

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

April 28, 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 Mississippi's evaluation design, which responded to CMS comments provided to the state, for the section 1115 demonstration entitled "Healthier Mississippi" (Project Number 11-W-00185/4), effective through September 30, 2023. We sincerely appreciate the state's commitment to a rigorous evaluation of your demonstration.

CMS has added the approved evaluation design to the demonstration's Special Terms and Conditions (STC) as Attachment C. A copy of the STCs, which includes the new attachment, is enclosed with this letter. The approved evaluation design may now be posted to the state's Medicaid website within thirty days of CMS approval 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 this approved evaluation design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the renewal 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 with you and your staff on the Healthier Mississippi section 1115 demonstration. If you have any questions, please contact your CMS project officer, Ms. Lorraine Nawara. Ms. Nawara can be reached by email at Lorraine.Nawara@cms.hhs.gov.

Sincerely,



Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation



Andrea J. 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
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00185/4

TITLE: Healthier Mississippi Demonstration

AWARDEE: Mississippi Division of Medicaid

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Healthier Mississippi section 1115(a) Medicaid demonstration extension (hereinafter “demonstration”). The parties to this agreement are the Mississippi Division of Medicaid (state) 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 for the demonstration extension are effective as September 11, 2018 through September 30, 2023, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

- II.** Program Description and Objectives
- III.** General Program Requirements
- IV.** Eligibility, Benefits, and Cost Sharing
- V.** Delivery Systems
- VI.** General Reporting Requirements
- VII.** General Financial Requirements
- VIII.** Monitoring Budget Neutrality for the demonstration
- IX.** Evaluation of the Demonstration
- X.** Schedule of State Deliverables

Attachment A: Developing the Evaluation Design

Attachment B: Preparing the Evaluation Report

Attachment C: Evaluation Design (reserved)

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II. PROGRAM DESCRIPTION AND OBJECTIVES

The Healthier Mississippi demonstration was approved in September 2004 and provides coverage for aged, blind, or disabled individuals with incomes at or below 135 percent of the federal poverty level (FPL) who are not eligible for Medicare and do not otherwise qualify for Medicaid.

In the 2004 legislative session, the Mississippi Legislature voted to discontinue Medicaid coverage for the optional Poverty Level Aged and Disabled (PLAD) group effective July 1, 2004. Concerned that this population was at risk for costly adverse events, including institutional placement, if medical regimens were not maintained, the state applied and received approval for a section 1115 demonstration to continue coverage for this population.

The demonstration was predicated on the assumption that continued access to medical care by the PLAD population, will delay deterioration in health status which drives hospitalization and/or institutionalization in a nursing facility. Under the 2010 renewal, the state requested and CMS increased the enrollment cap from 5,000 to 5,500. Under the 2015 renewal, CMS approved two changes: increasing the enrollment limit from 5,500 to 6,000 and adding to the benefit package the following previously excluded services: podiatry, eyeglasses, dental, and chiropractic services.

With this demonstration, Mississippi expects to achieve the following goals:

1. Reduce hospitalizations, and improper use of the emergency department;
2. Increase the utilization of ambulatory/preventive health visits each demonstration year.
3. Increase the number of preventive health screenings each demonstration year.
4. Increase the proportion of adults with diabetes who have a hemoglobin A1c (HbA1c) measurement at least once a year each demonstration year.
5. Increase the proportion of adults with diabetes who have an annual dilated eye examination each demonstration year.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.
- 3. Changes in Medicaid Law, Regulation, and Policy.** The state must, within the

timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

CMS reserves the right to amend these STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration per STC 7. CMS will notify the state thirty (30) days in advance of the expected approval date of the amended

s to align with mandated changes in Medicaid law, regulation, and policy that directly impact this demonstration program.

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

- a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
- b) If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. State Plan Amendments. The state will not be required to submit a title XIX state plan amendment for changes to any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs.

6. Changes Subject to the Amendment Process. Changes related to program design, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS

for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with 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 herein. Amendment requests must include, but are not limited to, the following:

- a) An explanation of the public process used by the state, consistent with the requirements of STC 8, to reach a decision regarding the requested amendment;
- b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and,
- d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

- 8. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 Code of Federal Regulations (CFR) section 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 section 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 section 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state’s approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

- 9. Extension of the Demonstration.** No later than twelve (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 CFR section 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 10.

10. Demonstration Transition and 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.

- 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, together with the effective date and a transition and phase-out plan. At least six (6) 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 thirty (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 thirty (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 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 determined eligible, 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 fourteen (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 sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR sections 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 section 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 section 435.916.
- e) Exemption from Public Notice Procedures 42.CFR section 431.416(g): CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR section 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 (6) 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.

11. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the demonstration project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. Finding of Non-Compliance. CMS may issue deferrals in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter 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 (30) 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. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).
 - 1) CMS may decline the extension request.
 - 2) Should CMS agree in writing to the state’s request, a corresponding extension of the deferral process described below can be provided.
 - 3) 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) The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
- d) When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
- e) 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 renewing a demonstration or obtaining a new demonstration.

- f) CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

13. 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 waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the 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.

14. 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.

15. Federal Financial Participation (FFP). No federal matching for administrative or medical assistance payments for services provided under this demonstration will take effect until the effective date identified in the CMS demonstration approval documents.

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

IV. ELIGIBILITY, BENEFITS AND COST SHARING

17. Demonstration Eligibility.

- a) The group described in STC 17(b), which is made eligible for the demonstration by virtue of the expenditure authority expressly granted in this demonstration, is subject to all applicable Medicaid laws or regulations in accordance with the state plan, except as specified as not applicable in the expenditure authority for this demonstration.
- b) Eligibility for the Healthier Mississippi demonstration is limited to aged, blind, or disabled individuals who are not eligible for Medicare and do not otherwise qualify for Medicaid, who are not inpatients in a long term care institution, and whose:

- i. Income is at or below 135 percent of the FPL for an individual or couple, calculated using a methodology based on the SSI program, as well as income exclusions approved under the state plan under the authority of section 1902(r)(2) of the Social Security Act; and,
- ii. Resources are below \$4,000 for an individual and \$6,000 for a couple.

