September 30, 2013

Cynthia B. Jones
Director
Commonwealth of Virginia, Department of Medical Assistance Services
600 East Broad Street Suite 1300
Richmond, VA23219

Dear Ms. Jones:

This letter is to inform you that Virginia's request for a new section 1115(a) Medicaid demonstration, entitled the "Early MAGI Implementation" (Early MAGI demonstration) (Project Numbers 11-W-00291/3 and 21-W-00065/3), has been approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective from October 1, 2013 through December 31, 2013.

Under this demonstration, Virginia will implement, on a state-wide basis, modified adjusted gross income (MAGI)-based eligibility determination methods, from October 1, 2013, through December 31, 2013, for coverage effective during that time period, for all Medicaid and Children's Health Insurance Program (CHIP) populations who will be subject to MAGI-based rules effective January 1, 2014. This approval of "early MAGI" is subject to the Commonwealth's successful completion of its Operational Readiness Review demonstrating that the Commonwealth's eligibility system can accurately make MAGI-based eligibility determinations, and is able to be fully operational on October 1, 2013. This demonstration makes no other changes to Virginia's Medicaid or CHIP programs.

Our approval of this demonstration is subject to the limitations specified in the enclosed approved waiver authority and special terms and conditions (STCs). These documents specify the agreement between the Virginia Department of Medical Assistance Services and CMS. The Commonwealth may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly identified as waived in the waiver authorities shall apply to the Early MAGI demonstration.

This approval is also conditioned upon compliance with the enclosed STCs which set forth in detail the nature, character, and extent of federal involvement in this demonstration and the Commonwealth's obligations to CMS, including an evaluation of this demonstration, during the term of the approval period. This award letter is subject to our receipt of your written acceptance of the award, including the waiver authorities and the STCs, within 30 days of the date of this letter.

With this letter, we also approve an amendment to your existing section 1115 demonstration, "FAMIS MOMS and FAMIS *Select*" (Project Number 21-W-00058/3), which will allow the

state to implement, on a state-wide basis, modified adjusted gross income (MAGI)-based eligibility determination methods, from October 1, 2013, through December 31, 2013, for coverage effective during that time period, for this demonstration's populations, which will be subject to MAGI-based rules effective January 1, 2014. This amendment approval of "early MAGI" is subject to the Commonwealth's successful completion of its Operational Readiness Review demonstrating that the Commonwealth's eligibility system can accurately make MAGI-based eligibility determinations, and is able to be fully operational on October 1, 2013. This amendment makes no other changes to Virginia's FAMIS MOMS and FAMIS *Select* demonstration.

Your project officer is Ms. Michelle Mack, who may be reached at (410) 786-6714 and through e-mail at Michelle.Mack@cms.hhs.gov. Ms. Mack is available to answer any questions concerning your section 1115 demonstration. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Ms. Mack at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communication regarding program matters should be submitted simultaneously to Ms. Mack and Mr. Francis McCullough, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in the CMS Philadelphia Regional Office. Mr. McCullough's contact information is as follows:

Centers for Medicare & Medicaid Services
Philadelphia Regional Office
Division of Medicaid and Children's Health Operations
The Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, PA 19106

We appreciate your cooperation throughout the review process, and look forward to successful implementation of this demonstration. If you have additional questions, please contact Mr. Eliot Fishman, Director of the Children and Adults Health Programs Group within the Center for Medicaid and CHIP Services, at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/
Marilyn Tavenner

Enclosures

cc:
Ms. Cindy Mann, CMCS
Mr. Eliot Fishman, CMCS
Mr. Francis McCullough, ARA, Philadelphia Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00291/3 (Title XIX) and 21-W-00065/3 (Title XXI)**

TITLE: **Virginia Early MAGI Implementation Demonstration**

AWARDEE: **Virginia Department of Medical Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration from October 1, 2013 through December 31, 2013.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted in order to enable Virginia to implement the Early MAGI section 1115 demonstration.

