DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

December 16, 2020

Drew Snyder
Executive Director
Division of Medicaid
Mississippi Department of Human Services
550 High Street, Suite 1000
Walters Sillers Building
Jackson, MS 39201

Dear Mr. Snyder:

The Centers for Medicare & Medicaid Services (CMS) has approved the evaluation design for Mississippi's section 1115(a) demonstration entitled, "Mississippi Family Planning Medicaid Waiver Section 1115 Demonstration" (Project Number: 11-W-000157/4), and effective through December 31, 2027. We sincerely appreciate the state's commitment to a comprehensive evaluation of your demonstration.

CMS has added the approved family planning evaluation design to the demonstration's Special Terms and Conditions (STC) as Attachment B. A copy of the STCs, which includes the new attachment, in enclosed with this letter. The approved evaluation design may now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(c). CMS will also post the approved evaluation design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an interim evaluation report, consistent with the approved evaluation design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a summative evaluation report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period.

We look forward to our continued partnership on the Mississippi Family Planning Medicaid Waiver Section 1115 Demonstration. If you have any questions, please contact your CMS project officer, Dina Payne. Ms. Payne is available to answer any questions concerning your section 1115 demonstration and may be reached either by phone at 410-786- 3574 or by email at dina.payne1@cms.hhs.gov.

Sincerely,

Danielle Daly -S
Digitally signed by Danielle Daly -S
Date: 2020.12.21 05:16:42 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Andrea J. Casart -S
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Date: 2020.12.21 10:33:47 -05'00'

Andrea Casart
Director
Division of Eligibility and Coverage Demonstrations

cc: Etta Hawkins, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: **11 -W-00 157/4**

TITLE: **Mississippi Section 1115 Family Planning Medicaid Waiver**

AWARDEE: **Mississippi Division of Medicaid**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Mississippi 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 Mississippi to operate its demonstration effective through December 31, 2027:

- Expenditures for extending Medicaid eligibility for family planning and family planning related services to women and men, ages 13 through 44, with income up to 194 percent of the federal poverty level (FPL) that are not otherwise eligible for Medicaid, Medicare, the Children's Health Insurance Program (CHIP), or other creditable health insurance coverage that provides family planning services. These expenditures also provide coverage for women who are losing Medicaid pregnancy coverage at the expiration of the 60-day postpartum period.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Methods of Administration: Transportation **Section 1902(a)(4) insofar as it incorporates 42 CFR §431.53**

To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

2. Amount, Duration, and Scope of Services (Comparability) **Section 1902(a)(10)(B)**

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services.

3. Retroactive Coverage **Section 1902(a)(34)**

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) **Section 1902(a)(43)(A)**

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations.

Centers for Medicare & Medicaid Services
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00 157/4

TITLE: Mississippi Family Planning Medicaid Waiver Section 1115 Demonstration

AWARDEE: Mississippi Division of Medicaid

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Mississippi family planning section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Mississippi Division of Medicaid and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of January 1, 2018 through December 31, 2027. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

Effective through December 31, 2027, the Mississippi Family Planning section 1115(a) Medicaid demonstration expands the provision of family planning and family planning related services to women and men that are capable of reproducing, ages 13 through 44, with income of no more than 194 percent of the FPL (post Modified Adjust Gross Income (MAGI) conversion) and are not otherwise enrolled in Medicaid, Medicare, the Children's Health Insurance Program (CHIP), or any other creditable coverage that includes family planning services. This includes women who are losing Medicaid pregnancy coverage at the

expiration of the 60-day postpartum period.

Historical Context and Objectives

The Mississippi Family Planning demonstration was initially approved on January 31, 2003 and implemented October 1, 2003. The demonstration has been consistently extended since that date. The Mississippi Family Planning demonstration was originally implemented to provide family planning services to women between the ages of 13 through 44, with income up to 194 percent of the FPL, that lost Medicaid eligibility at the conclusion of their pregnancy coverage and who otherwise could not qualify for Medicaid, the Children's Health Insurance Program (CHIP), or any other creditable coverage that included family planning services. With the January 1, 2015 extension of the demonstration, the state received CMS approval to expand the program to begin covering men at the same age and income level set for the demonstration and also to provide family planning related services.

On December 20, 2016, Mississippi submitted a request to extend the demonstration for a five-year period with no program changes. CMS is approving this extension request for a period of ten years, through December 31, 2027, as agreed upon with the state, in accordance with new 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 Mississippi Family Planning demonstration through Demonstration 31, 2027.

CMS and Mississippi expects this demonstration program will promote Medicaid program objectives by:

- Improving the access to and use of Medicaid family planning services by women who have received a Medicaid pregnancy related service;
- Improving birth outcomes and the health of women by increasing the child spacing interval among women in the demonstration population;
- Decreasing the number of Medicaid paid deliveries, which will reduce annual expenditures for prenatal, delivery, and newborn services;
- Reducing the number of unintended pregnancies among women in the demonstration population;
- Reducing teen pregnancy by reducing the number of repeat teen births; and,
- Increasing the overall savings attributable to providing family planning services by covering women for one year postpartum.