18. Enrollment Cap. The Healthier Mississippi enrollment cap is 6,000. When enrollment reaches 6,000, further enrollment is suspended and individuals making an application are placed on a waiting list. Individuals are moved off the waiting list and enrolled in the demonstration as openings become available.

19. Benefit Package. Children (ages 0 through 20) enrolled in the demonstration receive all Medicaid state plan benefits, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Adults (ages 21 and older) enrolled in the demonstration receive most services covered under the Medicaid state plan with the same service limits per the Medicaid state plan. Maternity and newborn care are available to individuals who need them by enrolling in Medicaid on a different basis.

Services Not Covered for Adults
Swing bed in a skilled nursing facility
Long-term care services (nursing facility, home and community based waiver, and ICF/IID services)
Maternity and Newborn Care

Admission to Nursing Facilities: Expenditures incurred for any services received while a Healthier Mississippi enrollee is an inpatient in a long term care institutional setting will not be claimed under the demonstration. Any individual enrolled in Healthier Mississippi who is admitted to a nursing facility or other long term care setting, either temporarily (for less than 30 days) or for a longer admission, will be assessed for eligibility under a Medicaid State Plan covered category. Such individuals will be disenrolled from the demonstration upon admission to an institution and assessed for re-enrollment into the demonstration upon discharge from the institutional setting.

20. Cost Sharing. There are no cost-sharing requirements for children enrolled in the demonstration. Adult recipients are subject to cost sharing requirements that would be applicable if they were provided coverage under the state plan. A family's total annual out-of-pocket cost sharing cannot exceed five percent of the family's gross income. There is no premium charged for any recipient under the demonstration.

V. DELIVERY SYSTEMS

21. Service Delivery. Demonstration services are delivered through the state's fee-for-service provider network.

VI. GENERAL REPORTING REQUIREMENTS

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

23. 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.

24. Cooperation with Federal Evaluators. As required under 42 CFR section 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 12.

25. Annual Monitoring Reports. The state must submit one (1) Annual Report each DY. The Annual Report is due no later than ninety (90) days following the end of the DY. The state shall also submit semi-annual report(s) *at the request* of CMS. If semi-annual reports are requested, the state will have ninety (90) days to submit the first semi-annual report following the CMS request, and subsequent semiannual reports must be submitted in six-month intervals following the first semiannual report. In addition, CMS reserves the right to increase the frequency of reporting as deemed necessary by CMS (e.g., to require quarterly reports). If CMS increases the frequency of required reports (e.g., to

semiannual or quarterly), all required reports must meet the requirements for the Annual Reports. The Annual Reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

- a) Operational Updates – Per 42 CFR section 431.428, the Annual Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b) Performance Metrics – Per 42 CFR section 431.428, the Annual Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Annual Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
- c) Budget Neutrality and Financial Reporting Requirements – Per 42 CFR section 431.428, the Annual Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.
- d) Evaluation Activities and Interim Findings – Per 42 CFR section 431.428, the Annual 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.

26. Close out Report. Within 120 days after the expiration of the demonstration, the state

must submit a draft Close Out Report to CMS for comments.

- a) The draft report must comply with the most current guidance from CMS.
- b) The state will present to and participate in a discussion with CMS on the Close-Out report.
- c) The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
- d) The final Close Out Report is due to CMS no later than thirty (30) 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 12.

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

- a) The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.
- b) CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- c) The state and CMS will jointly develop the agenda for the calls.

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

VII. GENERAL FINANCIAL REQUIREMENTS

29. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section VIII.

30. Expenditures Subject to the Budget Neutrality Expenditure Limit. All expenditures for health care services for demonstration participants, as defined in STC 31(d), are subject to the budget neutrality agreement.

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

- a) **Tracking Expenditures.** In order to track expenditures, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All 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 (11-W-00185/4) assigned by CMS, including the project number extension which indicates the demonstration year (DY) in which services were rendered.
- b) **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. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the state Medicaid Manual.
- c) **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64. 9 Waiver for the demonstration, and not on any other CMS-64. 9 form (to avoid double counting). Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.
- d) **Use of Waiver Forms.** For each DY, a Waiver Form CMS-64.9 Waiver and/or 64. 9P Waiver must be submitted each quarter to report title XIX expenditures associated with the demonstration. The expression in quotations marks, for the Population below, is the waiver name to be used to designate this waiver form in the MBES/CBES system.
 - i. **Demonstration Population 1 "Medicaid Only":** Aged, blind, or disabled individuals enrolled in the demonstration at or below 135 percent of the FPL

who are not eligible for Medicare and do not otherwise qualify for Medicaid.

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

32. 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 FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and state and Local Administrative 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 the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter that just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

33. Extent of FFP. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in section

- a) Administrative costs, including those associated with the administration of the demonstration; and,
- b) Net expenditures and prior period adjustments, made under an approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

34. Sources of Non-federal Share. The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures that such funds shall not be used as the 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.

- d) CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- e) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- f) The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

35.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; and,
- e) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures.

Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state 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, and 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.

36. Monitoring the Demonstration. The state must provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

37. 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.

VIII. MONITORING BUDGET NEUTRALITY

38. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS's assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

39. Risk. Mississippi shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not for the number of demonstration eligibles. Because CMS provides FFP for all demonstration eligibles, Mississippi shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Mississippi at risk for the per capita costs for current, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

40. Demonstration Population Used to Calculate the Budget Neutrality Expenditure Cap. The following describes the method for calculating the budget neutrality expenditure cap for the demonstration:

- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group (EG) described as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under STC 29 for the demonstration

population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (ii) below.

- ii. The PMPM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility group subject to the budget neutrality agreement under this demonstration are specified below. The PMPM was constructed based on the 2019 President’s Budget for Medicaid and the PMPMs in approved STCs from the previous eligibility period. The growth rate and PMPM amounts for the demonstration population are shown below. The demonstration population is a “pass-through” or “hypothetical” population. Therefore, the state may not derive savings from this population.

Eligibility Group	Growth Rate	DY 15	DY 16	DY 17	DY 18	DY 19
		10/01/2018 through 09/30/2019	10/01/2019 through 09/30/2020	10/01/2020 through 09/30/2021	10/01/2021 through 09/30/2022	10/01/2022 through 09/30/2023
Demonstration Population 1 – Medicaid only	4.1%	\$2,672.71	\$2,782.29	\$2,896.36	\$3,015.11	\$3,138.73

- iii. The annual budget neutrality expenditure cap for the demonstration as a whole is the sum of the projected annual expenditure cap for the demonstration population calculated in subparagraph (i) above.
- b) 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 extension approval period, as reported on the forms listed in STC 31 above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period, 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.
 - c) The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality expenditure caps calculated in subparagraph (a)(iii). The federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration population described in STC 31(d) during the demonstration period reported in accordance with STC 30.

