DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

State Demonstrations Group

June 25, 2025

Stuart Portman
Executive Director, Division of Medical Assistance Plans
Department of Community Health
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Atlanta, GA 30303-3159

Dear Director Portman:

The Centers for Medicare & Medicaid Services (CMS) is updating the section 1115 demonstration monitoring approach to reduce state burden, promote effective and efficient information sharing, and enhance CMS's oversight of program integrity by reducing variation in information reported to CMS.

Federal section 1115 demonstration monitoring and evaluation requirements are set forth in section 1115(d)(2)(D)-(E) of the Social Security Act (the Act), in CMS regulations in 42 CFR 431.428 and 431.420, and in individual demonstration special terms and conditions (STCs). Monitoring provides insight into progress with initial and ongoing demonstration implementation and performance, which can detect risks and vulnerabilities to inform possible course corrections and identify best practices. Monitoring is a complementary effort to evaluation. Evaluation activities assess the demonstration's success in achieving its stated goals and objectives.

Key changes of this monitoring redesign initiative include introducing a structured template for monitoring reporting, updating the frequency and timing of submission of monitoring reports, and standardizing the cadence and content of the demonstration monitoring calls.

Updates to Demonstration Monitoring

Below are the updated aspects of demonstration monitoring for the Georgia Pathways to Coverage (Project Number 11-W-00342/4) demonstration.

Reporting Cadence and Due Date

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, CMS is updating the cadence for this demonstration to annual monitoring reporting (see also section

1115(d)(2)(D)-(E) of the Act). This transition to annual monitoring reporting is expected to alleviate administrative burden for both the state and CMS. In addition, CMS is extending the due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state's work to draft, review, and submit the report timely.

CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. The standard for determining the frequency of monitoring reporting will ultimately be included in each demonstration's STCs. CMS expects that this standard will permit CMS to make on-going determinations about reporting frequency under each demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. *See* 42 CFR 431.420(d)(1)-(2).

The Georgia Pathways to Coverage demonstration will transition to annual monitoring reporting effective June 25, 2025. The next annual monitoring report will be due on March 30, 2026, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting cadence and due date.

Structured Monitoring Report Template

As noted in STC 44, "Monitoring Reports," monitoring reports "must follow the framework to be provided by CMS. The framework is subject to change as monitoring systems are developed / evolve, and will be provided in a structured manner that supports federal tracking and analysis." Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report's content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

This structured template will include a set of base metrics for all demonstrations. For demonstrations with certain waiver and expenditure authorities, there are additional policy-specific metrics that will be collected through the structured reporting template.

Demonstration Monitoring Calls

As STC 47 "Monitoring Calls" describes, CMS may "convene periodic conference calls with the state," and the calls are intended "to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration." Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the

structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

CMS will continue to be available for additional calls as necessary to provide technical assistance or to discuss demonstration applications, pending actions, or requests for changes to demonstrations. CMS recognizes that frequent and regular calls are appropriate for certain demonstrations and at specific points in a demonstration's lifecycle.

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent Georgia Pathways to Coverage section 1115 demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

If you have any questions regarding these updates, please contact Danielle Daly, Director of the Division of Demonstration Monitoring and Evaluation, at Danielle.Daly@cms.hhs.gov.

Sincerely,

[redacted]

Karen LLanos
Acting Director

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00342/4

TITLE: Georgia Pathways to Coverage

AWARDEE: Georgia Department of Community Health

Title XIX Costs Not Otherwise Matchable Authority

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

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

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

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

Title XIX Requirements Not Applicable to the Demonstration Eligible Populations

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

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

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

   To the extent necessary to enable the state to begin Medicaid coverage on the first day of

the month following receipt of a beneficiary's initial premium payment and verification of compliance with the qualifying hours and activities requirement as described in the STCs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00342/4

TITLE: Georgia Pathways to Coverage

AWARDEE: Georgia Department of Community Health

I. PREFACE

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

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

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

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the

Medicaid program, expressed in federal law, regulation, and written policy, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

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

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

5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plans governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for

administrative or service-based expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
   a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
   b. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;
   c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
   d. An up-to-date CHIP allotment worksheet, if necessary; and
   e. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

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

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

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

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan, the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities, including community resources that are available.
c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.
d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR part 431 subpart E. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.
e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.
g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

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

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

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

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

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

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

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

IV. ELIGIBILITY

16. **Eligibility.** Only adults ages 19 through 64 with income up to 95 percent of the FPL

(effectively 100 percent with the 5 percent income disregard) are eligible to opt into Medicaid coverage under the Georgia Pathways to Coverage demonstration by meeting the requirements specified in these STCs. Individuals must also meet non-financial eligibility requirements (e.g., residency, citizenship or satisfactory immigration status) and other eligibility requirements as described in these STCs. This demonstration eligible population is not otherwise eligible for Medicaid through the state plan and can only be covered under Medicaid through this demonstration.

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

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

V. BENEFITS

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

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

VI. MEMBER REWARDS ACCOUNTS

21. **Member Rewards Account.** All beneficiaries enrolled in Medicaid under the demonstration (except beneficiaries receiving premium assistance through the HIPP) will be provided with a Member Rewards Account (MRA). The MRA is an educational tool used to "deduct" beneficiary copayments, reflect accrued premium payment amounts (if applicable), and deposit incentives that have a dollar-value equivalent for completing healthy behavior activities as described in STC 22. Points in the MRA are non-monetary credits, that are converted to dollars for purposes of payment and when deducted for copayments and other allowable expenses. Any deduction does not result in actual charges to the beneficiary. If there are insufficient funds in the MRA to pay a copayment or other allowable expense, copayments will continue to be deducted, and any future premium payments or healthy

incentive points will be applied to the negative balance. Beneficiaries will not be responsible for any copayments or other allowable expenses due to a negative MRA balance. Beneficiaries will have access to view their balance, including copayment deductions, premium credits, and healthy behavior credits consistent with the requirements in 42 CFR 435.918, and will also receive account statements that will include information about the amount used, the amount paid out of the MRA, and the remaining balance

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

VII. COST SHARING

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

Table 1. Copayment Amounts

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

24. **Non-Emergent Use of the Emergency Department.** A beneficiary's MRA will be reduced

by thirty (30) dollars of non-monetary credits for each non-emergent visit to the emergency department. This deduction will be waived for any beneficiary who contacts their MCO's 24-hour nurse hotline prior to utilizing the emergency department. The beneficiary must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA, of the Act and have a medical professional determine that it is not an emergency using the prudent layperson standard—before their MRA balance can be reduced. Notwithstanding the fact that the MRA deduction is not cost sharing, the state must ensure that hospitals comply with the requirements described in 42 CFR 447.54(d)(2) related to educating beneficiaries about appropriate alternative settings before the state deducts the amount from the MRA. Emergency services are not subject to cost sharing per 42 CFR 447.56(a)(2).

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

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

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

surcharge is not appealable for beneficiaries who attest to using tobacco but do not participate in a smoking cessation, or other qualified health improvement activity.

Table 3. Premium and Tobacco Surcharge Amounts		
Income	**Monthly Single Premium**	**Tobacco Surcharge**
From 50 percent up to 85 percent FPL	$7.00	$3.00
From 85% and up to 95 percent FPL (effectively 100 percent with the 5 percent income disregard)	$11.00	$5.00

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

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

will be disenrolled from Medicaid and will need to reapply for coverage.

c. Redetermination. If at any time, including at redetermination, the state is made aware of a change in the beneficiary's income during the current enrollment period, the state will evaluate whether the beneficiary's premium amount should be adjusted. Outstanding premium payments from the prior benefit year will be forgiven.

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

a. Permit the state or the MCO to attempt to collect the unpaid premiums from the beneficiary, but the state or the MCO will not report the premium amount owed to credit reporting agencies, place a lien on a beneficiary's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the beneficiary's earnings for enrollees at any income level. The state will not "sell" the obligation for collection by a third-party. Further, while the amount is collectible by the state, re-enrollment is not conditioned upon repayment.

b. Monitor that beneficiaries do not incur household cost sharing and premiums that, when combined, exceed five (5) percent of the aggregate household income, in accordance with 42 CFR 447.56(f), without regard to MCO enrollment of members in the household. Once a household reaches the cap, the state assures that no further copayments can be charged to beneficiaries, and the premium amount will be reduced for the remainder of the quarter to retain access to the My Rewards Account.

c. Charge copayment amounts, if applicable, that do not exceed Medicaid cost sharing permitted by federal law and regulation and the terms of this demonstration.

d. Ensure that the state, or its designee, does not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing are considered an administrative expense by the state.

e. Ensure that all payments from the beneficiary, or on behalf of the beneficiary, are accurately credited toward unpaid premiums in a timely manner, and provide the beneficiary an opportunity to review and seek correction of the payment history.

f. Ensure that the state has a process to refund any premiums paid for a month in which the beneficiary is ineligible for Medicaid services for that month.

g. Ensure that a beneficiary will not be charged a higher premium the following month due to nonpayment or underpayment of a premium in the previous month(s), except that amounts outstanding and due from the previous month/s may be reflected separately on subsequent invoices.

h. Ensure the state notifies beneficiaries whose eligibility has been suspended for failure to meet the qualifying hours and activities requirement, and provide written notice to prevent overpayment of premiums.

i. Conduct outreach and education to beneficiaries to ensure that they understand the program policies regarding qualifying hours and activities, good cause, premiums and associated consequences for nonpayment. Beneficiaries must be informed of how

premium payments should be made; the potential impact of a change in income on premium payments owed; the consequences of failure to report a change in income or circumstances that affect eligibility; the time period over which income is calculated (e.g., monthly income); the deadline for reporting changes in circumstances; and how to reenroll if disenrolled for non-payment of premiums.

j. Provide all applicants timely determinations of eligibility in accordance with 42 CFR 435.912.
k. Provide all applicants and beneficiaries with timely and adequate written notices of any decision affecting their eligibility, including an approval, denial, termination, or suspension of eligibility, or a denial or change in benefits and services pursuant to 42 CFR 435.917 and consistent with 42 CFR 435.905(b) and 431.206-214.
l. The state must send a notice at least 10 days in advance of the date of action (as defined at 42 CFR 431.201 pursuant to 42 CFR 431.211-214.
m. Provide all applicants and beneficiaries with fair hearing rights consistent with 42 CFR part 431, subpart E.
n. Ensure program information is available, and accessible in accordance with 42 CFR 435.901 and 435.905.
o. Provide beneficiaries written notice of requirements to qualify for reactivation of Medicaid coverage following suspension or disenrollment due to non-payment of premiums described in STC 33.
p. Provide notice (consistent with 42 CFR 435.917 and 431.206-214) in advance of any adverse action, including information about the suspension period with an explanation of what the status means, including but not limited to: the right to appeal; the right to apply for Medicaid on a basis not affected by this status; what the suspension status means with respect to the ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange); what to do if circumstances change such that they may be eligible for coverage in another Medicaid category; as well as any implications with respect to whether they have minimum essential coverage.
q. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable accommodations related to premium payments.
r. Maintain a system that identifies, confirms, and provides reasonable accommodations related to the obligation to pay premiums to beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Patient Protection and Affordable Care Act.
s. Ensure the state will monitor the demonstration and, using information available to the state, work to identify any disparate impact on certain beneficiaries, based on characteristics including gender, sexual orientation, race or ethnicity.

