.** Changes related to demonstration features such as eligibility, enrollment, benefits, 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 Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below.
- 6. Amendment Process.** Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to,

the following:

- a) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
 - b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit;
 - c) An explanation of the public process used by the state consistent with the requirements of STC 14; and
 - d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
- 7. Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase-out plan consistent with the requirements of STC 8.
- 8. Demonstration Phase Out.** The state may only suspend or terminate this demonstration, in whole or in part, at any time prior to the date of expiration consistent with the following requirements:
- a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination. At least six months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with the requirements of STC 14. Once the 30-day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the comments received into the transition and phase-out plan submitted to CMS.
 - b) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its 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 those beneficiaries whether currently enrolled or

determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

- c) Phase-out Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
 - d) 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 are afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant 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 as found in 42 CFR §435.916.
 - e) Exemption from Public Notice Procedures 42 CFR §431.416(g): CMS may expedite or waive the federal and state public notice requirements in the event it determines that the objectives of titles XIX or XXI would be served or 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): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
- 9. CMS Right to Amend, Suspend, or Terminate.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.
- 10. Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of \$1,000,000 per deliverable (federal share) when items required by these STCs (e.g., monitoring reports, evaluation design documents, required data elements and analyses, presentations, and any other deliverable specified in these STCs (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

- a) Thirty days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
- b) For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).
 - i. CMS may decline the extension request.
 - ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
 - iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.
- c) When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
- d) As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from extending a demonstration or obtaining a new demonstration.
- e) CMS will consider with the state an alternative set of operational steps for implementing the deferral associated with this demonstration to align the process with any existing deferral process the state is undergoing (e.g., the quarter the deferral applies to and how the deferral is released).

11. Finding of Non-Compliance. The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

12. Withdrawal of Waiver/Expenditure Authority. CMS reserves the right to amend or withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the amendment or withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

13. 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 applicable to the demonstration; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. 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 Organization consultation requirements at section 1902(a) (73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, or contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

15. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY AND ENROLLMENT

16. Eligibility for the Demonstration. The TEFRA-like demonstration provides Medicaid State Plan services to children who were previously included in the state's optional Medicaid TEFRA Program. To be eligible for this demonstration, all of the following eligibility criteria must be met:

- a) Child must be age 18 or younger;
- b) Child must meet the Social Security Administration's definition of disability;
- c) Child must be a U.S. citizen or qualified alien;
- d) Child must have established residency in the state of Arkansas;
- e) Child must have a Social Security Number or have applied for one;
- f) Child's annual gross countable income must be less than the current Medicaid State Plan income limit established for long-term care services in accordance with section 1902(a)(10)(A)(ii)(V) of the Act (i.e., the child would be Medicaid eligible if institutionalized);
- g) Child countable assets do not exceed \$2,000 (parent(s) assets are not considered);
- h) Child meets the medical necessity requirement for institutional placement, or level of care, or be at risk, in the future, for institutional placement. Institutional placement or level of care includes:
 - i. An acute care facility including acute care mental health facilities;
 - ii. A skilled nursing facility;
 - iii. Residential placement at the Immediate Care Facility for Individuals

with Intellectual Disabilities (ICF/IID) level of care; or
iv. Alternative Home placement as a child if risk of placement is due to the medical condition of the child.

- i) If eligibility criteria a – h is met, the child must also have access to medical care in the home, it must be deemed appropriate to provide such care outside an institution, and the estimated cost of care in the home must not exceed the estimated cost of care if the child were in an institution.

17. Enrollment and Choice. The state will facilitate eligibility and enrollment into the appropriate title XIX or title XXI program for families applying for the TEFRA-like demonstration. Families applying to participate in the TEFRA-like demonstration will be assessed for all basis of title XIX or title XXI eligibility and if found to be eligible under more than one eligibility group/program, the family shall be counseled on the benefits of and any applicable beneficiary cost-sharing for each eligible program, and given the opportunity to make an informed choice of which program to enroll.

18. Enrollment in other Health Insurance. A child can be enrolled and receive TEFRA-like demonstration services and retain other creditable health insurance coverage. A family who voluntarily drops other creditable health insurance coverage for the coverage provided by this demonstration, will result in the child being determined ineligible for demonstration benefits for a period of six months from the date the insurance is dropped. At the annual reevaluation of eligibility, if it is determined that creditable health insurance coverage was voluntarily dropped after TEFRA eligibility was approved, the case will be closed for six months beginning with the month following the month of discovery (i.e., TEFRA-like demonstration eligibility will end for a period of six months).