41. 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.

42. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

43.

Year	Cumulative Target Expenditures	Percentage
DY15	DY15 budget limit plus:	2 percent
DY16	DY15 and DY16 combined budget limit amount plus:	1.5 percent
DY17	DY15 through DY17 combined budget limit amount plus:	1.0 percent
DY18	DY15 through DY18 combined budget limit amount plus:	0.5 percent
DY19	DY15 through DY19 combined budget limit amount plus:	0 percent

44. Exceeding Budget Neutrality. If, at the end of this demonstration period, the cumulative budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

IX. EVALUATION OF THE DEMONSTRATION

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

46. 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.

47. Draft Evaluation Design. The draft evaluation design must be developed in accordance with attachment A “Developing the Evaluation Design.” 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 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 C” 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 25, 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.

49. Evaluation Questions and Hypotheses. Consistent with attachments A and B (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).

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 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."

51. 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.

52. 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.

53. 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.

54. 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.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Quarterly Expenditures Reports	Within 30 days following the end of each quarter using Form CMS-64	STC 29
Annual Monitoring Report	Within 90 days following the end of each demonstration year (unless CMS requests reports more frequently than annually)	STC 25
Draft Evaluation Design Plan	Within 120 days after the approval of the demonstration extension	STC 47
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 48
Interim Evaluation Reports	With submission of a demonstration extension request.	STC 50
Summative Evaluation Report	Within 18 months following the end of the demonstration approval period identified in these STCs.	STC 51

ATTACHMENT A: Developing the Evaluation Design

Introduction

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

Expectations for Evaluation Designs

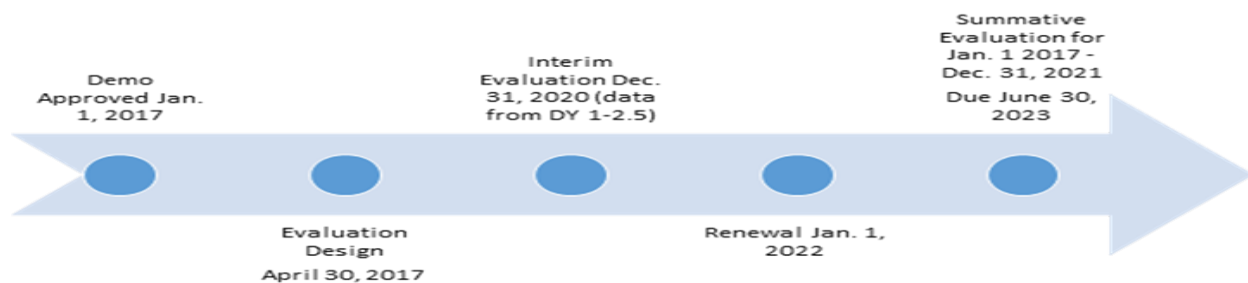
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses,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

The format for the Evaluation Design is as follows:

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

Submission Timelines

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



Required Core Components of All Evaluation Designs

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

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

- 1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

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

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

- 2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams:
<https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>
- 3) Identify the state's hypotheses about the outcomes of the demonstration:
 - a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
 - b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

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

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

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

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

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
- b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
- c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
- d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

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

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

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

E. Special Methodological Considerations- CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

- 1) When the state demonstration is:
 - a. Long-standing, non-complex, unchanged, or
 - b. Has previously been rigorously evaluated and found to be successful, or
 - c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)
- 2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes; and
 - b. No or minimal appeals and grievances; and

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

F. Attachments

- 1) Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.
- 2) Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
- 3) Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B: Preparing the Evaluation Report

Introduction

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

Expectations for Evaluation Reports

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

Intent of this Attachment

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

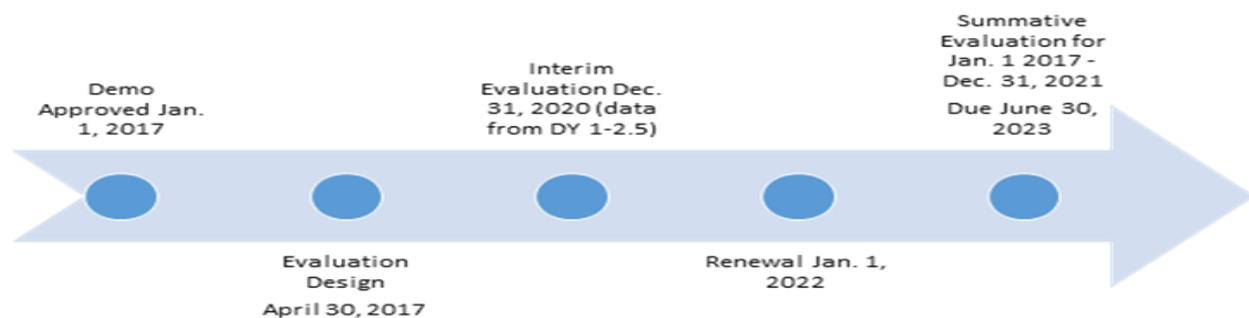
The format for the Interim and Summative Evaluation reports are as follows:

- A. Executive Summary;
- B. General Background Information;

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

Submission Timelines

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



Required Core Components of Interim and Summative Evaluation Reports

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

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

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

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

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

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

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

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

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

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

E. Methodological Limitations

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

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

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

- 1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
- 2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

- a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives –

In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

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

- 1) What lessons were learned as a result of the demonstration?
- 2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

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

**ATTACHMENT C:
Evaluation Design (reserved)**



MISSISSIPPI DIVISION OF
MEDICAID

***Healthier Mississippi Project
Section 1115 Demonstration
Project Number 11-W-00185/4
Evaluation Design***

April 15, 2020

*550 High Street, Suite 1000
Jackson, Mississippi 39201
Website: medicaid.ms.gov*

The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

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**Healthier Mississippi Project
Section 1115 Demonstration
Project Number 11-W-00185/4**