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 programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the expenditure authority document (which is 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 explicitly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

    a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

    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, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the 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 must 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 Mississippi 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 Transition and Phase-Out.** The state may suspend or terminate this demonstration, in whole or in part, at any time prior to the date of expiration.

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 its approved tribal consultation State Plan Amendment. 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 received comments 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 of Payment for Failure to Provide Deliverables on Time.** CMS will withhold payments to the state in the amount of $1,000,000 per occurrence when deliverables are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS.

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.

b) For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Should CMS agree to the state's request, a corresponding extension of the deferral process described below 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) The deferral would be issued against the next quarterly expenditure report following the written deferral notification (subject to any extension granted under (b)).

d) When the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in the STCs, the deferral(s) will be released.

e) 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 extension, amendment, or for a new demonstration.

f) If applicable, 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 structure of the state's request for an extension, what 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 to the extent they apply; 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, and 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.** Family planning services are provided to eligible individuals for 12 months of continuous eligibility. An individual found to be income-eligible for this demonstration upon initial application or annual redetermination will not require reporting of changes in income or household size for this 12-month period.

    Eligibility for this demonstration is limited to women and men, ages 13 through 44, who are capable of reproducing, have countable income of no more than 194 percent of the FPL (post Modified Adjust Gross Income (MAGI) conversion) and are not otherwise enrolled in Medicaid, Medicare, the Children's Health Insurance Program (CHIP), or any other creditable coverage that includes family planning services. Eligibility also includes women who are losing Medicaid pregnancy coverage at the expiration of the 60-day postpartum period.

17. **Redeterminations.** The state must ensure that redeterminations of eligibility for Mississippi Family Planning enrollees are conducted no more than once every 12 months. At the states option, redeterminations may be administered in nature.

18. **Demonstration Disenrollment.** If a woman becomes pregnant while enrolled in the demonstration, she may be determined eligible for Medicaid under the State Plan. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State Plan. In addition, women and men who receive a sterilization procedure and complete all necessary follow-up procedures will subsequently be disenrolled from the demonstration.

V. BENEFITS AND DELIVERY SYSTEMS

19. **Family Planning Benefits.** Individuals eligible under this demonstration will receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act, which are reimbursable at the 90 percent Federal matching rate. The specific family planning services provided under this demonstration are as follows:

    a) Four (4) family planning visits annually;

b) FDA-approved methods of contraception;

c) Laboratory tests done during an initial family planning visit for contraception, including Pap smears, screening tests for STIs/STDs, blood counts and pregnancy tests. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception;

d) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements such as oral contraceptive agents, topical patches, injectable contraceptives and self-inserted contraceptive products; birth control implants such as Nexaplanon; and,

e) Contraceptive management, patient education, and counseling.

20. Family Planning-Related Benefits. Individuals eligible under this demonstration will also receive family planning-related services and supplies defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:

a) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.

b) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.

c) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.

d) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

e) Treatment of major complications arising from a family planning procedure such as:
    i. Treatment of a perforated uterus due to an intrauterine device insertion;

ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

21. Minimum Essential Coverage (MEC). The Mississippi family planning demonstration is limited to the provision of services as described in STCs 19 and 20. Consequently, this demonstration is not recognized as Minimum Essential Coverage (MEC) as indicated by CMS in its February 12, 2016 correspondence from Vikki Wachino to David Dzielak, Mississippi Medicaid Director, regarding the designation of MEC for the state's section 1115 demonstrations.

22. Primary Care Referrals. Primary care referrals to other social service and health care providers as medically indicated will be provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for enrollees, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration enrollees. The written materials must explain to enrollees how they can access primary care services.

23. Delivery of Services. Enrollees in the Mississippi family planning demonstration will receive services on a fee-for-service (FFS) basis. Beneficiary freedom of choice of family planning provider shall not be restricted.

VI. GENERAL REPORTING REQUIREMENTS

24. General Financial Requirements. The state must comply with all general financial requirements under title XIX and as set forth in section VII.

25. Reporting Requirements Relating to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section VII.

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

27. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 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.

28. Annual Monitoring Calls. CMS and Mississippi will participate in annual conference calls following the receipt of the annual progress report, unless CMS determines that more 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. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, anticipated or proposed changes in 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. CMS will update the state on any amendments under review as well as federal policies and issues that may affect any aspect of the demonstration. Mississippi and CMS will jointly develop the agenda for the calls.

29. 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 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; descriptions of any public forums held, and a summary of program integrity and related audit activities for the demonstration. The Annual Monitoring Report should 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.

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, 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.

30. 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 29(a).