V. BENEFITS AND DELIVERY SYSTEMS

19. Benefits. Individuals enrolled in the demonstration receive coverage for all Medicaid State Plan benefits.

20. Service Delivery. Services provided under the demonstration are delivered through the state's existing network of Medicaid providers and reimbursed on a fee-for-service basis. Demonstration beneficiaries must select a primary care physician through which to receive eligible demonstration services.

VI. COST SHARING

21. Program Premiums. As a condition of participation, custodial parent(s) with income above 150 percent of the Federal Poverty Level (FPL) (after applicable deductions as determined by the state) will be required to pay a sliding monthly premium based on the following schedule:

Family Income		Monthly Premiums (applicable <u>only</u> to families with incomes in excess of 150 percent of the FPL)		
From	To	Percent	From	To
\$0	\$25,000	0%	\$0	\$0
\$25,001	\$50,000	1.00%	\$20	\$41
\$50,001	\$75,000	1.25%	\$52	\$78
\$75,001	\$100,000	1.50%	\$93	\$125
\$100,001	\$125,000	1.75%	\$145	\$182
\$125,001	\$150,000	2.00%	\$208	\$250
\$150,001	\$175,000	2.25%	\$281	\$328
\$175,001	\$200,000	2.50%	\$364	\$416
\$200,001	No Limit	2.75%	\$458	\$458

22. Payment of Premiums.

- a) At the time of the initial TEFRA eligibility determination, Ppremium payments, if applicable, are assessed beginning in the month after TEFRA demonstration eligibility is approved. The premium will be charged on a monthly basis and will not be pro-rated. When a TEFRA applicant is approved for eligibility, a Notification Packet is auto-triggered from the state's Medicaid Management Information System (MMIS) and sent to the custodial parent(s)/guardian of the newly enrolled TEFRA beneficiary. This Notification Packet includes a notification letter of approval for TEFRA, a TEFRA Premium Payment Selection form on which the custodial parent(s)/guardian is provided the option of authorizing an automatic bank draft or making quarterly payments in advance for payment of the TEFRA premium and a postage paid envelope in which to return the completed TEFRA Premium Payment Selection form. After the custodial parent(s)/guardian selects the method they wish to use for payment of the TEFRA premium, the state's TEFRA Premium Unit thereafter collects the TEFRA premium payments and sends premium invoices to TEFRA eligible enrollees' custodial parent(s)/guardian.

For the custodial parent(s)/guardian who choose to pay their TEFRA premium through monthly bank draft, the state's TEFRA Premium Unit will draft the custodial parent(s)/guardian's account on the third month after initial approval and each following month thereafter. Each draft will be made on the first day of the covered month. The state's TEFRA Premium Unit will send monthly invoices to the custodial parent(s)/guardian notifying their bank account has been drafted. For the custodial parent(s)/guardian who choose quarterly payments, the custodial parent(s)/guardian must initially pay for the month after the month of approval and the following month in advance by check, after which the state's TEFRA Premium Unit will send monthly invoices requesting premium payment in the month prior to the covered quarter. The draft or quarterly payment will begin with the third month after the month of approval. Regardless of payment choice, everyone will be required to pay for the first two months' premiums by check which must be sent in with the Payment Selection Form. Failure to provide the Payment Selection Form or make the two month initial payment will cause the

TEFRA enrollee to be ineligible, and the case will be closed after proper advance notice. The Department of Human Services' (DHS) County Office is notified by the TEFRA Premium Unit if the Payment Selection Form has not been submitted and/or the two month initial payment has not been made.

- b) For ongoing cases (i.e., active TEFRA demonstration enrollees), custodial parent(s)/guardian is allowed a 3-month grace period to pay past due premiums. During this 3-month grace period, the TEFRA enrollee's case will not be closed and providers will continue to be reimbursed for covered services. If the premium is not paid after this 3-month grace period, a 10-day advance notice of closure will be provided to the custodial parent(s)/guardian. If the premium payments in arrears are not made within the 10-day window, the case will be closed. If the arrearages are paid after the case is closed, a new application must be submitted for a new determination of demonstration eligibility. If medical necessity and appropriateness of care have been determined within the past 10 months, a new determination will not be necessary.

If the case has been closed less than 12 months because of premium payments in arrears, the three months of past due premiums must be paid before the child can again be approved to receive TEFRA demonstration services.