**Evaluation Design
April 15, 2020**

I. Historical Background of the Demonstration

Legislation passed during the Mississippi 2004 Legislative Session discontinued the optional Poverty Level Aged & Disabled (PLAD) category of eligibility, effective June 30, 2004. Due to concerns that this population was at risk for costly adverse events, such as institutional placement if medical regimens were not maintained, the state applied and received approval for a section 1115 demonstration to continue coverage for this population. The Healthier Mississippi Waiver (HMW) was originally approved by the Centers for Medicare & Medicaid Services (CMS) for a five (5) year period beginning on October 1, 2004 through September 30, 2009. The HMW demonstration continued to operate under a series of temporary approvals for an additional five (5) years from October 1, 2009 through July 23, 2015. The Division of Medicaid received an approval for a five (5) year extension for the period of July 24, 2015 through September 30, 2018. Beginning with the July 24, 2015 through September 30, 2018 extension, the HMW enrollment limit increased from 5,500 to 6,000 and provided coverage for podiatry, eyeglasses, dental, and chiropractic services which were excluded from previous demonstration years. Currently, the demonstration's special terms and conditions (STCs) are approved from October 1, 2018 through September 30, 2023. There were no changes in the eligibility requirements or covered services from the previous demonstration.

Eligibility for the Healthier Mississippi demonstration is limited to aged, blind, or disabled individuals who are not eligible for Medicare, do not qualify for Medicaid, and are not in a long term care institution, and whose:

- Income is at or below 135% of the Federal Poverty Level (FPL) for an individual or a couple calculated using a methodology based on the Supplemental Security Income (SSI) program, as well as income exclusions approved under the State Plan under the authority of Section 1902(r)(2) of the Social Security Act, and
- Resources are below \$4,000 for an individual and \$6,000 for a couple.

Children (ages 0 through 20) enrolled in the demonstration receive all Medicaid state plan benefits, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Adults (ages 21 and older) enrolled in the demonstration receive all services covered under the

Medicaid state plan with the same service limits with the exception of the following services:

- Long-term care services(nursing facility, home and community based waiver, and Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) services),
- Swing bed services in a skilled nursing facility, and
- Maternity and newborn care services.

HMW beneficiaries who require long-term care, swing bed services in a skilled nursing facility, or maternity and newborn care services would qualify for Medicaid and, therefore, would be deemed ineligible for the waiver. HMW enrollees are assigned to a specific category of eligibility (045) to ensure the population is easily identifiable and to ensure the number of enrollees does not exceed the cap of 6,000.

II. Demonstration Goals and Evaluation Hypotheses and Research Questions

Mississippi Medicaid intends to measure the performance of the demonstration goals through the following quantifiable target percentages. These percentages were determined by using the percent change for demonstration years 12 through 14 (fiscal years 2016-2018):

1. Reduce hospitalizations and improper use of the emergency department (ED) by two percent (2%) for the duration of the demonstration.
2. Increase the utilization of ambulatory/preventive health visits by two percent (2%) for the duration of the demonstration.
3. Increase the number of preventive health screenings by one percent (1%) for the duration of the demonstration.
4. Increase the proportion of adults with diabetes who have a hemoglobin A1c (HbA1c) measurement at least once a year by two percent (2%) for the duration of the demonstration.
5. Increase the proportion of adults with diabetes who have an annual dilated eye examination by four percent (4%) for the duration of the demonstration.

The hypotheses and research questions listed below promote the objectives of Title XIX by:

- Providing payments for medical assistance to low-income aged, blind, and disabled individuals, not eligible for Medicaid or Medicare; and
- Providing access to needed medical services.

Evaluation Question 1: How do the rates of inpatient hospitalization and non-emergent use of emergency department visits evolve over time among the HMW beneficiaries? Will HMW beneficiaries who access ambulatory and preventive services have fewer hospitalizations and emergency department visits?

Hypothesis 1: The rates of hospitalization and improper use of the emergency department visits will fall among HMW beneficiaries over time, and the HMW beneficiaries will have fewer hospitalizations and emergency department visits after accessing ambulatory and

preventive services.

Evaluation Question 2: Will providing benefits under the HMW demonstration lead to an increase in the utilization of ambulatory/preventive health visits among HMW beneficiaries?

Hypothesis 2: HMW beneficiaries with access to benefits under the HMW demonstration will have an increase in the utilization of ambulatory/preventive health visits.

Evaluation Question 3: Will providing benefits under the HMW demonstration result in an increase in age appropriate preventive screenings?

Hypothesis 3: HMW beneficiaries with access to benefits will have an increase in the utilization of age appropriate preventive screenings.

Evaluation Question 4: Will providing benefits under the HMW demonstration increase the number of annual HbA1c tests among HMW beneficiaries diagnosed with diabetes?

Hypothesis 4: HMW beneficiaries diagnosed with diabetes are more likely to have an annual HbA1c test performed as a result of having access to HMW benefits.