31. 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.

VII. GENERAL FINANCIAL REQUIREMENTS

This project is approved for title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

32. 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 42.

33. Reporting Expenditures Subject to the title XIX Budget Neutrality Agreement. 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 15 (1/1/2018 – 12/31/2018), the state would use "15" 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 "Family Planning" to report expenditures in the MBES/CBES and in the budget neutrality workbook required to be submitted with the Annual Monitoring Report per STC 29.

c) MBES/CBES Schedule C Reporting Adjustments. To the extent necessary to align with the current demonstration cycle periods specified in STC 42, the state must submit prior period adjustments subsequent to the routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual to correct medical assistance expenditures reported starting with demonstration year 12 (10/1/2014 – 12/31/2015) through the current demonstration year 14. The state must complete any corresponding corrective adjustments to administrative costs reported for demonstration year 12 through demonstration year 14. The state shall complete these reporting adjustments within 12 months of the date of CMS' approval of this extension and provide written certification of the accuracy of the adjusted expenditures upon completion.

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.

34. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report administrative

costs that are directly attributable to the demonstration. All administrative costs must be identified on Form CMS-64.10.

35. 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.

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

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 29, 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.

37. 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 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.

38. Extent of Federal Financial Participation (FFP) for the Demonstration. CMS shall provide FFP for family planning and family planning related services at the applicable federal matching rates as described in STCs 19 and 20, subject to the limits and processes described below:

a) For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management, and sterilizations), and which are provided in a family planning setting, FFP will be available at the 90 percent federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

   Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate of 90 percent, as described in STC 19, should be entered in Column (D) on the CMS-64.9 Waiver Form.

b) Pursuant to 42 CFR §433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if provided by eligible Medicaid providers. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

39. 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 must 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.

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

a) Units of government, including governmentally operated health care providers, may

certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

VIII. MONITORING BUDGET NEUTRALITY

The following is the method by which budget neutrality will be monitored for the Mississippi Family Planning section 1115(a) Medicaid demonstration.

41. 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 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 budget neutrality expenditure limit shall be reported by the state using the procedures described in STC 33.

42. Budget Neutrality Annual Expenditure Limits. For each demonstration year, an annual budget limit will be calculated for the demonstration. Per agreement with the state, this program's annual demonstration cycle is now January 1 through December 31 instead of the original cycle period of October 1 through September 30. The state's adjusted demonstration years are as follows:

Demonstration Year 1 = October 1, 2003 – September 30, 2004
Demonstration Year 2 = October 1, 2004 – September 30, 2005
Demonstration Year 3 = October 1, 2005 – September 30, 2006
Demonstration Year 4 = October 1, 2006 – September 30, 2007
Demonstration Year 5 = October 1, 2007 – September 30, 2008
Demonstration Year 6 = October 1, 2008 – September 30, 2009
Demonstration Year 7 = October 1, 2009 – September 30, 2010
Demonstration Year 8 = October 1, 2010 – September 30, 2011
Demonstration Year 9 = October 1, 2011 – September 30, 2012
Demonstration Year 10 = October 1, 2012 – September 30, 2013
Demonstration Year 11 = October 1, 2013 – September 30, 2014
Demonstration Year 12 = October 1, 2014 – December 31, 2015*
Demonstration Year 13 = January 1, 2016 – December 31, 2016
Demonstration Year 14 = January 1, 2017 – December 31, 2017
Demonstration Year 15 = January 1, 2018 – December 31, 2018
Demonstration Year 16 = January 1, 2019 – December 31, 2019
Demonstration Year 17 = January 1, 2020 – December 31, 2020
Demonstration Year 18 = January 1, 2021 – December 31, 2021
Demonstration Year 19 = January 1, 2022 – December 31, 2022
Demonstration Year 20 = January 1, 2023 – December 31, 2023
Demonstration Year 21 = January 1, 2024 – December 31, 2024
Demonstration Year 22 = January 1, 2025 – December 31, 2025
Demonstration Year 23 = January 1, 2026 – December 31, 2026
Demonstration Year 24 = January 1, 2027 – December 31, 2027

*Demonstration Year 12 is a 15-month period for purposes of calculating budget neutrality and reporting on the Form CMS-64 quarterly Medicaid expenditure report in order to properly realign the demonstration cycle period to a calendar year basis.

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 2.78 percent) and the PMPM (total computable) ceiling for each demonstration year.

PMPM Ceilings for Family Planning Services			
DY 15	$67.08	**DY 20**	$76.93
DY 16	$68.94	**DY 21**	$79.07
DY 17	$70.86	**DY 22**	$81.27

DY 18	$72.83	**DY 23**	$83.53
DY 19	$74.85	**DY 24**	$85.85

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 forms listed in STC 32 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) Structure. The demonstration's budget neutrality model is structured as a "pass-through" or "hypothetical" expenditure population. Therefore, the state may not derive savings from the demonstration.

c) Risk. Mississippi 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, Mississippi shall not be at risk of changing economic conditions that impact enrollment levels. However, by placing Mississippi 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.

d) 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.