VIII. DELIVERY SYSTEM

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

beneficiaries participating in ESI are exempt from mandatory managed care enrollment.

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

IX. QUALIFYING HOURS AND ACTIVITIES REQUIREMENT

32. **Overview**. As a requirement for eligibility, applicants must complete a minimum of 80 hours of qualifying activities, as described in STC 33 before Medicaid coverage will begin. As a condition of maintaining Medicaid eligibility, beneficiaries will be required to continue meeting the qualifying hours and activities requirement and report compliance, as specified in STC 34, unless they require a reasonable accommodation due to a disability as described in STC 37, or experience a circumstance that gives rise to good cause for non-compliance after enrollment, as described in STC 36.

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

34. **Hour Requirements and Reporting.** All applicants must be in compliance with the 80 hour qualifying activities and income eligibility requirements for the month prior to the application to be enrolled. Applications of individuals not in compliance with the qualifying hours and activities requirement at the time of application will be denied if the individual is not eligible for any other category of assistance. The individual may reapply at any time. Applicants and beneficiaries who report a disability at the point of application, or after initial

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

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

36. **Good Cause.** The state will consider a beneficiary who has been compliant with the qualifying hours and activities requirement for good cause if the beneficiary demonstrates a need for the good cause as a result for failing to meet or report the qualifying hours and activities requirement for that month. Beneficiaries may request a good cause from the qualifying hours and activities requirement up to a maximum of 120 hours during a 12 month benefit year. The circumstances constituting good cause must have occurred during the month for which the beneficiary is seeking a good cause exception. The circumstances that may give rise to good cause include, but are not limited to, the following verified

circumstances:

a. The beneficiary or an immediate family member experiences a hospitalization or a serious illness and as a result, is unable to fulfill the qualifying hours and activities;
b. The beneficiary experiences a short-term injury or illness and as a result, is unable to fulfill the qualifying hours and activities;
c. The beneficiary experiences the birth, adoption, or death, of an immediate family member;
d. The beneficiary accepts a foster child placement, including those in kinship care;
e. The beneficiary experiences a natural or human-caused disaster (including a public health emergency declared by the state in the county the person resides) and as a result, is unable to meet the requirements;
f. The beneficiary has a family emergency or other life event (e.g., divorce, civil legal matter, or is a victim of domestic violence) and as a result, is unable to fulfill the hours and activities requirements;
g. The beneficiary is temporarily homeless and as a result, is unable to fulfill the hours and activities requirements;
h. The beneficiary is quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, or exposure to COVID-19, or because of a closure of the place(s) where the beneficiary was meeting the hours requirement related to COVID-19 and as a result, is unable to fulfill the hours and activities requirement; or
i. Other good cause reason(s) as defined and approved by the state.

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

a. Reasonable accommodations may include:
    i. Modified activities hours when a beneficiary or applicant is unable to participate due to the otherwise-required number of hours if agreed upon by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity;
    ii. Other accommodations that have been agreed upon by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity;
    iii. Alternative mechanisms to report compliance; and
    iv. Support services necessary to participate; including, referrals to state programs currently providing rehabilitation services for individuals with disabilities
b. The state must also provide reasonable accommodations and protections for program procedures, including but not limited to: understanding notices and program rules related to the qualifying hours and activities requirement; documenting qualifying hours and activities; assistance with demonstrating eligibility; circumstances that give rise to good cause; appealing disenrollments; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable accommodations.

c. Disability Reported at Application. If an individual has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the qualifying hours and activities requirement for reasons related to that disability at the time of application, the state will determine if the individual is eligible for another eligibility category. If the individual is not eligible for another eligibility category, the beneficiary will be referred to a state rehabilitation services program for individuals with disabilities. If the individual accepts the referral and meets the program requirements set by the referral agency within (90) days, the individual will be determined eligible for the demonstration.

d. Disability Reported After Enrollment. If beneficiary becomes unable to meet the qualifying hours and activities requirement after enrollment due to a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act, or due to having to care for a family member with a disability defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act, the state will:

    i. Modify the number of hours of required for participation if agreed upon by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity;

    ii. Provide other accommodations that have been agreed to by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity, alternative mechanisms to report compliance; and/or

    iii. Provide support services, including referrals to state programs currently providing rehabilitation services for individuals with disabilities.

e. Beneficiary Compliance with Reasonable Accommodation. If a beneficiary participates in a qualifying program that provides rehabilitation services and meets the activities requirements determined by the program, the beneficiary will continue to receive Medicaid enrollment under the demonstration.

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

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

a. Ensure that there are processes and procedures in place to stop or recoup payments to an MCO when a beneficiary is suspended for failure to comply with program requirements and to trigger payment when eligibility is reinstated.

b. Ensure, to the maximum extent practicable, that there are processes and procedures in place to seek data from other sources, including SNAP and TANF, regarding a beneficiary's potential satisfaction of the qualifying hours and activities requirement and systems to permit beneficiaries to efficiently report qualifying hours and activities or demonstrate circumstances that give rise to good cause, in accordance with 42 CFR 435.907(a), 435.916(c), and 435.945, and to permit the state to monitor compliance.
c. Ensure that activities that may be used to satisfy qualifying hours and activities requirement are available during a range of times and through a variety of means (e.g., online, mail, in person, by telephone) at no cost to the beneficiary.
d. Ensure that beneficiaries have been screened and determined ineligible for all other bases of Medicaid eligibility prior to disenrollment or denial of eligibility and reviewed for eligibility for insurance affordability programs in accordance with 42 CFR 435.916(f).
e. Maintain system capabilities to operationalize both the suspension of eligibility and the prospective reinstatement of eligibility once the qualifying hours and activities requirement is met as described in STC 36.
f. Provide outreach and education to inform new applicants about the qualifying hours and activities requirement and how the requirement must be satisfied beginning at the time of application.
g. Ensure that there are timely and adequate beneficiary notices provided in writing consistent with 42 CFR 435.917(a), 435.905(b), and 431.206-214, including but not limited to:
    i. The specific number of qualifying hours per month that a beneficiary is required to complete, and when and how the beneficiary must report participation or request a good cause exception;
    ii. A list of the specific qualifying activities that must be used to satisfy the qualifying hours and activities requirement and a list of the specific activities that beneficiaries can engage in;
    iii. Information about resources that help connect beneficiaries to opportunities for activities that would meet the qualifying activities and information about the community supports that are available to assist beneficiaries in meeting their qualifying hours and activities;
    iv. Information about how qualifying hours will be counted and documented;
    v. Information about what gives rise to a suspension of eligibility, what suspension of eligibility would mean for the beneficiary, including how it could affect redetermination, and how to avoid suspension, including how to apply for good cause exception and what kinds of circumstances might give rise to good cause;
    vi. If a beneficiary has sought to demonstrate good cause, that the good cause has been approved or denied with an explanation of the basis for the decision and how to appeal a denial;
    vii. If a beneficiary is not in compliance, that the beneficiary is out of compliance, and, if applicable, how the beneficiary can resume compliance in the month immediately following in order to avoid suspension of eligibility;
    viii. If a beneficiary is suspended, information on how to appeal that decision and/or how to demonstrate compliance so that coverage can be reinstated or reapply for Medicaid benefits if the beneficiary has been disenrolled; and

ix. The right of individuals with disabilities to establish reasonable accommodations of their qualifying hours and activities with examples of the reasonable accommodations in those requirements to which individuals may be entitled, including, assistance with documenting participation, referrals for vocational rehabilitation services or accommodations through a state program, good cause exceptions if after initial eligibility an individual becomes unable to participate for a disability-related reason, and if applicable, reductions in hours of required participation if an individual is unable to participate in the otherwise required numbers of hours.

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

i. Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements.

j. Develop and implement an outreach strategy to inform applicants and beneficiaries about the qualifying hours and activities requirement, how to report compliance with or request good cause exceptions from the qualifying hours and activities requirements and how to report changes in circumstances. Notices provided at enrollment, and suspension will provide information on resources available to beneficiaries who may require assistance reporting compliance with qualifying activates, requesting good cause exceptions, or reporting changes in circumstances.

k. Establish beneficiary protections, including assuring to the maximum extent practicable, that beneficiaries do not have to duplicate requirements, if applicable, to maintain access to all public assistance programs that require employment or another form of qualifying hours and activities.

l. Make good faith efforts to connect beneficiaries to existing community supports that are available to assist beneficiaries in meeting their qualifying hours and activities, including available non-Medicaid assistance with transportation, child care, language access services and other supports.

m. Ensure the state assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with a lack of public transportation to determine whether there should be further good cause exceptions from the qualifying hours and activities requirement and/or additional mitigation strategies, so that the qualifying hours and activities requirement will not be unreasonably burdensome for applicants and beneficiaries to meet.

n. Develop and maintain an ongoing partnership with the Georgia Department of Community Health and other state entities such as the Georgia Department of Labor, the Department of Behavioral Health and Developmental Disabilities, and the Georgia Vocational Rehabilitation Agency, to assist recipients with identifying and accessing opportunities for workforce training, complying with qualifying hours and activities, and

moving toward independence and self-sufficiency.

o. Provide each beneficiary who has been disenrolled from Medicaid with information on how to access primary care and preventative care services at low or no cost to the beneficiary. This material will include information about free health clinics and community health centers including clinics that provide behavioral health and substance use disorder services. Georgia shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries who have lost coverage.

p. Make the general assurance that the state is in compliance with protections for beneficiaries related to STC 37 and:

   i. Make good faith efforts to connect beneficiaries with disabilities as defined above with services and supports necessary to enable them to meet their qualifying hours and activities;

   ii. Maintain a system that provides reasonable accommodations related to meeting the qualifying hours and activities to beneficiaries with disabilities as defined above;

   iii. Ensure the state will assess whether people with disabilities have limited job or other opportunities for reasons related to their disabilities. If these barriers exist for people with disabilities, the state will consider further good cause exceptions from the qualifying hours and activities requirement;

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

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

X. GENERAL REPORTING REQUIREMENTS

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

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

a. CMS will issue a written notification to the state providing advance notification of a

pending deferral for late or non-compliant submission of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.
c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

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

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

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

42. **Implementation Plan.** The state must submit a draft Implementation Plan to CMS for review and comment no later than ninety (90) calendar days after the start date of the demonstration approval period. The state must submit a revised Implementation Plan within sixty (60) calendar days after receipt of CMS' comments. The Implementation Plan must cover at least the key policies being tested under this demonstration, including qualifying hours and activities requirements, premiums, and the non-applicability of retroactive eligibility. Additionally, the state may be expected to provide additional details not captured in the STCs regarding implementation of the other demonstration policies, such as incentives for healthy behaviors, copayments for the non-emergent use of the emergency department,

and the non-applicability of hospital presumptive eligibility, retroactive eligibility and NEMT. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment D. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the Implementation Plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

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

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

44. **Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each demonstration year (DY). The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The

framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. The operational updates will focus on progress towards meeting the milestones identified in CMS's framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's annual goals and overall targets as will be identified in the approved Monitoring Protocol, and will cover key policies under this demonstration, including but not limited to qualifying hours and activities, premiums, including tobacco surcharge, incentives for healthy behaviors, and the non-applicability of retroactive eligibility. The state is also expected to provide monitoring data on demonstration policies around ESI cost-effectiveness and cost sharing, and—if appropriate—the non-applicability of hospital presumptive eligibility. The performance metrics will also reflect all other components of the state's demonstration**.** For example, these metrics will cover enrollment, disenrollment or suspension by specific demographics and reason, participation in the qualifying hours and activities requirement, access to care, and health outcomes. Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances, and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the CMS framework provided by CMS to support federal tracking and analysis.