Virginia Title XIX Waiver

1. MAGI Implementation — Section 1902(a)(17)

To the extent necessary to enable the state to implement MAGI-based eligibility determination methods, from October 1, 2013 through December 31, 2013, for all populations who will be subject to MAGI-based rules effective January 1, 2014.

Virginia Title XXI Waiver

1. MAGI Implementation — Section 2102(b)

To the extent necessary to enable the state to implement MAGI-based eligibility determination methods, from October 1, 2013 through December 31, 2013, for all populations who will be subject to MAGI-based rules effective January 1, 2014.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00291/3 (Title XIX) and 21-W-00065/3 (Title XXI)

TITLE: Virginia Early MAGI Implementation Demonstration

AWARDEE: Virginia Department of Medical Services

I. PREFACE

The following are the special terms and conditions (STCs) for ***Virginia's "Early MAGI Implementation"*** section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable the Commonwealth of Virginia to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) and 2102 of the Social Security Act (Act), which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of **October 1, 2013** unless otherwise specified. This demonstration is approved through **December 31, 2013.**

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Virginia Early MAGI Implementation demonstration seeks to streamline the state's eligibility and enrollment process during the open enrollment period for calendar year 2014 coverage, and to ease the state's transition to the new Modified Adjusted Gross Income (MAGI) methodology.

Effective January 1, 2014, eligibility for health coverage under all health insurance affordability programs – including Medicaid, the Children's Health Insurance Program (CHIP) and the Advanced Premium Tax Credit – generally will be based on a new MAGI methodology. Calculating applicants' MAGI-based income will entail defining household composition and executing income-counting procedures according to rules that differ from those currently in effect for Medicaid and CHIP.

During the 2013 open enrollment period (October 1, 2013 to December 31, 2013), eligibility for certain applicants will be determined using MAGI-based methodologies for coverage scheduled to start on January 1, 2014. In addition, during this period people applying for or renewing Medicaid or CHIP coverage for 2013 will also need to have their eligibility assessed based on existing Medicaid and CHIP rules. As a result, for populations subject to the MAGI-based rules, Virginia will have to determine Medicaid and CHIP eligibility under both the current rules and the MAGI-based rules during this limited period of time.

This demonstration will address the requirement that the state utilize two different eligibility methodologies from October 1 through December 31, 2013, through a waiver that will instead allow Virginia to begin applying solely the MAGI-based methodology to appropriate populations for new applications and renewals beginning October 1, 2013. Given that the use of MAGI-based methodologies becomes a requirement on January 1, 2014, this authority is only necessary through December 31, 2013.

This will allow Virginia to apply the MAGI-based eligibility determination rules as described in 42 CFR 435.603 beginning October 1, 2013. This demonstration will apply to the state plan populations that are subject to MAGI-based eligibility determinations effective January 1, 2014. The state projects that approximately 55,000 individuals will be affected by the demonstration.

The state's goals in implementing the demonstration are to:

- Enable Virginia to avoid having to operate two sets of rules for children, parents and caretaker relatives, pregnant women and other non-disabled, non-elderly adults who may be eligible for Medicaid and CHIP enrollment from October 1 through December 31, 2013.

- Improve the state's capacity to process applications in a timely fashion during the first open enrollment period under the Affordable Care Act.

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 and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, 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), apply to the demonstration.

3. **Changes in Medicaid and CHIP 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 or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.** 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 Title XIX or XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to 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 either through an approved amendment to the Medicaid state plan or amendment to the demonstration. 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.

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 these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. Demonstration of Public Notice and tribal consultation: The state must provide documentation of the state's compliance with public notice and documentation that the tribal consultation requirements outlined in STC 13 have been met.

    b. Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI state plan amendment, if necessary.

    c. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment.

    d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Demonstration Phase Out.** If the state determinates that it needs to suspend or terminate this demonstration prior to its scheduled end date, the state must immediately notify CMS in writing. The state must then work with CMS on a phase out process, which cannot be implemented without CMS approval.

    a. Natural Phase Out: At the conclusion of the current approval period, this demonstration will naturally expire, as the statutory requirement to determine eligibility using MAGI is effective January 1, 2014. No phase out plan or process is required in this case.

    b. 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.