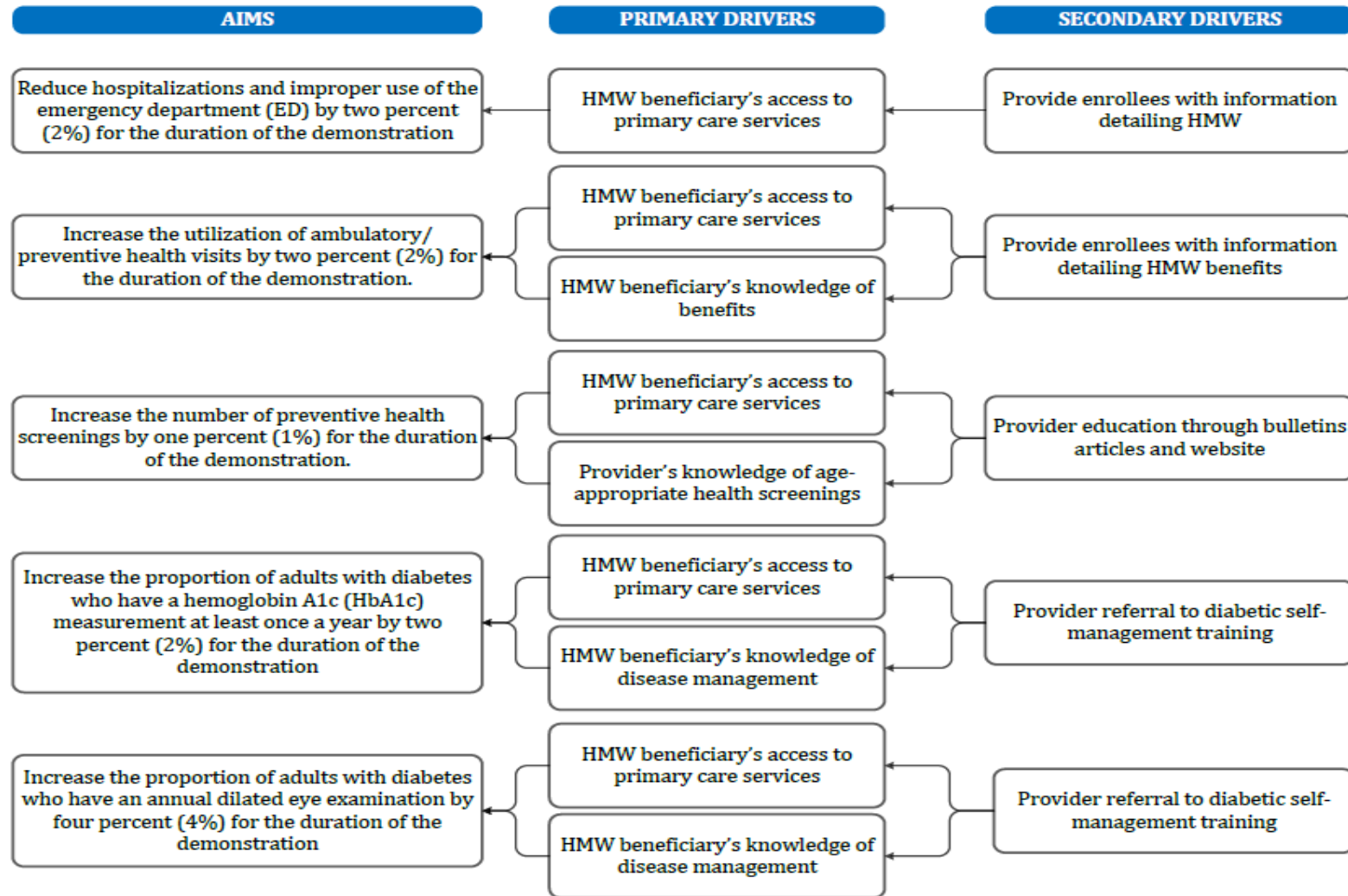
Evaluation Question 5: Will providing benefits under the HMW demonstration increase the number of annual dilated eye examinations among HMW beneficiaries diagnosed with diabetes?

Hypothesis 5: HMW beneficiaries diagnosed with diabetes are more likely to have an annual dilated eye examination as a result of having access to HMW benefits.

Evaluation Question 6: Are HMW beneficiaries satisfied with the demonstration services?

Hypothesis 6: HMW beneficiaries are more likely to report being satisfied than not with the benefits under the demonstration.

III. Healthier Mississippi Waiver Driver Diagram



Methodology

Evaluation Design

This evaluation will assess the performance of the demonstration goals using a one-group posttest-only design of HMW beneficiaries and their utilization of the available services provided under the HMW benefit plan. Also, the trend analysis will incorporate appropriate statistical testing to show if changes over time are statistically significant. Qualitative findings from three focus groups and key informant interviews will be used to complement and contextualize the descriptive quantitative analyses.

All findings over the period of the demonstration will be assessed against the target goals for changes in service utilization outlined under the objectives of the demonstration for the current period of performance in Section II above.

Target and Comparison Populations

The target population is individuals that are aged, blind, or disabled who are not eligible for Medicare or Medicaid, not in a long term care institution, and whose:

- Income is at or below 135% of the Federal Poverty Level (FPL) for an individual or a couple calculated using a methodology based on the SSI program, as well as income exclusions approved under the State Plan under the authority of Section 1902(r)(2) of the Social Security Act, and
- Resources are below \$4,000 for an individual and \$6,000 for a couple.

The state was unable to determine a population that was comparable to the HMW population; therefore, the state is using data from demonstration years 12 through 14 (FY 16-18) to analyze trends.

Evaluation Period

The evaluation will be conducted for the demonstration period of October 1, 2018 through September 30, 2023.

Table 1: Evaluation Outcomes Measures

Metric	Description	Numerator/Denominator
Inpatient hospitalization rate	Beneficiaries under age 75 who had at least one acute care hospitalization during the measurement year	Number of HMW beneficiaries under age 75 with at least one inpatient hospitalization during the measurement year/Number of beneficiaries under age 75 during the measurement year
Non-emergent use of emergency department	Beneficiaries under age 75 who had at least one non-emergent ED visit during the measurement year	Number of HMW beneficiaries under age 75 with at least one non-emergent ED visit during the measurement year/Number of beneficiaries under age 75 during the measurement year
Inpatient hospitalization rate for beneficiaries who access ambulatory and preventive services	Number of hospitalizations for beneficiaries under age 75 who had at least one acute care hospitalization, who also accessed ambulatory and preventive services during the measurement year	Number of hospitalizations for HMW beneficiaries under age 75 that accessed ambulatory and preventive services during the measurement year/Number of hospitalizations for HMW beneficiaries under age 75 during the measurement year
Emergency department rate for beneficiaries who access ambulatory and preventive services	Number of ED visits for beneficiaries under age 75 who accessed ambulatory and preventive services during the measurement year	Number of ED visits for beneficiaries under 75 that accessed ambulatory and preventive services during the measurement year/Number of ED visits for HMW beneficiaries under age 75 during the measurement year
Ambulatory/Preventive Health Visits	Percentage of beneficiaries age 20 years and older who had at least one ambulatory or preventive care visit per year	Number of beneficiaries 20 and older who had at least one ambulatory or preventive care visit during the measurement year/Number of HMW 20 and older during the measurement year
Cervical Cancer Screening	Percentage of women 21-64 years of age who received one or more Pap test to screen for cervical cancer	Number of HMW women, ages 21-64, who received screenings for cervical cancer during the measurement year/Number of HMW women 21-64 years of age during the measurement year
Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer once during the measurement year	Number of HMW women, ages 50-74, who had a mammogram during the measurement year/ Number of women, ages 50-74, during the measurement year
Colorectal Cancer	Percentage of beneficiaries 50-75	Number of HMW beneficiaries, ages 50-75, who received