If a case is closed 12 months or more because of premium payments in arrears, the payment of the past due premiums will not be required.

If TEFRA eligibility for a child ends during a quarter, any premiums already paid for months after the month of closure will be reimbursed. Whether paying by monthly bank drafts or through quarterly payments, if eligibility ends in the middle of the month in which payment has been made, the premium will be prorated and the custodial parent(s)/guardian will be reimbursed for the partial month.

- c) The state may attempt to collect unpaid premium debts from the custodial parent(s)/guardian of TEFRA demonstration enrollees, but shall not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of individual/family earnings. The state also shall not transfer the debt to a third-party. Further, while the debt is collectible by the state, re-enrollment in the TEFRA demonstration is not conditional on repayment after the case has been closed for 12 months as indicated in subpart "b" above.

23. Premium Adjustments. Custodial parent(s)/guardian income will be reviewed annually for purposes of calculating the premium; or, when there is a change that will make a difference of more than 10 percent in annual household income or there is a change in the number of family members. An adjustment can be made to the premium at any time during the year if the custodial parent(s)/guardian reports a significant change in excess of 10 percent of expected annual income or if the custodial

parent(s)/guardian reports there is a change in the household size. Verification of the income change must be provided. The premium can only be adjusted at a maximum of once every six months. If the change in income has significantly lowered enough that the custodial parent(s)/guardian's TEFRA enrolled child could be potentially eligible for full Medicaid or the Children's Health Insurance Program (CHIP) coverage, the state will conduct an eligibility determination for such coverage and work with the custodial parent(s) guardian to facilitate enrollment of the child. Income that fluctuates due to the type of employment (e.g. teachers, farmers, etc.) will not affect the monthly premium.

- 24. Cost-sharing Limits.** There are no co-payment requirements for services to TEFRA demonstration enrollees. The total out-of-pocket cost sharing assessed on TEFRA enrollee's custodial parent(s)/guardian (i.e., the premiums assessed on custodial parent(s)/guardian with income in excess of 150 percent of the FPL) shall not exceed five percent of the family's gross income.

VII. GENERAL REPORTING REQUIREMENTS

- 25. General Financial Requirements.** The state must comply with all general financial requirements under title XIX and as set forth in section VIII.
- 26. Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section IX.
- 27. Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.
- 28. 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, Transformed Medicaid Statistical Information System (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.
- 29. Quarterly Operational Progress Updates and Monitoring Calls.** CMS and Arkansas will participate in quarterly conference calls, unless CMS determines that less frequent calls are necessary to adequately monitor the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration in areas such as health care delivery, enrollment, quality of care, access, benefits, anticipated or proposed changes in monthly premium charges or payment rates, audits, lawsuits, changes in state sources of funding for financing this demonstration,

progress on evaluations, state legislative developments, and any demonstration amendments the state is considering submitting.

These quarterly calls will also be used to address the state's progress in addressing certain operational issues raised during the renewal period of the state's TEFRA demonstration. The primary areas to be addressed during these calls are as follows:

- a) Progress with aligning TEFRA demonstration initial and renewal application processes with federal requirements at 42 CFR §435.911 and §435.916, including a report of timeframes for individuals actively pending TEFRA demonstration eligibility determinations;
- b) Progress with providing TEFRA-related notices in alignment with federal requirements at 42 CFR §431.211, §435.917 and §435.918; including notices related to family changes in income for premium reconsideration;
- c) Progress with improving TEFRA-specific customer service response rate; particularly regarding inquiries related to family changes in income for premium reconsideration; and,
- d) Progress with improving information made available (minimally at time of initial application and at annual renewal) on TEFRA services, benefits, participating providers, changes to the sliding scale of monthly premiums required for families with income above 150 percent of the FPL, and instructions for how to pay any applicable premium or to request a change in how family pays any applicable premium.

The state shall submit a narrative update describing its implementation progress on each of these operational issues at least 10 days before the quarterly monitoring call between Arkansas and CMS is held. Arkansas and CMS will jointly develop the date/time and agenda for the quarterly monitoring calls. The state will also be required to report its progress on addressing these specific operational issues as part of the Annual Monitoring Report required in STC 30, until the issue has been deemed resolved upon agreement by CMS and the state.