9. **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 project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

10. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

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

12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 7, are proposed by the state.

    a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR.§431.408(b)(3)).

    c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

14. **FFP.** No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

15. **Post Award Forum.** Within six months of the demonstration's implementation, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 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 can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the final report, as specified in STC 26.

IV. ELIGIBILITY FOR THE DEMONSTRATION

16. Eligibility Groups Affected By the Demonstration. Mandatory and optional state plan groups derive their eligibility through the Medicaid and CHIP state plans, and are subject to all applicable Medicaid and CHIP laws and regulations in accordance with the Medicaid and CHIP state plans, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid or CHIP state plan amendments (SPA) to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration.

17. Mandatory Eligibility Groups Reflected in the Medicaid State Plan. Eligibility for all mandatory eligibility groups are as reflected in the state plan. Should the state amend the state plan to make any changes to eligibility for Medicaid mandatory populations, upon submission of the state plan amendment, the state must notify CMS in writing of the pending state plan amendment.

18. Optional Eligibility Groups Reflected in the Medicaid State Plan. Eligibility for all Optional eligibility groups are as reflected in the state plan. Should the state amend the state plan to make any changes to eligibility for Medicaid Optional populations, upon submission of the state plan amendment, the state must notify CMS in writing of the pending state plan amendment.

19. Eligibility Groups Reflected in the CHIP State Plan. Eligibility for all eligibility groups are as reflected in the CHIP state plan. Should the state amend the CHIP state plan to make any changes to eligibility for CHIP populations, upon submission of the state plan amendment, the state must notify CMS in writing of the pending state plan amendment.

20. Virginia Early MAGI Implementation Demonstration Medicaid and CHIP State Plan Mandatory and Optional Groups.

a. Participating Medicaid and CHIP Groups. The criteria for the Early MAGI demonstration participation are outlined below in a chart that summarizes each specific group of individuals and the authority under which they are eligible for coverage.

Eligibility Chart

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Parent/caretaker relatives Low Income Families	§1902(a)(10)(A)(i)(I) and §1931	28%-46% FPL based on locality groupings
Pregnant Women	§1902(a)(10)(A)(i)(I), §1931, §1902(a)(10)(A)(i)(III), §1902(a)(10)(A)(i)(IV)	143% FPL
Children	§1902(a)(10)(A)(i)(I) and §1931, §1902(a)(10)(A)(i)(III), §1902(a)(10)(A)(i)(IV), §1902(a)(10)(A)(i)(VI), §1902(a)(10)(A)(i)(VII), §1902(a)(10)(A)(ii)(IV),	143% FPL
Reasonable classifications of individuals under age 21	§1902(a)(10)(A)(ii)(I) and (IV) §1902(a)(10)(A)(ii)(VIII)	28%-40% based on locality groupings
Family Planning Option	§1902(a)(10)(A)(ii)(XXI)	211% FPL
CHIP Children	§2102(b) 42 CFR 457.310 & 320	200%

V. ELIGIBILITY PROCESS

21. Application of MAGI. The state will implement, on a state-wide basis, MAGI-based eligibility determination methods, from October 1, 2013 through December 31, 2013, for all Medicaid and CHIP populations who will be subject to MAGI-based rules effective January 1, 2014.

VI. BENEFITS

22. Early MAGI Demonstration Benefits. This demonstration does not affect benefits for the populations affected by the demonstration. Individuals will receive benefits as specified in the approved state plan.

VII. COST SHARING

23. Cost sharing. This demonstration does not affect cost sharing for the populations affected by the demonstration. Cost sharing will operate as specified in the approved state plan. Cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies and be reflected in the state plan. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR §447(b) applies to the demonstration.

VIII. DELIVERY SYSTEM

24. Services will be Delivered. This demonstration does not affect the delivery system for the populations affected by the demonstration. Benefits will be delivered as specified in the approved state plan.