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

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

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

46. **Close Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.
    a. The draft report must comply with the most current guidance from CMS.
    b. The state will present to and participate in a discussion with CMS on the Close-Out report.
    c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
    d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
    e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 39.

47. **Monitoring Calls.** CMS will convene periodic conference calls with the state.
    a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.
    b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
    c. The state and CMS will jointly develop the agenda for the calls.

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

XI. GENERAL FINANCIAL REQUIREMENTS

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

50. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

51. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section XII: Monitoring Budget Neutrality.

a. Administrative costs, including those associated with the administration of the demonstration;
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

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

a. The state acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding

sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. The state acknowledges that any amendments that impact the financial status of this section 1115 demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

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

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

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

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

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

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

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

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

Table 4: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Low Income Adults	Hypo 1	X		X	See Expenditure Authority #1

56. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS 11-W-00342/4. Separate reports must be submitted by MEG (identified by Waiver Name) and DY (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the DY will be offset against

expenditures incurred in the DY for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the table below, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita, and as also indicated in the table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

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

Table 5: MEG Detail for Expenditure and Member Month Reporting

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

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

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

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

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

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

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

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

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

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

XII. MONITORING BUDGET NEUTRALITY

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

61. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

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

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

64. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population

or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

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

Table 8: Hypothetical Budget Neutrality Test

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

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

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

based on the time period through the termination date.

68. **Mid-Course Correction.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

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

XIII. EVALUATION OF THE DEMONSTRATION

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

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

methodology in appropriate circumstances.

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

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

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

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

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

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

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

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

75. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.
    a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted, should be included. If

the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

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

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

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

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

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

80. Additional Publications and Presentations. For a period of twelve (12) months following

CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

Attachment A:
Developing the Evaluation Design

Introduction

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

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

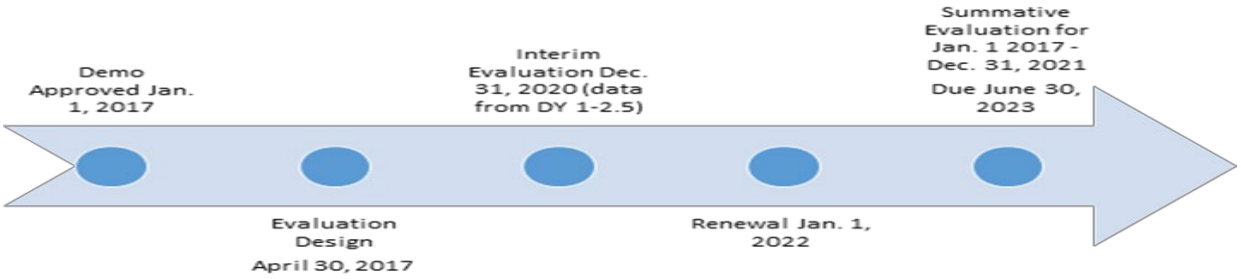
Expectations for Evaluation Designs

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

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

Submission Timelines

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



Required Core Components of All Evaluation Designs

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

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

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

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

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

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

e. Describe the population groups impacted by the demonstration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
1) Operating smoothly without administrative changes; and

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

E. Attachments

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

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

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

Attachment B:
Preparing the Evaluation Report

Introduction

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

Expectations for Evaluation Reports

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

Intent of this Attachment

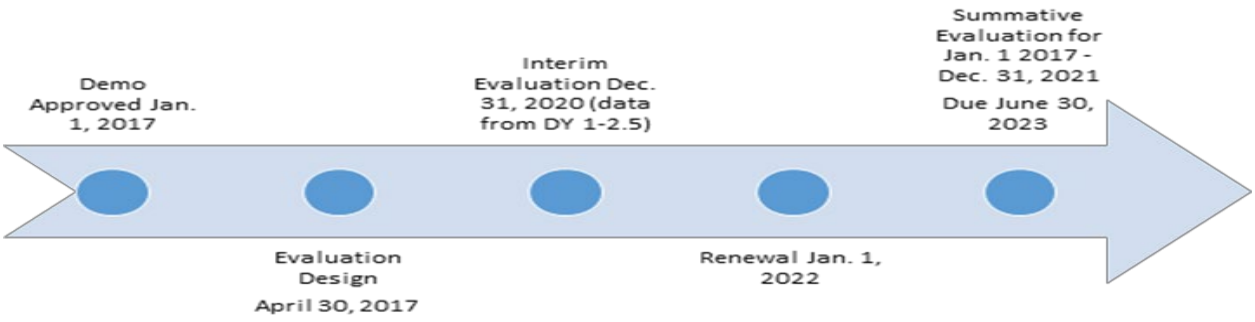
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified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

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

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

Submission Timelines

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



Required Core Components of Interim and Summative Evaluation Reports

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

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

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

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

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

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

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable. An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support

developing an interim evaluation.

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

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

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

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

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

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

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

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

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

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

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

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

J. Attachment(s)

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

Attachment C: Evaluation Design

Evaluation Design: Georgia Pathways Demonstration Program

Document prepared by the Public Consulting Group: May 19th, 2023

EDD Revision Submission Date: November 8th 2024

PUBLIC CONSULTING GROUP

TABLE OF CONTENTS

A. GENERAL BACKGROUND INFORMATION

1. DEMONSTRATION NAME AND TIMING

On October 15, 2020, The Centers for Medicare and Medicaid Services (CMS) approved the Georgia Pathways to Coverage application to expand the state's Medicaid program for a period of five years through the Social Security Act's section 1115(a)(2) waiver authority. The Georgia Department of Community Health (DCH) Division of Medical Assistance Plans administers the Georgia Medicaid program and is responsible for the implementation of the waiver.

2. DEMONSTRATION GOALS

The mission of Georgia DCH is to provide access to affordable, quality health care to millions of Georgians, including some of the state's most vulnerable and underserved populations.[1] Georgia's overall aim to create "A Healthy Georgia" informs the demonstration goals of improved access, affordability, and quality through strategies that:

- Improve the health of low-income Georgians by increasing their access to affordable healthcare coverage by encouraging work and other employment-related activities;
- Reduce the number of uninsured Georgians;
- Promote member transition to commercial health insurance;
- Empower Georgia Pathways members to become active participants and consumers of their healthcare;
- Support member enrollment in employer-sponsored insurance by providing premium assistance for qualifying employer-sponsored health plans, if doing so is cost-effective for the state;
- Increase the number of persons who become employed or engaged in employment-related activities;
- Increase wage growth for those who are employed; and
- Support the long-term, fiscal sustainability of the Medicaid program.

To achieve these goals, DCH developed "opt-in" criteria for eligibility including participation in qualifying hours and activities (QHA). These criteria are designed to strengthen individual earnings and employment which are in turn expected to result in higher levels of participation in employer-sponsored or commercial insurance along with improved financial security. Additionally, the demonstration will include health insurance premiums which include surcharges and incentives to reinforce healthy behavior and personal responsibility.

The state expects this demonstration to expand coverage beyond what is currently provided by Medicaid, improve the fiscal sustainability of the state's Medicaid program, and improve beneficiary health and well-being.

3. DESCRIPTION

Georgia Pathways expands Medicaid coverage for working Georgians with household incomes up to 100% of the Federal Poverty Level (FPL) who complete at least 80 hours of work or employment related activities per month. As of 2019, 18.9% of individuals between the ages of 19 and 64 and 39.9% of the state's adult population with an income below 100% of the FPL were uninsured.[2,3] Georgia Pathways was designed to provide coverage for the 60% of this group that is working at least part-time. The State of Georgia currently provides Medicaid coverage to non-disabled adults with incomes up to 35% of the FPL

[1] Georgia Department of Community Health, "About Us." dch.georgia.gov.
[2] Kaiser Family Foundation, Health Insurance Coverage of Adults 19-64, based on 2008-2019 ACS, 1-Year Estimates, 2019.
[3] Kaiser Family Foundation, Health Insurance Coverage of Adults 19-64 Living in Poverty (under 100% FPL) based on 2008-2019 ACS, 1-Year Estimates, 2019.

through its Medicaid managed care program, Georgia Families. During the Public Health Emergency (PHE), the Families First Coronavirus Response Act (FFCRA) provided for continuous coverage for individuals who were or became eligible, resulting in a steady increase in enrollment from 421,000 adults in 2019 to approximately 2.6 million adults as of March 2023. During the unwinding process, redeterminations will identify members who are no longer eligible for traditional Medicaid and evaluate their eligibility for Pathways. The Georgia Pathways to Coverage Demonstration program will provide a new eligibility pathway to working Georgians with household incomes up to 95% of the FPL, with a 5% income disregard, who previously could not obtain Medicaid coverage or were provided continuous coverage during the PHE and are no longer eligible for traditional Medicaid. Eligibility in Georgia Pathways is prospective only. Individuals aged 19 to 64 with incomes up to 95% of the FPL, with a 5% income disregard, who meet the required hours and activities threshold of 80 hours a month, will have access to the Pathways demonstration. At the time of applying for the Section 1115 demonstration waiver, the state projected that enrollment for demonstration year (DY) 1, DY2, DY3, DY4, and DY5 would be 25,028, 47,362, 48,782, 50,490, 52,509, respectively[4]. Table 2 illustrates what the distribution will look like for various enrollment numbers.

The implementation plan of the Georgia Pathways program is spread across three phases, as reflected in Table 1 below. The first phase began July 1st, 2023, and introduced the following core functionalities of the Georgia Pathways program:

- Pathways Eligibility
- Qualifying Hours and Activities
- Good Cause Exceptions
- Reasonable Accommodations and Modifications

The second phase, beginning on January 6th, 2024, introduced the mandatory (HIPP) program. The pending third phase includes premiums, copayments, tobacco surcharge, and MRA.