30. Annual Monitoring Report. No later than 90 days following the end of each demonstration year, the state must submit an annual progress report that represents the status of the demonstration's various operational areas and any state analysis of program data collected for the demonstration year. The Annual Monitoring Report will include all elements required by 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 Annual Monitoring Report must follow the framework provided by CMS (incorporated in these STCs as "Attachment A"), which is subject to change as monitoring systems are developed and/or evolve, and will be provided in a structured manner that supports federal tracking and analysis. Each Annual Monitoring Report must minimally include the following:

- a) Operational Updates - Per 42 CFR §431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration.

The reports shall provide sufficient information to document programmatic issues or key challenges, underlying causes of issues/challenges, how issues/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; descriptions of any public forums held, and a summary of program integrity and related audit activities for the demonstration. The Annual Monitoring Report shall also include a summary of all public comments received through the post-award public forum required per 42 CFR §431.420(c) regarding the progress of the demonstration. The state's post-award public forum shall address beneficiary response to the state's reported progress with addressing the issues identified in STC 29(a) – (d), which shall be reported as part of the post-award public forum summary to be included in the Annual Monitoring Report.

- b) Performance Metrics – Per 42 CFR §431.428, the Annual Monitoring Report 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) and grievances and appeals. The required monitoring and performance metrics must be included in writing in the Annual Monitoring Report, and will follow the framework provided by CMS to support federal tracking and analysis.
- c) Budget Neutrality and Financial Reporting Requirements – Per 42 CFR §431.428, the Annual Monitoring Report must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Annual Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including a total annual member month count for the demonstration population, total annual expenditures for the demonstration population, total premiums collected for services to the demonstration population, and the resulting "per member, per month" calculation. The Annual Monitoring Report must also include the submission of corrected budget neutrality data upon request.
- d) Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Annual 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.

31. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration. The state must confirm its process for ensuring there is no duplication of federal funding in each Annual Monitoring Report as specified in STC 30(a).

32. Draft and Final Close-out Report. Within 120 days prior to the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

- a) The draft final Close-Out 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 30 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 10.

VIII. GENERAL FINANCIAL REQUIREMENTS

33. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports to report total expenditures for services provided under this Medicaid section 1115(a) demonstration following routine CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined cost limits specified in STC 43.

34. Reporting Expenditures Subject to the Budget Neutrality Expenditure Limit. The following describes the reporting of expenditures subject to the budget neutrality limit:

- a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES). All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS and the two digit project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made (e.g., For reporting expenditures with dates of services made in demonstration year 16 (1/1/2018 – 12/31/2018), the state would use "16" as the project number extension).
- b) Use of Waiver Forms. The state must report demonstration expenditures on separate forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report title XIX expenditures for demonstration services. The state will continue to use the waiver name "TEFRA Children" to report expenditures in the MBES/CBES and in the budget neutrality workbook required to be submitted with the Annual Monitoring Report per STC 30.

- c) Premium and Cost Sharing Adjustments. Premium contributions that are collected by the state for demonstration enrollees must be reported to CMS each quarter on 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 demonstration year on Form CMS-64 Narrative. The state shall also report the premium contributions reported during the demonstration year on the Form CMS-64 Narrative as an annual total (total computable) as part of the annual budget neutrality monitoring submission outlined in STC 30(c). In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits outlined in STC 43.
- d) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C.

35. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. To the extent the state does not have administrative costs that are directly attributable to the demonstration, a certification to that effect must be included in the Annual Monitoring Report required by STC 30; including description of how the state is tracking administration of the TEFRA-like demonstration to ensure there are no separate demonstration-related administrative costs.

36. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made 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 must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

37. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

- a) For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the Annual Monitoring Report required per STC 30, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

- b) 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.

38. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process set out in STC 10, 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.

39. Extent of Federal Financial Participation (FFP) for the Demonstration. CMS shall provide FFP at the applicable federal matching rates for demonstration expenditures incurred by the state as outlined below, subject to the limits described in section IX.

- a) Net expenditures reported on CMS-64 waiver forms as outlined in STC 34, as authorized in the CMS approved Expenditure Authority document associated with these STCs, and with dates of service during the operation of the demonstration; and,
- b) Administrative costs associated with the administration of the demonstration.

40. Sources of Non-Federal Share. The state must certify that matching the non-federal share of funds for the 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) CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

41. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

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

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

42. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding it may receive on approved demonstration service expenditures incurred during the period of demonstration approval. The limit is determined using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the approved demonstration period. Actual expenditures subject to the budget

neutrality expenditure limit shall be reported by the state using the procedures described in STC 34. CMS’ assessment of the state’s compliance with these annual limits will be done using the expenditures reported by the state on the CMS-64 waiver forms as outlined in STC 34. No savings can be accrued or used with this budget neutrality model.