43. 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.

44. 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, 2027. 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.

Year	Cumulative Target Expenditures	Percentage
DY15	DY15 budget limit plus:	2 percent
DY16	DY15 and DY16 combined budget limit amount plus:	1.75 percent
DY17	DY15 through DY17 combined budget limit amount plus:	1.5 percent
DY18	DY15 through DY18 combined budget limit amount plus:	1.25 percent
DY19	DY15 through DY19 combined budget limit amount plus:	1.0 percent
DY20	DY15 through DY20 combined budget limit amount plus:	0.75 percent
DY21	DY15 through DY21 combined budget limit amount plus:	0.5 percent
DY22	DY15 through DY22 combined budget limit amount plus:	0.25 percent
DY23	DY15 through DY23 combined budget limit amount plus:	0.25 percent
DY24	DY15 through DY24 combined budget limit amount plus:	0 percent

45. 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 the demonstration approval period, the cumulative 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 budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

IX. EVALUATION

46. Draft Evaluation Design. The Draft Evaluation Design must be developed in accordance with CMS' provided guidance for family planning demonstrations. The state must submit for CMS comment and approval a Draft Evaluation Design with 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 evaluator in the development of the Draft Evaluation Design.

47. 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.

48. **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 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 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. 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.

49. **Evaluation Questions and Hypotheses.** Consistent with CMS' provided guidance on "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'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).

50. **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 any 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, a 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 evaluation design was adapted should be included. If the state is not requesting an extension of the demonstration, a 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 CMS approval period, a 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 final Interim Evaluation Report must comply with CMS' provided guidance in the "Preparing the Evaluation Report" document.

51. Cooperation with Federal Evaluators. As required by 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.

52. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with CMS' guidance provided in the "Preparing the Evaluation Report" document. 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 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.

53. State Presentations for CMS. CMS reserves the right to request that the state present and participate in discussions with CMS on the Evaluation Design, the state's Interim Evaluation Report, and/or the Summative Evaluation Report.

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

55. Additional Publications and Presentations. For a period of 24 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.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Annual Monitoring Report	Within 90 days following the end of each demonstration year	STC 29
Draft Evaluation Design Plan	Within 120 days after the approval of the demonstration extension	STC 46
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 48
Summative Evaluation Report	Within 18 months following the end of this demonstration extension period	STC 52

ATTACHMENT A: Family Planning Section 1115 Demonstration
Template for Annual Monitoring Report

Purpose and Scope of Annual Report:

The state must submit annual progress reports in accordance with the Special Terms and Conditions (STCs) and 42 CFR §431.420. The intent of these reports is to present the state's analysis of collected data and the status of the various operational areas, reported by month in the demonstration year. The report should also include a discussion of trends and issues over the year, including progress on addressing any issues affecting access, quality, or costs. Each annual report must include:

A. Executive Summary
B. Utilization Monitoring
C. Program Outreach and Education
D. Program Integrity
E. Grievances and Appeals
F. Annual Post Award Public Forum
G. Budget neutrality
H. Demonstration evaluation activities and interim findings.

ANNUAL MONITORING REPORT
FAMILY PLANNING SECTION 1115 DEMONSTRATIONS

State: _____
Demonstration Reporting Period: _____
Demonstration Year: _____
Approved start and end date of the Demonstration _____

A. Executive Summary
- **1.** Synopsis of the information contained in the report
- **2.** Program Updates
  - **a.** Current Trends or Significant Program Changes
    - i. Narrative describing any administrative and operational changes to the demonstration, such as eligibility and enrollment processes, eligibility redetermination processes (including the option to utilize administrative redetermination), systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes).
    - ii. Narrative on any demonstration changes, such as changes in enrollment, service utilization, and provider participation. Discussion of any action plan if applicable.
    - iii. Narrative on the existence of or results of any audits, investigations, or lawsuits that impact the demonstration.

3. Policy Issues and Challenges
    a. Narrative of any operational challenges or issues the state has experienced.
    b. Narrative of any policy issues the state is considering, including pertinent legislative/budget activity, and potential demonstration amendments.
    c. Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable.