During phase two of implementation, Georgia Pathways will implement a mandatory Health Insurance Premium Payment (HIPP) program component, in which individuals who have access to Employer Sponsored Insurance (ESI) and become Medicaid-eligible through the Georgia Pathways program may obtain premium and cost-sharing assistance. For members who may have access to ESI, the state will determine whether paying premiums for the offered ESI is cost effective. If so, then the member is required to enroll in ESI, with premiums covered by Medicaid in lieu of receiving Medicaid benefits.

At the time of drafting this evaluation design, the implementation of phase three of the Georgia Pathways program is on hold. Phase three is intended to add consumer-engagement elements such as member premiums and copays, and Member Rewards Accounts (MRAs) to mimic private insurance and support a member's transition into the commercial health insurance market once their income exceeds 100% of the FPL. Due to the uncertainty of the start date and eventual implementation of phase three, this Evaluation Design does not include research questions, hypotheses, and analyses that will evaluate the outcomes and impacts of phase three components. The state will revisit and update the Evaluation Design once more information on this phase is available. As stipulated in the demonstration STCs, the Evaluation Design will integrate any applicable CMS guidance on relevant policy areas in revising the design if phase three is implemented. If phase three is not implemented, the evaluation will reflect phases one and two.

[4] See Section 2: Demonstration Eligibility, page 10 (https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathways-to-coverage-pa1.pdf)

TABLE 1 GEORGIA PATHWAYS IMPLEMENTATION PHASES

Phase	Start Date	Components
1	July 1st 2023	Core functionalities
2	January 6th 2024	Mandatory Health Insurance Premium Payment (HIPP) program
3	TBD	Premiums, copayments, tobacco surcharge policy and Member Rewards Account (MRA)

As part of the state's PHE unwinding plan, Georgia Medicaid delayed redeterminations until September 2023 for some beneficiaries who were identified, based on available information, as possibly no longer eligible for traditional Medicaid, and possibly eligible for Pathways. The purpose of the delay was that if redetermination found that an individual meets Pathways criterion, they may be moved directly into Pathways with no gap in coverage.[5] In this way, the state leveraged the PHE unwinding process to facilitate enrollment in Pathways.

4. POPULATION

The population studied will be adult Medicaid beneficiaries who are eligible through the Georgia Pathways program. This includes individuals aged 19-64 with household incomes up to 95% of the FPL with a 5% income disregard who are not otherwise eligible for Medicaid, and who are working or engaged in employment-related activities for at least 80 hours per month.

Because no true in-state comparison population is available for this demonstration, comparisons will be made of post-waiver trends to pre-waiver trends, and among subgroups within the Georgia Medicaid population, adjusted for demographic and other traits where possible. The population distribution percentages shown in Table 2 are based on a snapshot of Medicaid members (taken in January 2023) that may have transitioned into Pathways. These numbers have been used to determine the potential demographic distribution of the Georgia Pathways population for three levels of enrollment (Table 2).

Also, individuals who were enrolled in Medicaid pre-demonstration and transition to Pathways during unwinding represent a group who have experienced traditional Medicaid (without qualifying hours and activities requirements). These individuals, referred to as the unwinding subgroup, will be used as a pre-demonstration comparison population. Because Pathways members under age 21 will be provided non-emergency medical transportation (NEMT), they will be used as a comparison group for research questions regarding the waiver of NEMT.

[5] Georgia Department of Human Services, Medicaid Unwinding. https://dhs.georgia.gov/medicaid-unwinding Accessed 04/20/2023.

TABLE 2: PROJECTED ENROLLMENT

Population Distribution Estimates				
	Percent of total[6]	**If 100,000 Individuals Enroll**	**If 50,000 Individuals Enroll**	**If 10,000 Individuals Enroll**
Age bands				
19-20	34%	34,000	17,000	3,400
21-34	47%	47,000	23,500	4,700
35-54	17%	17,000	8,500	1,700
>54	2%	2,000	1,000	200
Gender				
Male	41%	41,000	20,500	4,100
Female	59%	59,000	29,500	5,900
Other/NA	NA	Not Available	Not Available	Not Available
Race				
White	42%	42,000	21,000	4,200
Black	47%	47,000	23,500	4,700
Asian	2%	2,000	1,000	200
Other	9%	9,000	4,500	900
Ethnicity				
Hispanic	21%	21,000	10,500	2,100
Not Hispanic	79%	79,000	39,500	7,900
Residence				
Urban/Suburban	19%	19,000	9,500	1,900
Rural	81%	81,000	40,500	8,100
Income				
< 50% FPL	54%	54,000	27,000	5,400
50-95% FPL	46%	46,000	23,000	4,600

5. CONTEXT

During the 2019-2020 Georgia General Assembly's Regular session, Senate Bill 106 the *Patients First Act* was passed to enable DCH to submit a Section 1115 Demonstration waiver to CMS requesting to increase the income threshold for eligibility to 95% of the FPL, with a 5% income disregard.[7] Senate Bill 106 also allows the Governor of Georgia to submit a demonstration application related to health insurance coverage and health insurance plans. The demonstration is intended to provide Georgians with improved access to affordable healthcare coverage and ultimately result in improved health and well-

[6] These percentages were based on a snapshot of existing Medicaid members that may transition into Pathways as of January 2023

[7] In 2023 100% FPL was approximately $14,580 for an individual and $30,000 for a family of four. https://www.healthcare.gov/glossary/federal-poverty-level-fpl/

being.[8] The program expansion, named Georgia Pathways to Coverage, was approved by CMS on October 15, 2020, originally for a five-year period. Implementation was delayed, resulting in a shortened demonstration period covering July 1, 2023 through September 30, 2025.

[8] Georgia Section 1115 Demonstration Waiver Application dated December 23, 2019.

B. EVALUATION QUESTIONS AND HYPOTHESES

1. LOGIC MODEL

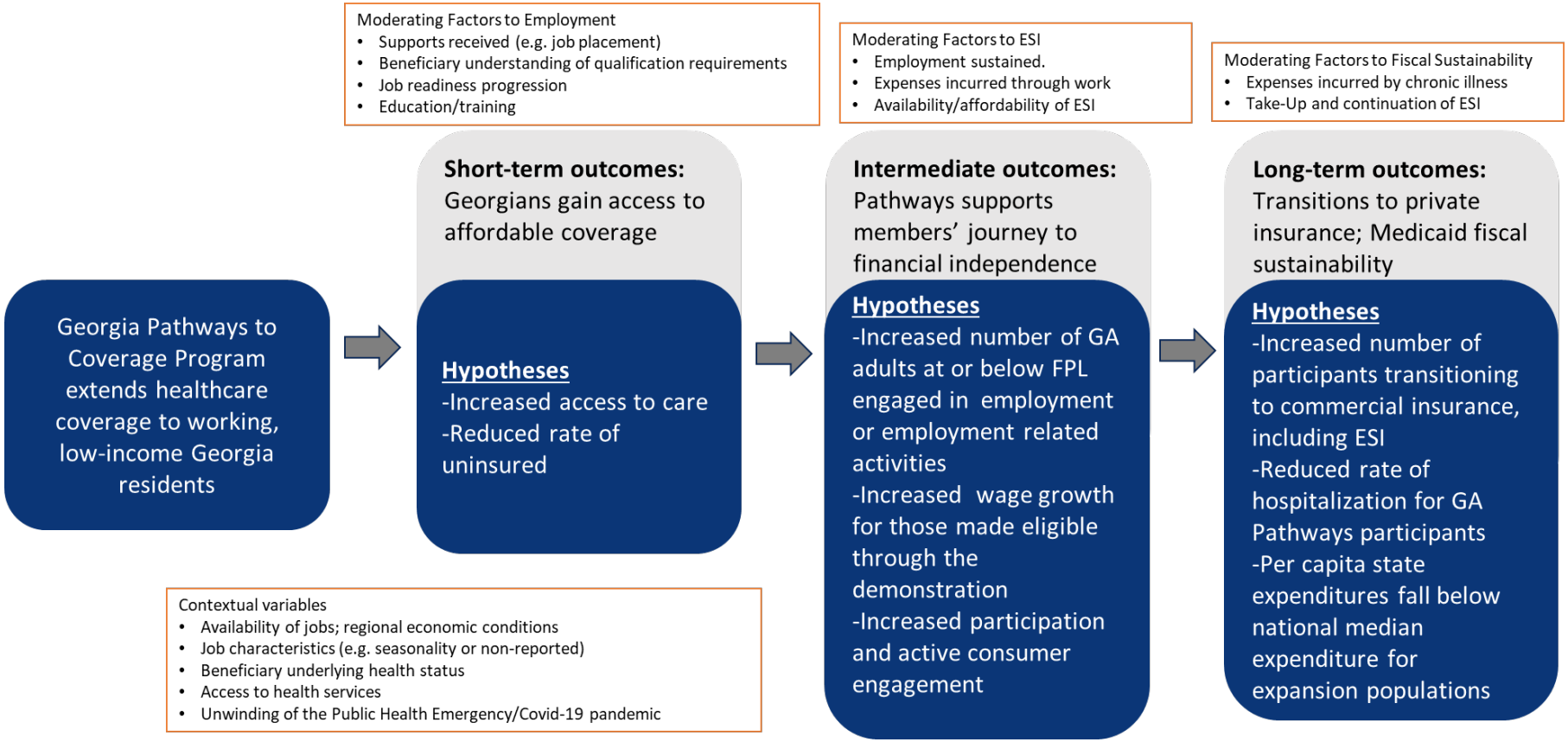


FIGURE 1: GEORGIA PATHWAYS LOGIC MODEL

2. HYPOTHESES AND RESEARCH QUESTIONS

The aims of the Georgia Pathways program are to improve access to affordable health coverage, to support members' financial independence, to help members transition to commercial insurance, and to ensure the fiscal sustainability of the state Medicaid program. The logic model in Figure 1, above, represents these goals as a natural progression from the proximate to distal outcomes the state expects to achieve through program elements. Each outcome corresponds to a testable hypothesis of the impact of the demonstration, as shown in Table 3. Table 10 specifies the measures that will be used to assess each hypothesis.

The immediate aim of the Georgia Pathways program is to improve access to affordable health coverage for members by increasing healthcare coverage to working, low-income Georgia residents. The first evaluation hypothesis that addresses this aim is that the Georgia Pathways Program policies will increase access to health care, reflected in increased engagement in primary care, and improvement in self-reported access and health status. The second evaluation hypothesis is that Georgia Pathways will reduce the prevalence of being uninsured among Georgia residents with incomes up to 95% of the FPL, with a 5% income disregard.

The intermediate aim of the Georgia Pathways program is to support members' financial independence by incentivizing them to engage in qualifying employment related activities. Individuals aged 19 to 64 with incomes up to 95% of the FPL, with a 5% income disregard, who meet the required hours and activities threshold of 80 hours per month, will have access to the Pathway demonstration.