IX. GENERAL REPORTING REQUIREMENTS

25. General Financial Requirements. The state must comply with all general financial requirements under Title XIX and XXI set forth in section X of these STCs.

26. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments. The final report should, at a minimum, address the following:

a. Describe the implementation of the demonstration, including the identification of any issues that arose and the resolution of said issues.

b. Total number of applications and renewals processed under the demonstration, including the outcomes of these determinations.

c. A summary of the comments and issues raised by the public at the Post Award Forum, as specified in STC 15.

X. GENERAL FINANCIAL REQUIREMENTS

27. Quarterly Financial Reports. The state must provide quarterly Title XIX expenditure reports using Form CMS-64. The state shall provide quarterly Title XXI expenditure reports using the Form CMS-21 to report total Title XXI expenditures for services provided under the approved CHIP.

28. 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) and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

29. Standard CHIP Funding Process. The standard CHIP funding process will be used during the demonstration. The state must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

30. Sources of Non-Federal Share. The state must comply with existing procedures to certify that the matching non-federal share of funds for its Medicaid and CHIP programs are state/local monies. The state further certifies 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.

a. CMS may review the sources of the non-federal share of funding at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. 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.

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

a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

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

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

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

Under all circumstances, health care providers must retain 100 percent of the 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 and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, 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.

32. Title XXI Limits. Federal Title XXI funding available for demonstration expenditures is limited to the state's available allotment, including currently available reallocated funds. Should the state expend its available Title XXI federal funds for the claiming period, no further enhanced federal matching funds will be available for costs of the approved Title XXI child health program or demonstration until the next allotment becomes available.

33. Exhaustion of Title XXI Funds Notification. The state must notify CMS in writing of any anticipated Title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures. The state must follow Medicaid state plan criteria for the beneficiaries unless specific waiver and expenditure authorities are granted through this demonstration.

XI. EVALUATION OF THE DEMONSTRATION

34. Submission of Draft Evaluation Design. The state must submit to CMS for approval, within 30 days of the approval date of the demonstration, a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives and specific testable hypotheses. The analysis plan must cover all elements in STC 36. The design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.

The design, including the budget and adequacy of approach, to assure the evaluation meets the requirements of STC 36, is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected in the paragraph above.

35. Cooperation with Federal Evaluators. Should HHS undertake an evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by HHS. The state shall submit the required data to HHS or its contractor

36. Evaluation Design.

a. Domains of Focus. The state must propose as least one research question that it will investigate within each of the domains listed below. The research questions should focus on processes and outcomes that relate to the CMS Three-Part Aim of better care, better health, and reducing costs.

    i. The effect of early MAGI on the state's ability to process new and renewal applications in a timely fashion during the open enrollment period for calendar year 2014 (October – December 2013).

b. Measures. The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:

    i. The baseline value for each measure;

    ii. The sampling methodology for assessing these outcomes; and

    iii. The methods of data collection.

c. Sources of Measures. CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

d. The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

37. Final Evaluation Design and Implementation. CMS shall provide comments on the draft evaluation design within 15 days of receipt, and the state shall submit a final design within 15 days of receipt of CMS' comments. The state must implement the evaluation design after submission of the final evaluation design. The state must submit to CMS a draft of the evaluation final report with the draft final report required per STC 26. The state must submit the final evaluation report within 120 days after receipt of CMS' comments.

The final evaluation report must include the following:

a. An executive summary;

b. A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;

c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;

d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);

e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and

f. Successes, challenges, and lessons learned.

XII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	STC Reference
Within 30 days of approval	Draft Evaluation Design	Section XI, STC 34
Within 6 month of approval	Post Award Forum	Section III, STC 15
Within 120 of the end of the demonstration	Submit a Draft Final Report	Section IX, STC 26
Within 120 of the end of the demonstration	Submit a Draft Evaluation Final Report	Section XI, STC 37
Within 120 of receipt of CMS feedback	Submit the Final Report	Section IX, STC 26
Within 120 of receipt of CMS feedback	Submit the Evaluation Final Report	Section XI, STC 37