43. Budget Neutrality Expenditure Limit. For each demonstration year, an annual budget limit will be calculated for the demonstration. The Arkansas TEFRA-like demonstration annual demonstration cycle is January 1 through December 31 as originally approved. The state's demonstration years approved with this five year demonstration extension are as follows:

- Demonstration Year 16 = January 1, 2018 – December 31, 2018
- Demonstration Year 17 = January 1, 2019 – December 31, 2019
- Demonstration Year 18 = January 1, 2020 – December 31, 2020
- Demonstration Year 19 = January 1, 2021 – December 31, 2021
- Demonstration Year 20 = January 1, 2022 – December 31, 2022

The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share.

PMPM Cost. The following table provides the approved demonstration cost trend (based on the state’s historical rate of growth of 3.28 percent) and the PMPM ceiling (total computable, net of premiums paid by demonstration enrollees) for each demonstration year:

PMPM Ceilings for TEFRA-like Services	
DY 16	\$1,143.87
DY 17	\$1,181.39
DY 18	\$1,220.14
DY 19	\$1,260.16
DY 20	\$1,301.49

- a) Composite 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, as reported on the CMS-64 forms listed in STC 34 above, by total computable demonstration expenditures for the same period as reported on the forms. Should the demonstration be terminated prior to the end of the approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.
- b) Risk. Arkansas shall be at risk for the per capita cost (as determined by the method described in this section) for demonstration enrollees, but not for the number of

demonstration enrollees. By providing FFP for eligible enrollees, Arkansas shall not be at risk of changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs for enrollees in the demonstration, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

- c) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures reported by the state on the CMS-64 forms. If at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess federal funds will be returned to CMS. If the costs of the demonstration services do not exceed the budget limit, the state may not derive or utilize any such savings.

44. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

45. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration extension, which will be from January 1, 2018 through December 31, 2022. No later than six months after the end of each demonstration year, the state will calculate and report to CMS an annual cumulative expenditure target for the completed year. This amount will be compared with the actual cumulative amount the state has claimed for FFP through the completed year. If cumulative spending exceeds the cumulative target by more than the indicated percentage, the state will submit a corrective action plan to CMS for approval. The state will subsequently implement the approved plan.

<u>Year</u>	<u>Cumulative Target Expenditures</u>	<u>Percentage</u>
DY16	DY16 budget limit plus:	2 percent
DY17	DY16 and DY17 combined budget limit amount plus:	1.5 percent
DY18	DY16 through DY18 combined budget limit amount plus:	1 percent
DY19	DY16 through DY19 combined budget limit amount plus:	0.5 percent
DY20	DY16 through DY20 combined budget limit amount plus:	0 percent

46. Exceeding Budget Neutrality. The state, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which includes submitting a corrective action plan to CMS within 21 days of the date the state is informed of the problem. While CMS will pursue corrective actions with the state, CMS will work with the state to set reasonable goals that will ensure that the state is in compliance.

If at the end of this demonstration approval period, the cumulative budget neutrality expenditure limit has been exceeded, the excess federal funds must be returned to CMS.

If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

X. EVALUATION OF THE DEMONSTRATION

- 47. Draft Evaluation Design.** The draft evaluation design must be developed in accordance with CMS' separately provided guidance for family planning demonstrations. The state must submit, for CMS comment and approval, a draft evaluation design with an implementation timeline by no later than 120 days after the effective date of these STCs. 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 state may choose to use the expertise of an independent party in the development of the draft evaluation design.
- 48. 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.
- 49. Evaluation Design Approval and Updates.** The state must submit a revised draft evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the final evaluation design, the document will be included as "Attachment B" to these STCs. Per 42 CFR §431.424(c), the state will publish the approved final evaluation design within 30 days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each Annual Monitoring Report as required by STC 34, including any required rapid cycle assessments specified in these STCs. 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.
- 50. Evaluation Questions and Hypotheses.** Consistent with CMS' separately provided guidance entitled, "Developing the Evaluation Design" and "Preparing the Evaluation Report," 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' 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).

51. Interim Evaluation Report. The state must submit an interim evaluation report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c) (2) (vi). When submitting an application for extension, the interim 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 extend the demonstration, the draft interim evaluation report is due when the application for extension is submitted. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting an extension of the demonstration, the draft interim evaluation report is due one 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 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 CMS' separately provided guidance entitled, "Preparing the Evaluation Report."