The state anticipates that more Georgia residents will participate in employment or related activities, and that these individuals' income will increase as a result. Evaluation hypothesis six, addressing this objective, is that Georgia Pathways will increase the number of adults with incomes below and up to 100% of the FPL who are engaged in at least 80 hours a month of employment or employment related activities. Evaluation hypothesis seven states that Georgia Pathways will increase income growth for employed individuals who are enroll in the Pathways program. The independent evaluator (IE) will measure growth in working hours as well as growth in income for Georgians engaging in the required employment related activities as part of the Pathways demonstration.

In addition, the state hypothesizes Georgia Pathways will increase members' engagement in their own care, which is the fourth evaluation hypothesis, as reflected in member participation in recommended preventive care and disease management.

The final aim, and expected long-term outcome, of the Georgia Pathways program is to promote the fiscal sustainability of the state Medicaid program, both through cost containment and through transitions to ESI. The state hypothesizes (evaluation hypothesis eight) that costs will be contained because access to affordable coverage will improve the health of members and enable them to receive care in appropriate and cost-effective settings, reflected in reduced hospitalizations. The state further anticipates (evaluation hypothesis five) that many Georgia Pathways members will, over time, transition to ESI, with the state paying less in premium support than the cost of providing traditional Medicaid benefits. Because Georgia Pathways will use a fully capitated payment model, the state will not pay claims directly for members. Therefore, cost containment will be estimated based on encounter data using average encounter costs. These cost estimates will be compared to CMS estimates of Medicaid expenditures by states to test the hypothesis that the per capita state expenditure for Georgia Pathways members will remain below the national median expenditure for Medicaid adult expansion populations.

Furthermore, the state anticipates that increased engagement in work and ESI (through HIPP) will lead to more transitions from Georgia Pathways to unsubsidized enrollment in employer sponsored insurance or individual health plan marketplace insurance (evaluation hypothesis three). The evaluation will assess the number of individuals who report having made this transition, and whether enrollment in private coverage is sustained over time.

GA Pathways Program

TABLE 3 GOALS AND RESEARCH QUESTIONS

Goals and Hypotheses	Research Questions
Goal 1: Improve the health of low-income Georgians through increased access to affordable health care. Hypothesis 1: The demonstration will improve the health care access of low-income Georgians.	RQ1. Did Georgia Pathways Improve the access to health care of low-income Georgians? 1. *Primary research question 1.1:* Did the percent of adult members with a primary care or ambulatory visit in the last 12 months change? 2. *Primary research question 1.2:* Did members' self-report of ability to obtain care change? 3. *Primary research question 1.3:* Did members' self-report of overall health status change? 4. *Primary research question 1.4:* What was the outcome of redetermination for members who were identified during unwinding as possibly eligible for Pathways? 5. *Primary research question 1.5:* What was the outcome of new applications to Pathways? 6. *Primary research question 1.6*: Were Pathways members able to meet qualifying hours and activities (QHA) requirements and sustain coverage?
Goal 2: Reduce the number of uninsured Georgians. Hypothesis 2: The demonstration will reduce the number of uninsured in Georgia residents with incomes up to 100% of FPL.	RQ2. Did Georgia Pathways Reduce the number of uninsured Georgians? 1. *Primary research question 2.1:* Did the number of uninsured adults aged 19-64 in GA change? 2. *Primary research question 2.2:* Did trends in the uninsured rate vary by geographic areas? 3. *Primary research question 2.3:* Did trends in the uninsured rate vary by age group? 4. *Primary research question 2.4:* Did trends in the uninsured rate vary by race/ethnicity group?
Goal 3: Promote member transition to commercial health insurance. Hypothesis 3: The demonstration will increase the number of Georgia Pathways members who transition to commercial health insurance, including employer sponsored insurance and individual health	RQ3. Did Georgia Pathways Promote member transition to commercial health insurance? 1. *Primary research question 3.1:* Did the number of members who lose eligibility due to gained income change?[9] 2. *Primary research question 3.2:* Did the number of former Georgia Pathways members who successfully transitioned to commercial health insurance coverage change?[9] 3. *Primary research question 3.3:* What is the pattern of coverage of members who transition to ESI?[9]

[9] The administrative data necessary to answer these research questions was not available at the time this EDD was written. If the data become available, these topics will be explored.

insurance market coverage, after separating from Medicaid.	4. *Primary research question 3.4:* What occupational or other characteristics are associated with transitioning to ESI? *Primary research question 3.5:* What is the coverage status by payer type of former Georgia Pathways members after separating from Medicaid?
Goal 4: Empower Georgia Pathways members to become active participants and consumers of their healthcare. Hypothesis 4: The demonstration will increase member engagement in health care.	RQ4. Did Georgia Pathways Empower Georgia Pathways members to become active participants and consumers of their healthcare? 1. *Primary research question 4.1:* To what extent and in what ways did members feel informed about their coverage and benefits, and engaged in their own healthcare decisions?
Goal 5: Support member enrollment in employer-sponsored insurance by providing premium assistance for qualifying employer-sponsored health plans, if doing so is cost-effective for the state. Hypothesis 5: The demonstration will increase the number of Georgia residents below and up to 100% of the FPL enrolled in employer sponsored insurance.	RQ5. Did Georgia Pathways Support member enrollment in employer-sponsored insurance by providing premium assistance for qualifying employer-sponsored health plans? 1. *Primary research question 5.1:* Did the percentage of members with income below and up to 100% of the FPL enrolling in the ESI through mandatory HIPP change? 2. *Primary research question 5.2:* Did the percentage of premium paid for by premium assistance for qualifying ESI health plans change?
Goal 6: Increase the number of persons who become employed or engaged in employment-related activities. Hypothesis 6: The demonstration will increase the number of adults below and up to 100% of the FPL who are engaged in at least 80 hours a month of employment or employment related activities.	RQ6. Did Georgia Pathways Increase the number of members who become employed or engaged in employment-related activities? 1. *Primary research question 6.1:* Did the average hours worked by employed individuals change? 2. *Primary research question 6.2:* Do members who initially participate in qualifying hours and activities other than employment gain employment within some defined time period (i.e., is there evidence of job-readiness progression?) 3. *Primary research question 6.3:* What are the characteristics of new jobs gained by qualifying hours and activities participants? 4. *Primary research question 6.4:* Is employment among individuals subject to qualifying hours and activities requirements sustained over time?
Goal 7: Increase wage growth for those who are employed. Hypothesis 7: The demonstration will increase wage growth for those made eligible for Medicaid through the Demonstration.	RQ7. Did Georgia Pathways Increase wage growth for those who are employed? 1. *Primary research question 7.1:* Did member earnings change at annual redetermination?
Goal 8: Support the long-term, fiscal sustainability of the Medicaid program.	RQ8. Did Georgia Pathways Support the long-term, fiscal sustainability of the Medicaid program? 1. *Primary research question 8.1:* Did the demonstration contain cost growth for Georgia Pathways members?

Hypothesis 8: The Georgia Pathways demonstration will improve the fiscal sustainability of the GA Medicaid program.	2. *Primary research question 8.2:* Did the rate of hospitalization decrease for Georgia Pathways members? 3. *Primary Research Question 8.3:* Did enrollment of members in ESI reduce costs for the Medicaid program? 4. *Primary Research Question 8.4:* What was the administrative cost of implementing and operating the demonstration?

Exploratory Research Questions

Primary research question 9: Was the demonstration implemented effectively?

a. Subsidiary research question 9a: *How did the Public Health Emergency/Covid-19 pandemic impact implementation and evaluation of the demonstration?*
   - Was the Public Health Emergency/COVID-19 pandemic a barrier to the demonstration implementation?
   - To what extent did the state's unwinding efforts interact with the implementation of the demonstration?
   - Were there additional unforeseen challenges due to the timing of the implementation in the backdrop of the unwinding activities, and how did the state overcome such challenges?

Primary research question 10: What barriers to meeting qualifying hours and activities requirements are experienced by demonstration participants and those interested in Pathways?

a. *Subsidiary Research Question 10a*: Do members understand the qualifying hours and activities requirements and how to satisfy them?
b. *Subsidiary Research Question 10b:* What are the common barriers to initial compliance with the qualifying hours and activities requirement as well as initial enrollment?
c. *Subsidiary Research Question 10c:* What are the underlying reasons for post-enrollment noncompliance with the qualifying hours and activities requirement, potentially leading to suspensions and disenrollments from the demonstration? Examples of such barriers and underlying reasons could include family caregiving obligations (including childcare), transportation hurdles, medical frailty and other medical conditions, administrative challenges of gathering documentation.
d. *Subsidiary Research Question 10d*: Did Pathways members utilize community supports and other services to satisfy the qualifying hours and activities requirement? Did the demonstration's intended, current and former participants perceive availability of such supports and services adequate?

Primary research question 11: What are the characteristics of members who meet or fail to meet qualifying hours and activities requirements? How do the characteristics change over time?

a. *Subsidiary Research Question 11a:* What are the characteristics of individuals who experience coverage suspension or disenrolled due to not meeting qualifying hours and activities requirement?
b. *Subsidiary Research Question 11b:* What is the average duration of coverage gap for individuals who experience coverage suspension or disenrollments?

Primary research question 12: Did members not eligible for NEMT experience any challenges with accessing care because of lack of transportation?

a. *Subsidiary Research Question 12a:* Do Pathways members over 21 report missing appointments due to lack of transportation?
b. *Subsidiary Research Question 12b:* Do Pathways members over 21 report that they would use NEMT if it were available?
c. *Subsidiary Research Question 12c:* Do Pathways members who are 21 or younger, or who were previously eligible for NEMT (due to being under 21, or having been traditional Medicaid beneficiaries previously), report using NEMT to access services?

C. METHODOLOGY

1. EVALUATION DESIGN SUMMARY

The IE will use a mixed-methods evaluation approach that will combine encounter data, administrative data, and survey data as well as qualitative methods to address the goals and hypotheses presented in the waiver application and answer all research questions in the evaluation design.

Because of the shortened demonstration period, the Interim Evaluation Report will focus on analyzing patterns of application, enrollment, suspension, disenrollment, and qualifying hours and activities in the first 13 months of the demonstration. The Summative Evaluation Report will continue this analysis and add analysis of each of the goals of the demonstration (Table 4).

2. TARGET AND COMPARISON POPULATIONS

In-State Comparison Groups

The population studied will be individuals who are eligible, or potentially eligible, for the Georgia Pathways program. This includes individuals aged 19-64 with household incomes up to 95% of the FPL, with a 5% income disregard, who are not otherwise eligible for Medicaid, and who are working or engaged in employment-related activities for at least 80 hours per month. Where data is available, the IE will report on applications, denials, and disenrollments for individuals who apply and are denied enrollment or disenrolled due to failing to satisfy or document qualifying hours and activities.