B. Utilization Monitoring

The state will summarize utilization through a review of claims/encounter data for the demonstration population in the subsequent tables. This includes the following:

Table 1. Utilization Monitoring Measures

Topic	Measure [Reported for each month included in the annual report]
Utilization Monitoring	Unduplicated Number of Enrollees by Quarter
	Unduplicated Number of Beneficiaries with any Claim by Quarter (by key demographic characteristics such as age, gender, and income level)
	Utilization by Primary Method and Age Group
	Total number of beneficiaries tested for any sexually transmitted disease
	Total number of female beneficiaries who obtained a cervical cancer screening
	Total number of female beneficiaries who received a clinical breast exam

Table 2: Unduplicated Number of Enrollees by Quarter

	Number of Female Enrollees by Quarter				
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Unduplicated Female Enrollment*
Quarter 1					
Quarter 2					
Quarter 3					
Quarter 4					
	Number of Males Who Utilize Services by Age and Quarter				
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Unduplicated Male Enrollment*
Quarter 1					
Quarter 2					
Quarter 3					
Quarter 4					

*Total column is calculated by summing columns 2-5.

Table 3: Unduplicated Number of Beneficiaries with any Claim by Age Group and Gender per Quarter in the Demonstration Year

	Number of Females Who Utilize Services by Age and Quarter					
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Female Users *	Percentage of Total Unduplicated Female Enrollment
Quarter 1						
Quarter 2						
Quarter 3						
Quarter 4						
	Number of Males Who Utilize Services by Age and Quarter					
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Male Users*	Percentage of Total Unduplicated Male Enrollment
Quarter 1						
Quarter 2						
Quarter 3						
Quarter 4						

*Total column is calculated by summing columns 2-5.

Table 4: Utilization by Primary Method and Age Group per Demonstration Year

Primary Method	Total Users					
	14 years old and under	15 – 20 years old	21 – 44 years old	45 years old and older	Total*	Percent of All Devices
Sterilization						
Emergency Contraception						
Intrauterine Device (IUD)						
Hormonal Implant						
1-Month Hormonal Injection						
3-Month Hormonal Injection						
Oral Contraceptive						
Contraceptive Patch						
Vaginal Ring						
Diaphragm						
Sponge						
Female Condom						
Male Condom						

*Total column is calculated by summing columns 2-5.

Table 5: Number Beneficiaries Tested for any STD by Demonstration Year

Test	Female Tests		Male Tests		Total Tests	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Unduplicated number of beneficiaries who obtained an STD test						

Table 6: Total Number of Female Beneficiaries who obtained a Cervical Cancer Screening

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who obtained a cervical cancer screening		

Table 7: Breast Cancer Screening

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who received a Breast Cancer Screening		

C. Program Outreach and Education

1. General Outreach and Awareness

a. Provide information on the public outreach and education activities conducted this demonstration year; and,

b. Provide a brief assessment on the effectiveness of these outreach and education activities.

2. Target Outreach Campaign(s) (if applicable)

a. Provide a narrative on the populations targeted for outreach and education campaigns and reasons for targeting; and,

b. Provide a brief assessment on the effectiveness of these targeted outreach and education activities.

D. Program Integrity

Provide a summary of program integrity and related audit activities for the demonstration, including an analysis of point-of-service eligibility procedures.

E. Grievances and Appeals

Provide a narrative of grievances and appeals made by beneficiaries, providers, or the public, by type and highlighting any patterns. Describe actions being taken to address any significant issues evidenced by patterns of appeals.

F. Annual Post Award Public Forum

Provide a summary of the annual post award public forum conducted by the state as required by 42 CFR §431.420(c) that includes a report of any issues raised by the public and how the state is considering such comments in its continued operation of the

demonstration.

G. Budget Neutrality

1. Please complete the budget neutrality workbook.
2. Discuss any variance noted to the estimated budget, including reasons for variance in enrollment and/or in total costs, and/or in per enrollee costs. Describe any plans to mitigate any overages in budget neutrality by the end of the demonstration period.

H. Demonstration Evaluation Activities and Interim Findings

1. Please provide a summary of the progress of evaluation activities, including key milestones accomplished. Include:
   - **a.** Status of progress against timelines outlined in the approved Evaluation Design.
   - **b.** Any challenges encountered and how they are being addressed.
   - **c.** Status of any evaluation staff recruitment or any RFPs or contracts for evaluation contractual services (if applicable).
2. Description of any interim findings or reports, as they become available

ATTACHMENT B

Mississippi Family Planning Section 1115 Demonstration
Evaluation Design

July 9, 2020

General Background

The Mississippi Division of Medicaid (DOM) Family Planning Waiver (FPW) is designed to provide family planning services and family planning related services to eligible women and men throughout the state. Because the Secretary of Health and Human Services has and continues to grant section 1115 program authority, Mississippi Medicaid can cover family planning services and supplies for individuals not otherwise eligible for Medicaid or covered through the State Plan.