Screening	years of age who had appropriate screening for colorectal cancer	screenings for colorectal cancer during measurement year/ Number of HMW beneficiaries, ages 50-75 during the measurement year
Comprehensive Diabetes Care: Eye Exam	Percentage of beneficiaries 18-75 years of age with diabetes who had a retinal or dilated eye exam during the measurement period	Number of HMW beneficiaries, ages 18 – 75, with diabetes who had a retinal or dilated eye exam during the measurement period/Number of HMW beneficiaries ages 18 - 75 with diabetes during the measurement year
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	The percentage of beneficiaries 18-75 years of age with diabetes who received an HbA1c test during the measurement year	Number of HMW beneficiaries, ages 18-75, with diabetes who received an HbA1c test during the measurement year/Number of HMW beneficiaries ages 18-75 with diabetes during the measurement year

Data Sources

The data will come from Medicaid claims, which are housed in the Medicaid Management Information Systems (MMIS) and Division Support System (DSS). DOM will carefully review claims data to ensure the best available data is used for reporting purposes. Data for the evaluation will be processed and validated throughout the demonstration period. Additionally, to contextualize and support the quantitative data analysis, we plan to use focus groups as a means to learn more in-depth about the beneficiary experience of the Healthy Mississippi Waiver. This will help gauge information on participant perception of their health, how they think the demonstration is helping with their specific health issues, and their experience with service delivery and access to care. The participants will be recruited accounting for geographic, race/ethnicity, age, tenure, and other relevant diversity criteria. A complete account of the participant selection criteria and recruitment protocol will be included in the demonstration's interim and summative evaluation reports.

To ensure the validity of the findings, our effort will adhere to the key principles of focus group methodology:

- (1) Remain neutral and unbiased in recruitment, questions development, and analysis;
- (2) Design strategies maximize the diversity of experiences represented;
- (3) Maintain consistency throughout the focus group process; and
- (4) Adhere to ethical obligation of confidentiality and informed consent.

The use of focus groups as a research tool to explore a particular topic by gathering the experiences and perceptions of a selected target population has certain advantages over other information gathering methods, such as (a) producing results more quickly, (b) group interaction is generally more comfortable for participants, (c) offers increased flexibility allowing the participant to individualize responses and researchers to probe deeper on particular points, (d) results are generally easier to understand than statistical findings, and (e) they complement more structured quantitative data.¹

In order to facilitate the focus group activities, we plan to ask key informants, such as Medicaid administrators, service/support providers, advocates, and perhaps family members, to constitute a focus group advisory committee. The committee will help to:

- (1) Refine the scope of the focus groups for clear project description;
- (2) Draft questions needed to facilitate participant discussion around the goals;
- (3) Recommend a recruitment protocol and plan;
- (4) Develop appropriate support materials (scripts for recruitment and question delivery, consent, registration, and other forms, etc.);
- (5) Identify appropriate focus group scheduling options;
- (6) Determine if and what incentives should be utilized; and
- (7) As key informants, to provide insightful feedback supporting Interpretations of both the quantitative findings and the information gathered from the focus groups.

¹ Ward, Helen and Atkins, Julie. 2002. "From Their Lives: A Manual on How to Conduct Focus Groups of Low-Income Parents." University of Southern Maine. Accessed on March 22, 2020 at: <https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1100&context=facbooks>.

Approximately two weeks after a sufficient number of the target population has successfully been recruited, the first focus group will be implemented. To facilitate convenience and thus, attendance, there will be in-person focus groups in three locations (north, central, and south) in the state. Approximately 14-16 participants will be recruited and confirmed for each group with the goal of having approximately eight beneficiaries participating in each. Staffing each focus group will be a primary facilitator, secondary facilitator, and a designated note-taker (that supports the electronic recording). A total of approximately 8-9 engagement, exploratory, and exit questions will be used to help participants get comfortable, acquire useful information, and solicit any additional comments. It is anticipated that each focus group session will last 60 - 90 minutes. A staff debriefing will occur after each session to provide guidance for subsequent sessions and identify any departures from protocol and to assess the group process. A final report of focus group findings will be drafted, analyzed, and included in the evaluation report for the demonstration. Progress of focus group activities and a summary of key findings will also be incorporated in the relevant monitoring reports due to CMS. If recommended by the advisory committee and authorized by the state, we plan to use an incentive (gift card or such) to promote and facilitate participation in the focus groups.

To better contextualize the quantitative data analysis, we plan to conduct the focus groups after we have initial indications of our quantitative findings. This way, we will be able to refine the scope and questions for focus groups further. It is anticipated that the focus group activities will begin in the first quarter of 2022, take approximately seven months to complete, and findings made part of the Interim Evaluation Report due in September later that year. A tentative timeline is illustrated in Attachment V of this document.

Analytic Methods

Proposed methods for addressing the evaluation questions and hypotheses of the demonstration are described in the following table.

The effects of the demonstration are isolated from other initiatives occurring in the state, as there are no other initiatives in Mississippi for this population. Enrollees in the HMW are not eligible for Medicaid.

Table 2: Summary of Evaluation Hypotheses, Research Questions, Outcome Measures, Population, Data Sources, and Analytic Approaches

Research Question	Outcome Measure(s)	Population	Data Sources	Analytic Approach
Hypothesis 1: The rates of hospitalization and improper use of the emergency department visits will fall among HMW beneficiaries over time, and the HMW beneficiaries will have fewer hospitalizations and emergency department visits after accessing ambulatory and preventive services.				
How do the rates of inpatient hospitalization and non-emergent use of emergency department visits evolve over time among the HMW beneficiaries? Will HMW beneficiaries who access ambulatory and preventive services have fewer hospitalizations and emergency department visits?	<p>Emergency department visit and inpatient hospitalization</p> <p>Emergency department visit and inpatient hospitalization for beneficiaries who access ambulatory and preventive services</p>	<ul style="list-style-type: none"> Beneficiaries under age 75 Beneficiaries under age 75 who access ambulatory and preventive services at least once during the past six months 	<p>Medicaid Fee for Service (FFS) claims data</p> <p>Enrollment data</p>	<p>Descriptive statistics (Central tendency measures such as mean and median; variability measures, such as standard deviation and range)</p> <p>Also, include subgroup analysis; compare beneficiaries under age 75 who had used ambulatory and preventive services at least once during the measurement year and those that did not.</p> <p>Regression adjusted trend analysis to show whether there is any noticeable pattern during the span of the demonstration.</p>
Hypothesis 2: HMW beneficiaries with access to benefits under the HMW demonstration will have an increase in the utilization of ambulatory/preventive health visits.				