52. 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 and providing data and analytic files to CMS, including 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 who collect, produce or maintain data and files for the demonstration, that they shall make such 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 10.

53. Summative Evaluation Report. The draft summative evaluation report must be developed in accordance with CMS' separately provided guidance entitled, "Preparing the Evaluation Report." 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 information as outlined 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 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 days of approval by CMS.

54. 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 state's interim evaluation, and/or the summative evaluation.

55. Public Access. The state shall post the final documents (e.g., monitoring reports, approved evaluation design, interim evaluation report, summative evaluation report, and close-out report) on the state's Medicaid website within 30 days of approval by CMS.

56. Additional Publications and Presentations. For a period of 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 30 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.

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Quarterly Monitoring Call & Progress Narrative	First Quarterly Monitoring call and Progress Narrative within 120 days of CMS approval, then on a quarterly basis (i.e., approximately every 90 days)	STC 29
Annual Monitoring Report	Within 90 days following the end of each demonstration year	STC 30
Draft Evaluation Design Plan	Within 120 days after the approval of the demonstration extension	STC 47

Deliverable	Timeline	STC Reference
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 49
Summative Evaluation Report	Within 18 months following the end of this demonstration extension period	STC 53

**ATTACHMENT A –
Annual Monitoring Report Template**

1. Preface

Complete the below table as the title page of all annual monitoring reports. The content of this transmittal table should stay consistent over time.

State	<i>Enter state name.</i>
Demonstration Name	<i>Enter full demonstration name as listed in the demonstration approval.</i>
Approval Date	<i>Enter approval date of the demonstration as listed in the demonstration approval letter.</i>
Approval Period	<i>Enter the entire approval period for the demonstration. This should include a start date and an end date</i>
Demonstration Goals and Objectives	<i>Enter summary of demonstration goals and objectives as summarized in the STCs and/or demonstration fact sheet.</i>

2. Executive Summary

This section should be brief and targeted to communicate key achievements, highlights, issues, and/or risks identified during the current reporting period. This section should also identify key changes since the last monitoring report, including the implementation of new program components; programmatic improvements (e.g., increased outreach or any beneficiary or provider education efforts); and highlight unexpected changes (e.g., unexpected increases or decreases in enrollment or complaints, etc.). Historical background or general descriptions of the waiver components should not be included in this section.

The state should embed substantive analytics in the sections that follow; this section is intended for summary level information only. The recommended word count for this section is 500 words or less.

3. Enrollment

In this section, the state should discuss any relevant trends that the data shows in enrollment, eligibility, disenrollment, access, and delivery network. Changes (+ or -) greater than two percent should be described here. As an example, the number of beneficiaries enrolled in the last quarter decreased by 5% due to a State Plan Amendment that decreased the FPL levels. The recommended word count for this section is no more than 250 words (1-2 paragraphs). Note that each distinct trend should be described more succinctly in the table below.

Enrollment Issues/Trends: New and Continued

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
<i>EXAMPLE</i> Managed Care Plan with 30% of County Y's enrollment will exit on 1/1/18	9/1/17; DY 2 Qtr. 3	75,000	Plan is exiting county because it is leaving the Medicaid line of business.	State is working to redistribute plan's population among the remaining two plans. Outreach and mail notification is occurring throughout the fall with toll-free plan counseling lines also available.

**Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

Anticipated Changes to Enrollment

The state should explain any anticipated program changes that may impact enrollment-related metrics. For example, the state projects an x% increase in enrollment due to an increase in the FPL limits which will be effective on "X" date. The recommended word count for this section is 150 words or less. If no changes are anticipated, the state should indicate so.

4. Benefits

In this section, the state should discuss any relevant trends that the data shows in benefit access, utilization, premium cost-sharing and delivery network. The recommended word count for this section is 150 words (1-2 paragraphs) or less. Note that issues should be described more succinctly in the sections that follow.

Benefit Issues: New and Continued

The state should explain any new benefit-related issues and provide updates on previously reported issues. For each issue, the state should provide a brief summary description of the issue, the estimated number of impacted beneficiaries, the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also provide updates on benefit-related issues identified in previous reports.

When applicable, the state should also note when issues are resolved. If the state is not aware of benefit issues, the state should indicate so.