The Mississippi FPW demonstration was initially approved on January 31, 2003 and implemented October 1, 2003. The demonstration has been consistently extended since that date. The demonstration was originally implemented to provide family planning services to women between the ages of 13 through 44; ineligible for Medicaid benefits at the conclusion of their pregnancy coverage and who otherwise could not qualify for Medicaid, the Children's Health Insurance Program (CHIP), or any other creditable coverage that included family planning services. With the January 1, 2015 extension of the demonstration, the state received the Centers for Medicare & Medicaid Services (CMS) approval to cover women and men, ages 13 through 44, who are capable of reproducing with a Modified Adjusted Gross Income (MAGI) adjusted income of no more than 194% of the federal poverty level (FPL) and to provide family planning related services to the target population. The current FPW demonstration extension is approved from January 1, 2018 through December 31, 2027. There were no changes from the previous demonstration regarding services or eligibility criteria.

Since the implementation of the FPW in 2003, the state continues to work toward reaching the goal of increasing the number of women and men utilizing family planning services and family planning related services to reduce the number of unplanned pregnancies and subsequent births to the target population. From October 1, 2004 through December 31, 2017, 342,342 FPW beneficiaries received at least one family planning service and/or family planning related service.

FPW Eligible Population

The women and men targeted by DOM for the FPW demonstration must meet the applicable eligibility criterion as follows:

- Family income no more than 194% of the federal poverty level (post MAGI conversion).
- Must be capable of reproducing.
- Women and men ages 13-44 years.
- Must not have had a procedure that prevents them from reproducing.
- Must not have Medicare, CHIP, or any other health insurance or third-party medical coverage.
- U.S. citizen or documented immigrant.
- Resident of Mississippi.

A. Demonstration Goals and Objectives

The goals of the FPW demonstration are the following:

- Goal 1: Ensure access to and utilization of family planning and/or family planning–related services for individuals not otherwise eligible for Medicaid.
- Goal 2: Improve birth outcomes and improve or maintain health outcomes for the target population as a result of access to family planning and related services.
- Goal 3: Increase the overall savings attributable to providing family planning services.

Program Objective and Measures

Goal 1: Ensure access to and utilization of family planning and/or family planning–related services for individuals not otherwise eligible for Medicaid.

- Objective 1: Improving the access to and use of Medicaid family planning services by women who have received Medicaid pregnancy related service.
- Objective 2: Improving the access to and use of Medicaid family planning-related services by women and men who are not otherwise eligible for Medicaid.

Goal 2: Improve birth outcomes and improve or maintain health outcomes for the target population as a result of access to family planning and related services.

- Objective 3: Improving birth outcomes (e.g., low birth weight) and the health of women in the demonstration population.
- Objective 4: Increasing the child spacing interval among female FPW enrollees.
- Objective 5: Reducing the number of unintended pregnancies among women enrolled in the FPW.
- Objective 6: Reducing overall pregnancy among teenage women in the demonstration population.
- Objective 7: Reducing the number of repeat births among teenage women in the demonstration population.

Goal 3: Increase the overall savings attributable to providing family planning services.

- Objective 8: Decreasing the number of Medicaid deliveries, which will reduce annual expenditures for prenatal, delivery, and newborn services.
- Objective 9: Increasing the overall savings attributable to providing family planning services by covering women for one year postpartum.

B. Evaluation Questions and Hypotheses

The demonstration's core evaluation questions, hypotheses, data sources and analytic approaches are included in the table located in Section C.

C. Summary of Key Evaluation Questions, Hypotheses, Data Sources, and Analytic Approaches

Evaluation Component	Evaluation Question	Hypothesis	Measure	Data Source	Analytic Approach
Demonstration Goal 1: Ensure access to and utilization of family planning and/or family planning–related services for individuals not otherwise eligible for Medicaid • Objective 1: Improving the access to and use of Medicaid family planning services by women who have received Medicaid pregnancy related service. • Objective 2: Improving the access to and use of Medicaid family planning-related services by women and men who are not otherwise eligible for Medicaid.					
Process	How did beneficiaries utilize covered health services?	FPW enrollees will utilize family planning services and/or family planning related services.	Number of women enrolled in the FPW/Number of eligible women Number of FPW beneficiaries utilizing services by race/ethnicity /Total Number of FPW beneficiaries Number of beneficiaries by county of residence/Total number of FPW beneficiaries Number of beneficiaries who had a family planning or family planning related service encounter in each year of the demonstration/total number of beneficiaries Number of family planning services utilized/total number of beneficiaries Number of Females by age group (13-19, 20-24, 25-29, 30-34, 35-39, 40-44) utilizing FPW services/Total number of female FPW beneficiaries Number of Males by age group (13-19, 20-24, 25-29, 30-34, 35-39, 40-44) utilizing FPW services/Total number of male FPW beneficiaries Number of female sterilization/Total number of female beneficiaries Number of male sterilization/Total number of male beneficiaries	• Administrative data • Medicaid Management Information System (MMIS) claims data • Encounter claims • Pharmacy RX data	Descriptive statistics (proportions and means); time trend analysis; subgroup analysis; benchmark comparison when benchmark is available