Research Question	Outcome Measure(s)	Population	Data Sources	Analytic Approach
Will providing benefits under the HMW demonstration lead to an increase in the utilization of ambulatory/preventive health visits among HMW beneficiaries?	Percentage of beneficiaries ages 20 and older who had at least one ambulatory/preventive visit during the measurement year	HMW beneficiaries ages 20 and older	Medicaid Fee for Service (FFS) claims data Enrollment data	Descriptive statistics (central tendency measures such as mean and median; variability measures, such as standard deviation and range) Statistical tests will include (1) McNemar test Cochran-Armitage test for trends), or regression adjusted trend analysis to show whether there is any noticeable pattern during the span of the demonstration.

Research Question	Outcome Measures	Population	Data Sources	Analytic Methods
Hypothesis 3: HMW beneficiaries with access to benefits will have an increase in the utilization of age-appropriate screenings.				
Will providing benefits under the HMW demonstration result in an increase in age appropriate screenings?	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer once during the measurement year	HMW women 50-74 years of age	Medicaid Fee for Service (FFS) claims data	Descriptive statistics (central tendency measure, such as mean and median; variability measures, such as standard deviation and range)
	Percentage of women 21-64 years of age received one or more Pap test to screen for cervical cancer	HMW women 21-64 years of age		
	Percentage of beneficiaries 50-75 years of age who had appropriate screening for colorectal cancer	HMW beneficiaries 50-75 years of age	Enrollment data	Statistical tests will include McNemar test or multiple regression.
Hypothesis 4: HMW beneficiaries diagnosed with diabetes are more likely to have an annual HbA1c test performed as a result of having access to HMW benefits.				

Research Question	Outcome Measures	Population	Data Sources	Analytic Methods
Will providing benefits under the HMW increase the number of annual HbA1c tests among HMW beneficiaries diagnosed with diabetes?	Percentage of beneficiaries 18-75 years of age with diabetes (Type 1 and Type 2) who received an HbA1c test during the measurement year.	HMW beneficiaries 18-75 years of age with a diabetes diagnosis	Medicaid Fee for Service (FFS) claims data Enrollment data	Descriptive statistics (central tendency measures such as mean and median; variability measures, such as standard deviation and range). Statistical tests will include McNemar test/ Cochran-Armitage tests for trends or multiple regression.
Hypothesis 5: HMW beneficiaries diagnosed with diabetes are more likely to have an annual dilated eye examination as a result of having access to HMW benefits.				
Will providing benefits under the HMW demonstration increase the number of annual dilated eye examinations among HMW beneficiaries diagnosed with diabetes?	Percentage of beneficiaries 18-75 years of age with diabetes who had a retinal or dilated eye exam during the measurement year	HMW beneficiaries 18-75 years of age with a diabetes diagnosis	Medicaid Fee for Service (FFS) claims data Enrollment data	Descriptive statistics (central tendency measures such as mean and median; variability measures, such as standard deviation and range). Statistical tests will include McNemar test/ Cochran-Armitage tests for trends.
Hypothesis 6: HMW beneficiaries are more likely to report being satisfied than not with the benefits under the demonstration.				
Are HMW beneficiaries satisfied with the demonstration services?	Beneficiary experience with demonstration services and benefits	HMW beneficiaries who participate in focus groups	Focus group findings and key informant interviews	Transcribed reports of focus group comments, systematic, manually-driven analysis of focus group findings supported by key informant interviews.

IV. Methodological Limitations

The HMW was designed to provide health care coverage to ABD individuals that do not qualify for Medicaid State Plan or Medicare. Within two (2) years, the majority of this population becomes eligible for Medicare (and thus ineligible for HMW), which limits the state's ability to evaluate the long-term impact of the demonstration. Additionally, no existing data is available for these beneficiaries prior to their enrollment in the HMW to perform a pre-comparison assessment. DOM was also unable to find a comparable population that had the same eligibility criteria as the HMW population. Reflecting on these limitations the state faces with the HMW population, a one-group posttest only design method will be conducted and utilized.

It is planned to use results from beneficiary focus groups to complement and contextualize the quantitative findings.

V. Special Methodological Considerations

DOM would like CMS to take into consideration the limitations listed above when reviewing the evaluation draft for scientific and academic rigor. DOM will rely on a non-experimental design because of the following reasons:

- There is no comparison group for this population that has been identified for this evaluation;
- A cause and effect relationship among HMW beneficiaries cannot be demonstrated; and
- Due to the lack of control population, DOM can only rely on interpretation and observations to draw a conclusion about the effectiveness of the HMW demonstration over time.

Attachment I: Independent Evaluator

As a result of a recent request for quotes, the Division of Medicaid (DOM) has secured the services of an independent evaluator and executed a professional services contract on June 18, 2019 with the Parham Group, LLC, and its sub-contractor, Dr. Hwanseok Choi.

The contractor has worked specifically with the evaluation and analysis of Federal and State programs for 17 years, including evaluation and support services with the DOM waiver-related programs: MYPAC, Money Follows the Person (B2i), and Person-centered Practices Training for waiver providers. Dr. Choi is an Associate Professor in the School of Health Professions at the University of Southern Mississippi and holds a Ph.D. in Applied Statistics from the University of Alabama. For over 16 years, Dr. Choi has participated in the design, data entry design, data coding, data editing, analysis, and statistical reporting on nearly 100 studies using multiple statistical packages such as SAS, SPSS, STATA, and ArcGIS.