Because no true in-state comparison population is available for the demonstration population, comparisons will be made of the demonstration period to a two-year pre-demonstration baseline of Medicaid members who were previously enrolled in traditional Medicaid and transitioned to Pathways at redetermination. The analysis of claims and administrative data will include all individuals enrolled in HIPP or Medicaid with no minimum enrollment period.

Within the demonstration population, the IE will stratify by age, gender, race/ethnicity, and rural/urban residence when feasible in order to examine any differential impact of the demonstration.

Other-State Comparison Groups

For additional context, comparisons of statewide outcomes to other states will be made, using the Centers for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) and American Community Survey Public Use Microdata Sample (PUMS), or ACS-PUMS, data. States that have expanded Medicaid and states that have not will form separate comparison groups, approximating two different counterfactuals, where the state either implements no additional coverage, or implements a full Affordable Care Act (ACA) Medicaid expansion.

3. EVALUATION PERIOD

The evaluation will include the demonstration period, from July 1st, 2023, through September 2025. Historical data on individuals who were enrolled in traditional Medicaid and transferred to Pathways at redetermination will be used as the pre-demonstration baseline for analyses of Medicaid encounter and administrative data. For out-of-state comparisons based on national survey data, the two years prior to demonstration launch will serve as the baseline.

Research Questions to be Addressed in Interim and Summative Evaluation Reports

The interim report will cover the first 13 months of the demonstration, July 1st 2023 to July 31st, 2024. Therefore, in the Interim Evaluation Report, the IE will rely on administrative data provided by Gateway, the state's vendor. As summarized in Table 4, the Interim Evaluation Report will focus on patterns of

enrollment, disenrollment, suspension, and satisfaction of qualifying hours and activity requirements. The IE anticipates that 13 months of data will be available for use in the Interim Evaluation Report. More rigorous analyses, such as interrupted time series (ITS) will be considered, however, with a limited amount of data available, such analyses may not be feasible. In addition to tracking all Pathways applicants, the IE will separate out the group of individuals who were previously enrolled in traditional Medicaid and applied to Pathways as part of redetermination, in order to investigate patterns of failure to enroll in Pathways, including individuals who may be denied enrollment due to not meeting qualifying hours and activities requirements, or who may not complete the enrollment process. Where numbers are sufficient for subgroup analysis, results will be stratified as discussed in Methodology, to investigate differences by age, gender, race/ethnicity, and urban/rural residence.

The Summative Evaluation Report will update these findings using encounter data, will incorporate survey results and qualitative findings, and will also use a quasi-experimental approach, employing difference-in-differences (DiD) analysis and synthetic control methods to evaluate the impact of the demonstration. Using BRFSS and ACS-PUMS through 2025, the Summative Evaluation Report will include DiD analysis covering pre-demonstration years, and the demonstration period. The Summative Evaluation Report will include findings for all hypotheses and research questions.

TABLE 4: ANALYSES TO BE INCLUDED IN INTERIM VERSUS SUMMATIVE EVALUATION REPORT

	Interim Evaluation Report **(Due December 30, 2024 to CMS)**	**Summative Evaluation Report** **(Due March 31, 2027 to CMS)**
Time period covered	July 1, 2023 – July 31, 2024	July 1, 2023 – Sept 30, 2025
Data sources	• Administrative Data (e.g., enrollment, suspension, qualifying hours and activities, etc.)	• Administrative Data (e.g., enrollment, suspension, qualifying hours and activities, etc.) • Medicaid Encounters (MMIS) • Beneficiary Survey and focus groups • BRFSS • ACS-PUMS • Key Informant Interviews (KII)
Analyses	• Trend over time • Subgroup analyses	• Trend over time • Subgroup analyses • Interrupted Time Series (ITS) • Difference-in-differences and synthetic control methods (SCM) comparison to other states population in the same income range (BRFSS and ACS-PUMS data) • Qualitative analysis
Approach	Descriptive	Quasi-experimental and Descriptive

Findings	Trends in enrollment, disenrollment, suspension, and satisfaction of qualifying hours and activities during the first 13 months of the demonstration.	• Trends in enrollment, disenrollment, suspension, and satisfaction of qualifying hours and activities during the demonstration. • Impact of demonstration

4. DATA SOURCES

The evaluation will use the following quantitative and qualitative data sources:

- Primary Survey Data and Focus Group Data
- National Survey Data
  - BRFSS
  - ACS-PUMS
- Key Informant Interviews (KIIs)
- Administrative Data (e.g., enrollment, suspension, qualifying hours and activities, etc.)
- Medicaid Encounters (MMIS)

The measures used for evaluation are listed in Table 10. Most are derived from claims and administrative data and will be reported to CMS as part of the approved GA Pathways waiver monitoring protocol. Wherever possible the Evaluation Design aligns measures with CMS monitoring metrics to ease administrative burden, but also includes additional measures to support robust econometric methods.

Primary Survey and Focus Group Data

In addition to the use of claims, administrative data and national surveys, the IE will collect primary data through a member survey, focus groups, and KIIs with providers/practice site administrators. Survey instruments will be tailored for this evaluation but will include questions from published validated surveys, where appropriate, to enable comparisons to national benchmarks.

The member survey will provide a fuller picture of members' access to affordable coverage and to health care services, and their employment status and trajectory.

Beneficiary Surveys

The member survey will be applied to previously enrolled as well as current Pathways members. Survey data will enable the evaluation to capture the impact of Georgia Pathways more fully on access to affordable coverage, supporting members' financial independence, and promoting transition into private coverage.

Beneficiaries will be surveyed between August 2025 and October 2025 during the evaluation period, to ensure that there is a sufficient population of current and former Pathways members available to sample from and that members have had experience with the program to be able to give informed responses to the survey. Survey topics are summarized below in Table 5: Beneficiary Survey Topics.

TABLE 5: BENEFICIARY SURVEY TOPICS

Research Question	Example topics
Primary research question 1.2: Did members' self-report of ability to obtain care change?	• Perceived impact of coverage on the ease of obtaining care

Primary research question 1.3: Did members' self-report of overall health status change?	• Perceived impact of coverage on health status • Perceived impact of qualifying hours and activities on health status[10] • Perceived impact of wage growth on health status
Primary research question 3.5: What is the coverage status by payer type of former Georgia Pathways members after separating from Medicaid?[9]	• Coverage status of Former Pathways members
Primary research question 3.4: What occupational or other characteristics are associated with transitioning to ESI?	• Occupation, job type, and demographic factors associated with transitioning to ESI from Georgia Pathways
Primary research question: 6.2: Do members who initially participate in qualifying hours and activities other than employment gain employment within some defined time period (i.e., is there evidence of job-readiness progression?)	• Employment • Length of time to gain part- or full-time employment • Perceived impact of qualifying hours and activities on ability to gain employment
Primary research question 6.3: What are the characteristics of new jobs gained by qualifying hours and activities participants?	• Occupation/Industry categories • Full time, part time, seasonal employment • Salaried or hourly • Wage growth compared to previously held positions
Primary research question 6.4: Is employment among individuals subject to qualifying hours and activities requirements sustained over time?	• Length of time employed by same employer • Length of time continuously employed
Primary research question 10a: Do members understand the qualifying hours and activities requirements and how to satisfy them?	• Whether beneficiaries report clearly understanding the requirements of Georgia Pathways and how to meet them • Whether beneficiaries report clearly understanding administrative process of applying and documenting qualifying hours and activities
Primary research question 10b: What are the common barriers to initial compliance with the qualifying hours and activities requirement as well as initial enrollment?	• Personal and social factors (e.g., childcare, transportation)

[10] The "perceived impact of qualifying hours and activities on health status" topic includes asking about impact of the requirement to satisfy qualifying hours and activities requirement, and the impact of working towards satisfying the qualifying hours and activities requirement.

	• Administrative challenges (e.g., documentation, phone/internet access) • Availability of jobs or opportunities for qualifying hours and activities

Note: This table is a sampling, and not an exhaustive list, of the topics and questions that will be asked to Pathways members.

Survey Design

The IE will design the survey to assess the impact of the Pathways program on members' access to health care and ultimately on their transition to private coverage. The survey will cover key topic areas related to members' recent history of health care coverage (the coverage they had prior to being enrolled in Pathways), access to health care (whether they have a primary care provider, if they have seen a specialist when needed, the regularity with which they obtain preventive care, etc.), availability of employer-sponsored health insurance, and plans to transition to commercial health insurance. In addition to capturing the usual demographic variables, the survey will also capture members' employment profile, such as length of employment, type of employment (full time, part time, casual), and frequency of job changes. Being mindful of respondent burden, the IE aims for the survey length to not exceed 12 minutes when administered by phone.

Sample Frame Development and Sampling

The IE will work with DCH to obtain the necessary data and contact information for Pathways members, applicants that were denied Pathways coverage, and former Pathways members who lost coverage. From this frame the IE will select a sample of 6,000 individuals. To ensure that the sample accurately reflects the target population, the IE will conduct implicit random sampling using the appropriate variables available in the dataset, such as gender, age, race/ethnicity, income, geography, status in the program, and length of enrollment in the program.

Assuming an approximately 35% response rate, we expect n=2,100 completed surveys. The margin of sampling error at the 95% confidence level for the full sample of respondents is estimated to be +/-2.1 percentage points. Assuming equal propensity for non-response between subgroups, we expect that this sample size will allow for reliable estimates for some subgroups of interest within a margin of error of +/- 5 percentage points, including by age group (individuals aged 19-20 years, aged 21-34 years, and aged 35 years and over), gender (male/female), race/ethnicity (non-Hispanic White, non-Hispanic Black, and Hispanic- individuals), community type (residents of urban communities and of rural communities), and household income relative to the FPL.

The ability to detect a significant difference between two groups is in part dependent on the measured prevalence of an outcome, and it will vary for each variable captured in the survey. Generally, if the prevalence of an outcome is around 50% in one group, this study is powered to detect a difference of 6.4 to 9.9 percentage points between respondents of different age groups, genders, racial groups, ethnic groups, community type, and household income levels, with probability (power) of 80% at the 95% confidence level. If the prevalence of an outcome is very rare or very common (e.g., prevalence of 5% or 95%), this study is powered to detect smaller differences of 2.4 to 5.3 percentage points.

Survey Preparation

To maximize response rates, the IE will prepare the survey for three modes of data collection – mail, online (via smartphone/tablet device/PC), and phone. Each version will be thoroughly tested for quality control. The survey will also be translated into Spanish for interviewing respondents whose preferred language may be Spanish.

Survey Administration

The IE will send the survey by mail to all members in the selected sample together with a cover letter (which will include an online link to the survey), and postage paid business reply envelope. For

beneficiaries for whom email addresses are available, we will also send an email invitation with a link to the survey, followed by weekly reminder emails. After 21 days from the mailing, the IE will begin phone follow-up to non-respondents to administer the survey over the phone. To maximize response rates, the IE will make up to five phone attempts to each non-respondent at different times of day and during different days of the week including weekdays and weekends.