Evaluation Component	Evaluation Question	Hypothesis	Measure	Data Source	Analytic Approach
			Number of female beneficiaries who utilized any contraceptive in each year of the demonstration/total number of female beneficiaries Number of female beneficiaries who utilized long-acting reversible contraceptives each year of the demonstration/total number of female beneficiaries Number of beneficiaries tested for any sexually transmitted disease (by STD)/total number of beneficiaries Number of female beneficiaries who obtained a cervical cancer screening/total number of female beneficiaries Number of female beneficiaries who received a clinical breast exam/total number of female beneficiaries		
	Do beneficiaries maintain coverage long-term (12 months or more)?	Beneficiaries will maintain coverage for one or more 12-month enrollment period.	Number of beneficiaries who completed one spell of 12-month coverage/total number of beneficiaries Number of beneficiaries re-enrolled for at least their second spell of coverage/total number of beneficiaries	• Administrative data • MMIS claims data • Encounter claims • Eligibility data/enrollment	Descriptive statistics (proportions); time trend analysis; subgroup analysis
Demonstration Goal 2: Improve or maintain health outcomes for the target population as a result of access to family planning and family planning-related services. • Objective 3: Improving birth outcomes (e.g., low birth weight) and the health of women in the demonstration population. • Objective 4: Increasing the child spacing interval among female FPW enrollees. • Objective 5: Reducing the number of unintended pregnancies among women enrolled in the FPW. • Objective 6: Reducing overall pregnancy among teenage women enrolled in the demonstration population. • Objective 7: Reducing the number of repeat births among teenage women in the demonstration population.					
Outcome/ Impact	Does the demonstration improve health outcomes?	Health outcomes of mothers and babies will improve as a result of increased	Number of FPW females with a second pregnancy less than 18 months of a previous birth/Total number of female enrollees Number of low birth-weight babies born to beneficiaries/Total number of babies born to beneficiaries	• Administrative data • MMIS claims data • Encounter claims	Descriptive statistics (proportions); time trend analysis;

Evaluation Component	Evaluation Question	Hypothesis	Measure	Data Source	Analytic Approach
		reproductive health care services.	Number of premature babies born to beneficiaries/Total number of babies born to beneficiaries	• MS State Department of Health (MSDH) vital statistics	subgroup analysis; benchmark comparison when benchmark is available
			Number of babies born to FPW females ages 13-19 years/Total number of female enrollees ages 13-19 years		
			Number of FPW females ages 13-19 years with a second pregnancy less than 18 months of a previous birth/Total number of female enrollees ages 13-19 years		
			Number of intended births among females aged 13-44 years/Number of live births plus abortions and fetal losses among females aged 13-44 years.		
	Are beneficiaries satisfied with services?	Beneficiaries will be satisfied with services	Satisfaction survey questions for FPW beneficiaries Number of respondents who have accessed family planning services and family planning-related services in the past 6 months/Total number of FPW survey respondents Number of respondents who were pleased with the care received/Total number of FPW survey respondents Number of respondents who reported if they received an appointment for care (FPW) as soon as they needed too/Total number of FPW survey respondents	• FPW beneficiary survey	Descriptive statistics (frequencies and means); time trend analysis; subgroup analysis; benchmark comparison when benchmark is available
Demonstration Goal 3: Increase the overall savings attributable to providing family planning services. • Objective 8: Decreasing the number of Medicaid deliveries, which will reduce annual expenditures for prenatal, delivery, and newborn services. • Objective 9: Increasing the overall savings attributable to providing family planning services by covering women for one year postpartum.					
Outcome/ Impact	Does the demonstration reduce the number of Medicaid deliveries?	As a result of increased reproductive health care services, FPW enrollees will have	Number of Medicaid deliveries/Total Number of Females aged 13-44 years	• Administrative data • MMIS claims data • Encounter claims • MS State Department of	Descriptive statistics (proportions); time trend analysis; subgroup

Evaluation Component	Evaluation Question	Hypothesis	Measure	Data Source	Analytic Approach
		fewer pregnancies which will lead to fewer Medicaid deliveries		Health (MSDH) vital statistics	analysis; benchmark comparison when benchmark is available
Outcome/ Impact	Does the demonstration reduce Medicaid expenditures for prenatal, delivery, and newborn services?	Access to reproductive health care services will reduce the number of Medicaid deliveries and related expenses	Medicaid expenditures related to prenatal, delivery, and newborn services	• Administrative data • MMIS claims data • Encounter claims	Descriptive statistics (proportions); time trend analysis; subgroup analysis; benchmark comparison when benchmark is available

D. Methodology

1. **Evaluation Design:** The evaluation design is a post-only assessment with sub-group stratification, with plans to include contemporaneous national benchmarks as comparisons (i.e., Healthy People 2020; National Survey of Family Growth (NSFG)) wherever feasible. The time frame for the post-only period will begin January 1, 2018 and end December 31, 2027. The demonstration will be evaluated annually, and a final evaluation will be conducted when the demonstration period ends.