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated Number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
<i>EXAMPLE</i> Mental health services in X county were impacted this quarter.	11/1/17: DY 3, Qtr. 3	10,000	X provider group unexpectedly exited the service area	State is working to contract with a new provider group. .

*Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.

Anticipated Changes to Benefits

The state should explain any anticipated program changes that may impact benefits. For example, new legislation was recently signed by the Governor which will add more dental benefits effective "X" date. The recommended word count for this section is 150 words or less. If none are anticipated, the state should indicate so.

5. Demonstration-related Appeals

The state should explain any appeals-related issues and provide updates on previously reported issues. For each issue, the state should provide a brief summary describing the issue, the estimated number of impacted beneficiaries, any known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on appeals-related issues identified in previous reports. When applicable, the state should also note when issues are resolved. If the state is not aware of appeals issues, the state should indicate so.

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated Number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Previously Reported*
<i>EXAMPLE</i> State is reviewing Health Plan X's Appeals process due to	3/1/17: DY 3 Qtr. 3	250	Under investigation by the state.	State has asked the plan to submit appeals data for the last two calendar years by 6/1/17. State is reviewing

<i>members' complaints that notifications are not being sent timely and appeals requests are not being reviewed timely.</i>				<i>data and draft findings are due by 9/1/17.</i>

**Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

Appeal-related Program Changes

The state should explain any anticipated program changes that may impact appeals-related metrics. The recommended word count for this section is 150 words or less. If none are anticipated, the state should indicate so.

6. Quality

The state should explain quality activities occurring over the current demonstration reporting period, any new quality-related issues, and provide updates on previously reported issues. For each issue, the state should provide a brief description of the issue, the estimated number of impacted beneficiaries (if applicable), the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on quality-related issues identified in previous reports. When applicable, the state should also note when issues are resolved. If the state is not aware of quality issues, the state should indicate so.

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated Number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
<i>EXAMPLE Difficulty with collecting data for X measure (i.e. lack of EHR data or need for hybrid data)</i>	<i>3/15/17; DY 3 Qtr. 3</i>	<i>N/A</i>	<i>Demonstration site in process of updating EHR to be completed X date.</i>	<i>Currently reporting X measure by deviating from current measure specifications in order to adhere to demo reporting requirements.</i>

** Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

Quality-related Program Changes

The state should use this section to explain any anticipated program changes that may impact quality-related metrics. If none are anticipated, the state should indicate so.

7. Financial/Budget Neutrality

This Financial/Budget Neutrality section incorporates a budget neutrality workbook for the demonstration. At the time of demonstration approval, CMS will work with states to confirm the appropriate workbook for this demonstration.

Financial/Budget Neutrality Issues: New and Continued

The state should provide an analysis of budget neutrality to date and to explain any new financial/budget neutrality-related issues using the below table. For each issue, the state should provide a brief summary description of the issue, including the fiscal impact on the demonstration population, the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on issues identified in previous reports.

When applicable, the state should also note when issues are resolved.

Summary of Issue, Including Fiscal Impact and Impacted MEG(s)	Date and Report in Which Issue Was First Reported	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported
<i>EXAMPLE: State is unable to report separate expenditures for Population MEG #2. In the interim, all Population MEG #2 expenditures are reported as part of Population MEG #1 on CMS 64 waiver form Pop MEG 1.</i>	<i>DY 1, Q1</i>	<i>State’s current system does not accommodate breaking out capitation payments between Population MEG 1 and Population MEG 2.</i>	<i>State is working on system changes so that Population MEG 1 and Population MEG 2 expenditures can be separately reported. Target date of system change is 12/31/2017.</i>

Financial/Budget Neutrality related Program Changes

The state should use this section to explain any anticipated program changes that may impact financial/budget neutrality metrics. The recommended word count for this section is 150 words or less. If none are anticipated, the state should indicate so.

8. Demonstration Operations and Policy

Using the table provided below, the state should highlight significant demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. The state should use this section to highlight demonstration operations or policy considerations specifically in response to STC 29(a) – (d). The state should also note any activity that may accelerate or create delays or impediments in achieving the demonstration’s approved goals or objectives, if not already reported elsewhere in this document. Such considerations could include the following, either real or anticipated:

- Any changes to populations served, benefits, access, cost-sharing, delivery systems, or eligibility;
- Legislative activities and state policy changes;
- Fiscal changes that would result in changes in access, benefits, populations, enrollment, etc.;
- Related audit or investigation activity, including findings;
- Litigation activity;
- Status and/or timely milestones for health plan contracts;
- Market changes that may impact Medicaid operations;
- Any delays or variance with provisions outlined in STCs;
- Systems issues or challenges that might impact the demonstration [i.e. eligibility and enrollment (E&E), Medicaid management information systems (MMIS)];
- Changes in key state personnel or organizational structure;
- Procurement items that will impact demonstration (i.e. enrollment broker, etc.);
- Significant changes in payment rates to providers which will impact demonstration or significant losses for managed care organizations (MCOs) under the demonstration;
- Emergency Situation/Disaster; and/or,
- Other

Consideration 1:

Type of Consideration	EXAMPLE <i>Ongoing litigation</i>
Summary of Consideration	<i>State is in ongoing state-court level litigation regarding inpatient hospital rate cuts under SPA 17-001 effective 10/1/17 in court case A vs. B filed on 8/1/17. There is a stay on the cuts effective 9/27/17.</i>
Date and Report in Which Consideration Was First Reported	8/5/17
Summary of Impact	<i>Stay on hospital rate cuts will prevent projected savings from being captured.</i>
Estimated Number of Beneficiaries	<i>3 million (state wide population)</i>
If Issue, Remediation Plan and Timeline for Resolution / Updates in Status if Previously Reported	<i>State will continue to follow state legal process.</i>

9. Implementation Update

The state should provide implementation updates on relevant aspects of the demonstration, as identified either during the approval process, in previous monitoring calls, or other implementation reviews or discussions pursuant to 42 CFR §431.420(b). The state should also report on any changes in implementation plans since the demonstration was approved, either via an amendment to the demonstration, or a change in how the state plans to execute the STCs.

In the table below, the state should include any relevant trends that the data shows in benefit access, utilization, and delivery network if not already reported elsewhere in this document.

Item	Date and Report in Which Item Was First Reported	Implementation Status
<i>EXAMPLE State is planning to submit an 1115 amendment for a freedom of choice waiver as a companion to its pending Health Homes SPA 17-010, per CMS guidance.</i>	<i>6/1/17</i>	<i>State will submit 1115 amendment by 12/1/17</i>

NOTE: If additional information is needed, the state should also provide a short narrative. The recommended word count is 150 words.

10. Demonstration Evaluation Update

The state should highlight relevant updates to the demonstration evaluation pursuant to 42 CFR §431.424 and/or any federal evaluations in which the state is involved [per 42 CFR §431.420(f) or 42 CFR §431.400(a)(1)(ii)(C)(4)]. The state should include timely updates on evaluation work and timeline. Depending on when this report is due to CMS and the timing for the demonstration, this might include updates on progress with:

- Evaluation design;*
- Evaluation procurement;*
- Evaluation implementation;*
- Evaluation deliverables (information presented in below table);*
- Data collection, including any issues collecting, procuring, managing, or using data for the state’s evaluation or federal evaluation;*
- For annual report per 42 CFR §431.428, the results/impact of any demonstration programmatic area defined by CMS that is unique to the demonstration design or evaluation hypothesis; and/or,*

- *Results of beneficiary satisfaction surveys, if conducted during the reporting year, grievances and appeals.*

The intent of this section is for the state to provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs. The recommended word count for any narrative related to the above is about 250 words (1-2 paragraphs) per update.

In addition to any status updates on the demonstration evaluation, the state should complete the below table to list anticipated evaluation-related deliverables and their due dates.

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
Interim Evaluation Report			
Summative Evaluation Report			

11. Other Demonstration Reporting

The state should report any pertinent information not captured in the above sections or in related appendixes. The recommended word count for each additional item reported should not exceed 250 words (2-3 paragraphs).

In addition to any status updates on the demonstration evaluation, the state should complete the below table to list any other deliverables related to this demonstration and associated due dates. Note that deliverables associated with the evaluation should be listed separately in the Demonstration Evaluation Update section.

Type of Other Post-Approval Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues or Requests for CMS Technical Assistance

12. Post Award Public Forum

The state should provide a summary of the annual post-award public forum held pursuant to 42 CFR §431.420(c) indicating any resulting action items or issues. The recommended word count for this narrative should not exceed 250 words (2-3 paragraphs).

13. Notable State Achievements and/or Innovations

This is a section for the state to provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes.

The narrative in this section should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries. The recommended word count for this narrative should not exceed 250 words (2-3 paragraphs).

ATTACHMENT B: Approved Evaluation Design

(Reserved pending CMS approval)