Data Analysis and Reporting

The IE will apply weights to the survey data to ensure that the weighted distribution of survey respondents accurately reflects the distribution of the member population on key population metrics, including gender, age, race/ethnicity, income, geography (urban/rural), and length of enrollment in the program. Analysis of the survey data will focus on understanding members' access to health care, availability of employer-sponsored health insurance, and plans to transition to commercial health insurance. The IE will include analysis by key subgroups of interest, such as gender, age, and race/ethnicity.

Focus Groups

The beneficiary survey will invite respondents to participate in focus groups to share more about their experiences with the Pathways program. Those who are interested in participation will be asked to provide contact information, and time/date preferences. The IE will conduct 3-6 focus groups, with 4-8 participants each, depending on the level of interest. Where feasible, participants will be grouped together based on relevant characteristics, such as residing in rural counties. Focus groups will be held online, using a secure and user-friendly platform, and moderated by an experienced social science researcher. Participants will be thanked with a gift card in a small amount for a local retail chain that does not sell alcohol or cigarettes and will be offered the chance to be contacted when the evaluation report is publicly available.

Focus group discussion guides will be developed based on the evaluation research questions and will be informed by survey results. Example topics are provided below in Table 6.

TABLE 6 EXAMPLE TOPICS FOR FOCUS GROUPS BASED ON RESEARCH QUESTIONS

Research Question	Example topics
Primary research question 9: Was the demonstration implemented effectively?	• How well do individuals presented the opportunity to apply for Pathways, in addition to Pathways members, understand the Pathways program and its qualifying hours and activities requirement, and cost sharing?

Primary research question 10: What barriers to meeting qualifying hours and activities requirements are experienced by demonstration participants and those interested in Pathways?	• Why individuals who were interested in being screened for Pathways did not gain coverage? (e.g. understanding of the program requirements, challenges meeting the qualifying hours and activities requirement, and challenges verifying qualifying hours and activities reported.)
	• Among those who gained Pathways coverage, what are the challenges to retaining Pathways coverage? Such as:
	  ○ understanding of the program requirements
	  ○ challenges meeting the qualifying hours and activities requirements
	  ○ challenges verifying qualifying hours and activities reported
	  ○ childcare or transportation

	○ impact of variations in qualifying hours and activities, such as seasonality in employment hours • How available or useful were any supports provided by the Care Management Organizations (CMOs), such as job readiness? • What are member experiences from not having retroactive eligibility (especially in the context of unpaid medical bills prior to Pathways enrollment and medical debt)?
Overall Experience **(Research Questions 1.2, 1.3, 3.2)**	• How do members describe the overall impact of Pathways on their health, financial stability, and well-being? • Do (former) members report transitioning to ESI or commercial coverage? • How satisfied are members with the Pathways demonstration?

Note: This table is a sampling, and not an exhaustive list, of the topics and questions that will be asked to Pathways members.

Participants will also be invited to share information about their previous experiences with Medicaid, private coverage, or being uninsured, and their recommendations for how the Pathways program could be improved.

Focus groups will be recorded with permission and privacy protections and transcribed for thematic qualitative analysis.

National Survey Data

The IE will use the ACS-PUMS data and the BRFSS data to conduct analyses related to certain research questions as shown in Table 10. Use of national survey data will allow quasi-experimental comparisons of Georgia to national and other states' trends.

The evaluator will utilize the ACS-PUMS to measure changes in the rate of uninsured, and in members' job-readiness, individual financial stability, and engagement in ESI as compared to beneficiaries and residents in other states. The BRFSS will be used to measure changes in access to preventive care and health status of low-income residents. Table 7 below outlines which survey questions will be referenced for the listed major topics.

The ACS-PUMS surveys more than 3.5 million households annually and collects data on employment status, health insurance, income, hours worked per week and industry and occupation. Due to the timing of demonstration start and Interim Evaluation Report deadlines, the IE will use the 1-year PUMS data for relevant years. The ACS-PUMS data will assist in identifying the effect of the demonstration on employment of Medicaid beneficiaries in the Summative Evaluation Report. The IE will create weighted population estimates using the ACS-PUMS data to identify changes in healthcare coverage status, employment status and income levels for Georgia residents.

BRFSS collects data on over 400,000 adult U.S residents' health related risk behaviors and events, chronic health conditions, and use of preventive service across all 50 states, the District of Columbia and three U.S territories. The IE anticipates leveraging the BRFSS data for Health-Related Quality of Life estimates. Specifically, the IE will use BRFSS to understand eligible Medicaid beneficiaries' general health status, physical health status, mental health status, and impact of health status on quality of life.

Measures employing national survey data for an out-of-state comparison for DiD analysis will use a two-year pre-demonstration baseline. The measurement period for national surveys does not align with the demonstration years or benefit periods, so the annual survey datasets will not perfectly represent the demonstration timeline. For the two years[11] prior to demonstration launch, and for each demonstration year, the closest available datasets will be used.

TABLE 7: APPLICATION OF NATIONAL SURVEY DATA

Topic	Survey Name	Survey Questions
Work/Income	**ACS-PUMS**	• Any work for pay • Industry, type of work • Laid-off status. • Total income in the last year • Income sources (self-employed, social security, • etc.)
	BRFSS	• Employment loss • Work hours reduced • SNAP status • Ability to afford food, mortgage, rent, utility bills, transportation • Industry, type of work
Coverage	**ACS-PUMS** **BRFSS**	• Whether insured • Type of coverage • Source of coverage (employer-sponsored)
Health Status	**BRFSS**	• Healthy days • Anxiety/depression symptoms

Key Informant Interviews

Qualitative data on program implementation will be gathered through key informant interviews with providers and state administrators. Semi-structured KIIs lasting 30-45 minutes will be conducted by phone or videoconference, with privacy protections in accordance with CMS guidelines. Interviews will be recorded and transcribed. Interview guides will be developed by the IE in collaboration with DCH for providers, and for state administrators involved in implementation of the waiver demonstration.

As appropriate, interviews will explore program implementation, and topics drawn from the logic model; examples are shown in Table 8.

[11] For the ACS-PUMs survey data, the 2021 5-year dataset will be used as a baseline to provide a larger baseline dataset, as described in Data Sources.

TABLE 8: TOPICS FOR KEY INFORMANT INTERVIEWS

Research Question	Example topics
RQ1. Did Georgia Pathways Improve the access to health care of low-income Georgians?	**In what ways did (or did not) the demonstration increase access to health care for members enrolled in Georgia Pathways?** • Perceived access to primary care • Perceived patterns of members seeking care at appropriate settings
RQ4. Did Georgia Pathways Empower Georgia Pathways members to become active participants and consumers of their healthcare?	**In what ways did (or did not) the demonstration encourage beneficiary engagement in their health care?** • Beneficiary understanding of their coverage and benefits • Beneficiary engagement in their own healthcare decisions
RQ9. Was the demonstration implemented effectively?	**In what ways did (or did not) implementation happen successfully?** • Perceived successes and challenges in implementation • Efforts undertaken by the state to facilitate more timely application processing, perceived results of such efforts
RQ9a. Was the Public Health Emergency/COVID-19 pandemic a barrier to the demonstration implementation? To what extent did the state's unwinding efforts interact with the implementation of the demonstration? Were there additional unforeseen challenges due to the timing of the implementation in the backdrop of the unwinding activities, and how did the state overcome such challenges?	**In what ways did (or did not) the unwinding of the Public Health Emergency have on implementation?** • Administrative challenges of launching Pathways • Perceived impact of the PHE/unwinding
N/A	**What changes might make the demonstration more effective in achieving program goals?** • Perceived administrative burden of the demonstration • Suggestions for improvements or course corrections

Administrative Data

The IE will have access to the Georgia Pathways' eligibility data which is being managed by the Georgia Department of Child and Family Services, through the vendor Gateway. Eligibility data will allow the IE to access member information at the time of enrollment. Examples of such data include employment status, income, and beneficiary compliance with qualifying hours and activities requirements.

Medicaid MMIS Encounter Data

The IE will have access to Claims/Encounter data called the Medicaid Management Information System (MMIS) from the state on an annual basis. Encounter data reported by plans is cleaned by the state's vendor and will also be checked for duplicates and missing fields by the IE. In addition, the IE will validate each batch of data received by checking counts of enrolled individuals, and key services against state analytics team estimates and monitoring metrics reported in aggregate. Encounter data will not include cost/charge, which is a noted limitation due to the fully capitated payment model used by DCH for the Managed Care Organizations (MCOs) covering beneficiaries.

5. ANALYTIC METHODS

Quantitative Analyses

In order to provide robust conclusions, the IE will employ multiple analytic strategies to answer the research questions. The IE will utilize statistical software packages including SAS, SQL, and Stata to analyze the data, generating descriptive statistics and assessing significant differences in comparisons of interest. Multivariate regression will be used to model outcomes over time, following individuals longitudinally. This approach allows for the trend over time to be adjusted for changes in the demonstration population as members enter and leave the Pathways program.

TABLE 9: SUMMARY OF ANALYTIC METHODS TO BE USED FOR EVALUATION OF THE GA PATHWAYS DEMONSTRATION

Method	Comparison	Data sources
Descriptive statistics Trend over time	Pre-demonstration comparison population Subgroups within demonstration population	Encounter data Administrative data Primary survey data
Linear Regression	Subgroups within demonstration population	Encounter data Administrative data
Interrupted Time Series	Pre-demonstration comparison population	Encounter data Administrative data
Regression discontinuity	Members enrolled in Pathways vs similar beneficiaries with incomes below the threshold for traditional eligibility categories	Encounter data Administrative data
Difference in differences	Pre/Post change in Georgia vs Pre/Post change in other states that have expanded Medicaid, and in those that have not expanded	National survey data

Synthetic Control Methods	Predicted outcomes for 'synthetic GA'	National survey data

Descriptive statistics and trend-over-time

The IE will use descriptive statistical methods to generate summary tables of population size and characteristics, outcomes for demonstration members and comparison groups where applicable, and distribution of outcomes by demographic characteristics and relevant subgroupings. Data will be analyzed using standard tests as rates, proportions, frequencies, and measures of central tendency (e.g., mean, median, mode). These tables will be used to develop a quantitative picture of the population, to describe raw trends, and to identify characteristics that will be included as covariates in regression modeling. The composition of the pre-demonstration comparison group will be compared to the enrolled Pathways population using t-tests to identify any significant differences in demographic or clinical characteristics. ANOVA/MANOVA tests will be used as a first pass comparison of mean outcomes for demonstration to pre-demonstration populations. Outcomes of interest will be plotted over time for the duration of the demonstration.