2. **Data Collection and Sources:** DOM will collect data retrospectively each year of the demonstration. DOM will use administrative and survey data to measure the processes and outcomes/impact components of the FPW demonstration. MSDH Public Health Vital Statistics data will be used to assess birth outcomes, abortions, and fetal deaths.

   DOM Medicaid providers and pharmacies are required to submit claims through DOM's fiscal agent. FPW beneficiaries are enrolled in a specific category of eligibility (COE 029) to track family planning services and family planning related services. FPW enrollees are required to report demographic information (including race and ethnicity, gender, family income, and household size, etc.) at the time of enrollment and recertification.

   Survey: DOM will conduct a longitudinal survey that will be administered throughout each calendar year of the demonstration beginning in January and ending in December**.** The survey will be mailed to a representative sample of the FPW population. The purpose of the survey is to gather data from the FPW population interviewed, which will help examine enrollee characteristics, pregnancy intentions, contraceptive utilization, access and satisfaction with family planning services and family planning-related services. The table below indicates the sample size needed to achieve a 40% response rate each year of the demonstration. Several of the survey questions represent an adapted version of similar items in in the Consumer Assessment of Healthcare Providers System (CAHPS) Health Plan Survey.

Calculation of Estimated Sample Size Needed for the FPW Survey

Demonstration Year	Goal Completed Surveys	Target Response Rate	Minimum Sample Size Needed
DY 16	1331	40 percent	3327
DY 17	1368	40 percent	3420
DY 18	1406	40 percent	3515
DY 19	1445	40 percent	3612
DY 20	1485	40 percent	3712
DY 21	1526	40 percent	3815

DY 22	1577	40 percent	3942
DY 23	1620	40 percent	4050
DY 24	1665	40 percent	4162
DY 25	1711	40 percent	4277

DOM will utilize enrollment data to obtain the minimum sample size. Enrollment data from DY 15 is the baseline used to determine the goal for the number of completed surveys for the minimum sample size needed each DY to achieve a 40 percent response rate (i.e. 1331/0.40 =3327 sample size needed).

Evaluation Questions, Objectives and Related Items on the Survey

Evaluation Questions (EQ)	Objectives	Related Items on Survey
EQ 1: How did beneficiaries utilize covered services? EQ2: Do beneficiaries maintain coverage long-term (12 months or more)?	**Obj. 1:** Improving the access to and use of Medicaid family planning services by women who have received Medicaid pregnancy related service **Obj. 2:** Improving the access to and use of Medicaid family planning-related services by women and men who are not otherwise eligible for Medicaid	See Questions: 1-4; 19-25
EQ3: Does the demonstration improve health outcomes? EQ4: Are beneficiaries satisfied with services?	**Obj. 3**: Improving birth outcomes (e.g., low birth weight) and the health of women in the demonstration population. **Obj. 4:** Increasing the child spacing interval among female FPW enrollees. **Obj. 5:** Reducing the number of unintended pregnancies among women enrolled in the FPW. **Obj. 6**: Reducing overall pregnancy among teenage women enrolled in the demonstration population. **Obj. 7:** Reducing the number of repeat births among teenage women in the demonstration population.	See Questions: 5-18

EQ5: Does the demonstration reduce the number of Medicaid deliveries? EQ6: Does the demonstration reduce Medicaid expenditures for prenatal, delivery, and newborn services?	**Obj 8:** Decreasing the number of Medicaid deliveries, which will reduce annual expenditures for prenatal, delivery, and newborn services. **Obj.9:** Increasing the overall savings attributable to providing family planning services by covering women for one year postpartum.	See Questions: 14-25

3. **Data Analysis Strategy:** Quantitative administrative (claims and encounter, plus pharmacy claims), vital statistics and survey data will be analyzed using descriptive statistics to assess the characteristics of FPW beneficiaries (e.g., frequencies and means). Unadjusted trend analyses will be used to present the change of process and impact outcome measures over time. The analyses may be further stratified by subgroups (e.g., geography, age, race/ethnicity, income). Generalized linear regressions may be used to test the variations in the trends for the entire demonstration population and across different subgroups, and where relevant, *t*-test or chi-squared test will be used to measure the statistical significance. A two-tailed p-value of less than 0.05 will be considered statistically significant.

4. **Simplified Evaluation Budget:** Computer programing, analyses of the data, reparation for the required reports will be performed by existing DOM staff. Therefore, DOM does not anticipate any additional costs to conduct the evaluation other than the purchasing and the renewal of statistical software in the amount $2,387.00 per year and postage for mailing and returning of the survey estimated at $4000.00 each year.

E. Independent Contractor

DOM will not be contracting with an independent contractor to perform the evaluation. DOM program staff will conduct a fair and impartial evaluation and prepare an objective evaluation report utilizing enrollment, eligibility, survey, and claims data.