DOM has measures in place to assure that the independent evaluator will conduct a fair and impartial evaluation, prepare an objective evaluation report and that there is no conflict of interest. The primary means employed by the State to accomplish these goals are the contract and contract monitoring process. DOM will ensure compliance through the use of carefully crafted contractual language outlining benchmarks, report due dates, and the use of approved methods. With these measures in place, DOM will be able to monitor the independent evaluator's progress while maintaining a "no conflict of interest" status. DOM has also specified that any subcontractor who is involved in the demonstration will have to be approved by DOM. DOM has approved both the contractor and sub-contractor for this project.

Attachment II: Evaluation Budget

We estimate the total cost of the evaluation for the waiver approval period at \$59,500 for the demonstration. The staffing, data collection, and administrative costs are listed in the accompanying table and described below.

Line Item	Components of Budget	Line Item Cost
1	Estimated staff	\$58,000
2	Focus Group implementation and other misc. administrative costs	\$1,500
	Total Amount	\$59,500

Staffing

Project Director

Project Director will have overall responsibility for the evaluation, including the developing the evaluation design and data collection instruments, overseeing evaluation staff and analysis of the claims and survey data, and preparing the annual reports.

Associate Project Director

Associate Project Director will provide guidance on the evaluation design and data collection instruments and will assist with data analysis and conceptualizing results for the annual report, based on their experience as the lead evaluator.

Statistical Analyst

Statistical Analyst will be responsible for data management, data cleaning and analyzing the enrollment, claims and survey data for the annual reports.

Dissemination/Special Project Coordinator

Dissemination/Special Project Coordinator will coordinate the administration of the annual surveys with a Survey Research Unit, prepare protocols for review, and assist with preparing the annual reports.

Focus Group Implementation

With significant input from a newly developed advisory committee (composed primarily of key informants) the independent evaluator team will organize, develop, and implement three planned beneficiary focus groups and provide a written report that synthesizes findings and analyzes results.

Attachment III: Timeline and Major Milestones

Deliverable	Timeline	Projected Submission Date
Annual Monitoring Report	Within 90 days following the end of each demonstration year	December 31, 2019
Draft Evaluation Design Plan	Within 120 days after the approval of the demonstration extension	January 25, 2019
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	Pending CMS Comment Period
Interim Evaluation Reports	With submission of a demonstration extension request.	September 30, 2022
Summative Evaluation Report	Within 18 months following the end of the demonstration approval period identified in these STCs.	March 31, 2025

Attachment IV: Healthier Mississippi Waiver Baselines

Criteria	FFY16	FFY17	FFY18	Average	Percent Change
<i>Colorectal Screening (Age 50-75)</i>					
Eligible	6,422	6,523	6,535	6,493	
No. Received	668	680	700	683	
% of Population Received Screening	10.4%	10.4%	10.7%	10.5%	0.96%
<i>Cervical Screening (Females, Age 21-64)</i>					
Eligible	4,619	4,726	4,692	4,679	
No. Received	440	422	439	434	
% of Population Received Screening	9.5%	8.9%	9.4%	9.3%	-0.35%
<i>Mammogram (Females, Age 50-74)</i>					
Eligible	3,550	3,639	3,626	3,605	
No. Received	634	802	793	284	
% Received Screening	17.9%	22%	21.9%	20.6%	7.45%
<i>Ambulatory/Preventive Visit (Age ≥20)</i>					
Eligible HMW Beneficiaries	8,570	8,738	8,742	8,683	
No. Received	6,752	6,846	6,916	6,838	
% Received Screening	78.8%	78.3%	79%	78.7%	0.08%
<i>Diabetic & Annual A1c Test (Age 18-75)</i>					
Eligible	2,285	2,344	2,305	2,311	
No. Received	1,552	1,648	1,626	1,609	
% Received Test	68%	70.3%	71%	69.8%	1.47%
<i>Diabetic & Annual Dilated Eye Exam (Age 18-75)</i>					
Eligible	2,285	2,344	2,305	2,311	
No. Received	593	655	678	642	
% Received Exam	26%	28%	29%	27.7%	3.85%

Emergency Department (ED) Visits

<i>0.47% Change</i>	FFY 16 (n=5,809)		FFY 17 (n=5,911)		FFY 18 (n=5,891)	
≥1 Preventive/ Primary Care Visit	# Visits (% of Total Visits)	Recipient Count	# Visits (% of Total Visits)	Recipient Count	# Visits (% of Total Visits)	Recipient Count
Yes	3,330 (57.3)	1,651	3,396 (57.5)	1,675	3,611 (61.3)	1,746
No	2,479 (42.7)	1,320	2,515 (42.5)	1,385	2,280 (38.7)	1,313

Hospitalizations (HMW Beneficiaries <75)

<i>1.93% Change</i>	FFY 16 (n=2,328)		FFY 17 (n=2,460)		FFY 18 (n=2,463)	
≥1 Preventive/ Primary Care Visit	# of Inpatient Claims	Recipient Count	# of Inpatient Claims	Recipient Count	# of Inpatient Claims	Recipient Count
Yes	1,263 (54.3)	802	1,306 (53.1)	807	1,374 (55.8)	865
No	1,065	767	1,154	802	1,089	788

	(45.7)		(46.9)		(44.2)	
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Attachment V
Estimated Timeline for Conducting Focus Group Activities

ACTIVITY	Mont h 1	Mont h 2	Mont h 3	Mont h 4	Mont h 5	Mont h 6	Mont h 7
Plan and Organize							
▪ Establish the project Adv. Com.							
▪ Identify goals							
▪ Identify project description							
▪ Develop 10-12 group questions							
▪ Establish operating protocols							
▪ Develop materials/forms							
Recruitment							
▪ Identify diverse sample							
▪ Establish procedure							
▪ Decide on if and what incentive							
▪ Develop recruitment script							
▪ Recruit 32-36 participants							
Implementation							
▪ Focus group script /protocol							
▪ Reminders sent out							
▪ Dry run through/tweak as needed							
▪ Staffing in place							
▪ Transportation set							
▪ Site preparation and set up							
▪ Electronic recording and manual note-taking in place							
▪ Conduct focus groups (3)							

<ul style="list-style-type: none"> ▪ Staff debrief of meeting and make adjustments as needed 							
Analysis and Reporting <ul style="list-style-type: none"> ▪ With support from the Advisory Committee, prepare a manually-driven, written report that synthesizes findings and analyzes the results of the three focus groups. ▪ Incorporate the focus group findings report into the interim evaluation report. 							