Multiple regression modeling with in-state comparison

The IE will employ quasi-experimental methods for outcomes that are based on Medicaid MMIS encounter data. The planned measures for regression analysis are Adults' Access to Preventative/Ambulatory Health Services (AAP), and Inpatient Days (IPU), as these include all or almost all Pathways members in the measure. Outcomes pertaining to behavioral health conditions (Follow-up After Emergency Department Visit for Mental Illness [FUM], Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence [FUA], and Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment [IET]) apply to a fraction of Pathways members, resulting in a smaller dataset; the IE will determine after data collection whether regression analysis is feasible for these outcomes.

For comparisons of the enrolled population to the pre-demonstration comparison group, ITS will be used to test for a change linked to the transition from traditional Medicaid to Pathways. The null hypothesis will be that the Pathways members who transitioned from traditional Medicaid experience the same trend in outcomes during the demonstration as during the pre-demonstration period.

For subgroup comparisons, the trend for each evaluation group will be modeled using multivariate linear regression and compared. For comparison of subgroups, the reference group will be the region with the highest number of members. The null hypothesis will be that the groups have identical trends. In order to account for demographic characteristics such as age and gender that may differ among the groups the IE will use inverse probability of treatment weighting. Individuals in each group will be assigned weights based on the composition of the reference group, producing groups that are equivalent for measurable characteristics and allowing any difference in outcomes to be attributed to the intervention.[12]

Subgroup analysis will compare rural to urban members, and will partition members by age, race/ethnicity and gender. Where possible, race will include White, Black, Asian, and Native American populations for stratification. Due to the low prevalence of some subgroups, it may be necessary to combine some racial groups into an "Other" category. Ethnicity will be characterized as Hispanic/Not Hispanic.

[12] Austin PC, Stuart EA. Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. Stat Med. 2015; 34(28):3661–79. Epub 2015/08/05. https://doi.org/10.1002/sim.6607 PMID: 26238958; PubMed Central PMCID: PMC4626409.

For additional insight, a regression discontinuity design (RDD) will be used to compare individuals on either side of the income threshold separating individuals eligible for traditional Medicaid and similar individuals eligible for Pathways. If sufficient data is available, the RDD method will also be used to compare members above and below the income threshold that triggers the premium requirement. The null hypothesis will be that the trend of outcome over income is the same above and below the eligibility threshold.

Difference-in-differences and synthetic control methods with out-of-state comparison

For some outcomes, national survey data will enable a quasi-experimental approach using other states as comparisons. The IE will use data from the ACS-PUMS survey for income and employment outcomes, and from the BRFSS for health outcomes. Demonstration members cannot be directly identified in national survey data, so Medicaid beneficiary status where possible, and income as a proxy otherwise, will be used to define the samples. Using DiD with inverse probability of treatment weighting (IPW), outcomes in GA will be compared to two groups of states, Medicaid expansion and non-expansion. The expansion group will be defined as those state which implemented Medicaid expansion under the ACA prior to the beginning of the baseline period defined above (two years prior to the launch of Georgia Pathways). The non-expansion group will be defined as those that did not implement Medicaid expansion as of the end of the evaluation period (end date of Georgia Pathways). Any states that implemented Medicaid expansion during the evaluation period will be excluded, as they do not fit into either comparison group. A three-year, pre-demonstration baseline will be used to determine the pre-intervention trend, and to test whether the historic trends in the comparison group and target population were parallel.

In addition to DiD, the IE will use synthetic control methods (SCM) to estimate the association between implementation of the demonstration and the key outcomes. For each outcome of interest, the IE will use ACS-PUMS and BRFSS data for all other states for the three years prior to demonstration launch to construct a synthetic control representing GA's outcomes during the baseline period.[13] The weights derived empirically during this stage will allow the IE to generate a predicted outcome value for "synthetic Georgia" for each quarter during the demonstration period. This model will be used to find mean differences between actual GA outcomes and predicted outcome of the synthetic control during the demonstration period.

Qualitative analysis

Qualitative analysis will be used for key informant interviews and focus group transcripts. Thematic analysis using a coding tree derived from the demonstration logic model will be used to excerpt transcripts. Additional themes that arise during coding will be added to the analysis. Results of provider interviews will be used to add context to the quantitative findings regarding experience of care, beneficiary engagement, and barriers to engagement. Results of provider and administrator interviews will address implementation and will inform the Evaluation Report chapter on Lessons Learned and Recommendations.

D. METHODOLOGICAL LIMITATIONS

1. **Short demonstration period.** The demonstration period is now only 27 months long, which reduces the likelihood of detecting changes in outcomes. Descriptive analyses will be presented in the Interim

[13] CMS White Paper, October 2020, "Selection of Out-of-State Control Groups and the Synthetic Control Method.

Evaluation Repot that precludes causal interpretation. Results from quasi-experimental methods and descriptive analyses will be presented in the Summative Evaluation Report. The IE will use the most appropriate statistical techniques to analyze the data that is available at the time of the Interim and Summative Evaluation Reports. To generate the most meaningful evaluation feasible, the IE has added additional primary data collection, including survey and qualitative research, and additional questions focused on implementation.

2. **Self-reporting, selection, and attrition bias.** The evaluation of the Georgia Pathways program relies heavily on self-reported data collected by the ACS-PUMS and BRFSS, which are subject to participation bias. The planned Pathways beneficiary surveys could also be biased by characteristics or experiences of individuals who choose to complete the survey. In interpreting survey findings, the IE will consider the ways in which survey respondents' responses may be biased. Attrition bias may tend to select for individuals who experience fewer obstacles to employment; the IE will mitigate this bias by actively seeking to survey individuals who have been suspended or disenrolled, and to include these individuals in focus groups.

3. **COVID-19 PHE.** During the COVID-19 PHE, from February 2020 to the end of March 2023, most eligibility redeterminations and potential disenrollments were paused. This continuous enrollment period likely impacted pre-demonstration data because the number of individuals enrolled in Medicaid increased temporarily, and individuals with incomes above the eligibility cutoff were maintained on the rolls. For analyses using pre-demonstration data, sensitivity analysis will be conducted to determine whether specific time periods should be eliminated from the analysis.

4. **Lack of a true in-state comparison group.** The Georgia Pathways program includes individuals aged 19-64 with household incomes up to 100% of the FPL who are not otherwise eligible for Medicaid, and who are working or engaged in employment-related activities for at least 80 hours per month. As such, no true comparison group for this population exists. Other Medicaid beneficiaries are not subject to the qualifying hours and activities requirements of Pathways. To mitigate this limitation, the IE plans to use pre-demonstration data from members who were identified as likely to be eligible for Pathways at redetermination.

5. **Lack of historic data for newly eligible individuals.** Some Georgia Pathways members will be newly eligible, and no pre-demonstration data is available for these individuals. Some Pathways members will come from the pre-demonstration comparison group, and those individuals will be tracked longitudinally and reported as a distinct subgroup.

6. **Sample size.** By the end of the approved demonstration period Georgia Pathways is anticipated to enroll between 10,000 – 50,000 Medicaid beneficiaries[4]. However, the data set for specific outcomes may not have sufficient size for sufficiently powered statistical analysis on all subgroups of interest.

7. **Data availability for HIPP participants**. As members transition from Medicaid to ESI through the HIPP program, their claims will be paid by private insurance and the evaluator will lose access to their encounter data. Members surveys and administrative data form eligibility determinations will be used to assess this population where possible, but they will not be included in measures derived from encounter data.

8. **Uncertainty about phase three implementation plan.** Implementation plans have not been finalized for phase three at the time of drafting this Evaluation Design. It is unlikely that this phase will be fully implemented. Therefore, the research questions concerning copays, premiums, tobacco

surcharge, and MRAs will not be applicable for the Interim Evaluation Report. Depending on implementation, these could be applicable for inclusion in the Summative Evaluation Report. If phase three is launched late, or involves too few members, it may not generate sufficient data to address these research questions, in which case the Summative Evaluation Report will provide a descriptive narrative of phase three components, with any available data. If phase three is fully implemented, the member survey and focus groups will include phase three components as topics, and Gateway data on enrollment, satisfaction of requirements, and MRA take-up will be analyzed for the Summative Evaluation Report. The IE will coordinate with the state to consult with CMS on the design, analysis, and content to be included in the Summative Evaluation Report pertaining to phase three, once implementation planning is known.

9. **Out of state comparisons.** The use of national survey data allows for out of state comparison groups but limits the ability to specifically identify individuals enrolled in the demonstration. An approximation will be achieved by using income and Medicaid enrollment to define a sample representing demonstration members as closely as possible.

10. **Lack of expenditure data**. As the state uses a fully capitated prospective payment model for the entirety of the demonstration, encounter data does not include cost/charge information. The independent evaluator will evaluate cost of care using proxies including hospital utilization and estimated cost derived from encounter data and average encounter costs.

11. **Historic effects.** The unwinding of the pandemic/PHE is expected to directly impact the ramp up of Pathways as described above, which means that enrollment will not reach steady state until delayed redeterminations have been processed. If the redetermination process occurs more slowly than expected, enrollments could be delayed. Ongoing economic trends may affect the job market in parts of GA differently. To mitigate this concern, the IE will stratify results by rural vs urban residents. If high unemployment rates lead to suspension of qualifying hours and activity requirements in some areas of the state but not others, the IE will compare results for members who are subject to qualifying hours and activities requirements with those who are not.

E. ATTACHMENTS

1. INDEPENDENT EVALUATOR

Procurement for an evaluation contractor to assist the state in executing its 1115 demonstration evaluation plan was accomplished pursuant to the State of Georgia procurement guidelines with resulting agreement contingent upon approval from Georgia's Governor. The state retains responsibility for monitoring the demonstration activities and providing oversight of the Evaluation Design and overall approach for the contractor. To mitigate any potential conflict of interest, the evaluation contractor is responsible for:

- Conducting an evaluation compliant with all requirements specified in the demonstration's Special Terms and Conditions;
- Developing the Evaluation Design;
- Leading the implementation of the evaluation and the evaluation itself;

- Conducting all analysis of the evaluation results in compliance with CMS timelines and deliverables;
- Ensuring the validity, reproducibility, and interpretation of the results;
- Collaborating with DCH through the implementation of the waiver and the duration of all evaluation activities; and
- Producing evaluation reports.

As part of the focused independent evaluation, the evaluator is responsible for final measure selection, identifying, if viable, other state systems that may serve as comparisons, conducting all data analysis, measuring change overtime and developing sensitivity models as necessary to address study questions.

The State issued one procurement for all evaluation activities and the production of required CMS reports. As the successful bidder, Public Consulting Group (PCG) demonstrated the following qualifications:

- Provision of a workplan that met the evaluation deliverables and deadlines required by CMS;
- An ability to comply with CMS' evaluation requirements, including a proposed method for measuring the impacts and goals of the Pathways program and a high-level vision of the evaluation approach;
- A cost proposal that included all proposed costs through 2026;
- A staffing plan that identified who would be responsible for the project components and who would be the project manager and point of contact for DCH;
- A proposed communication approach that met the requirements set forth by DCH; and
- Prior experience with similar evaluations.

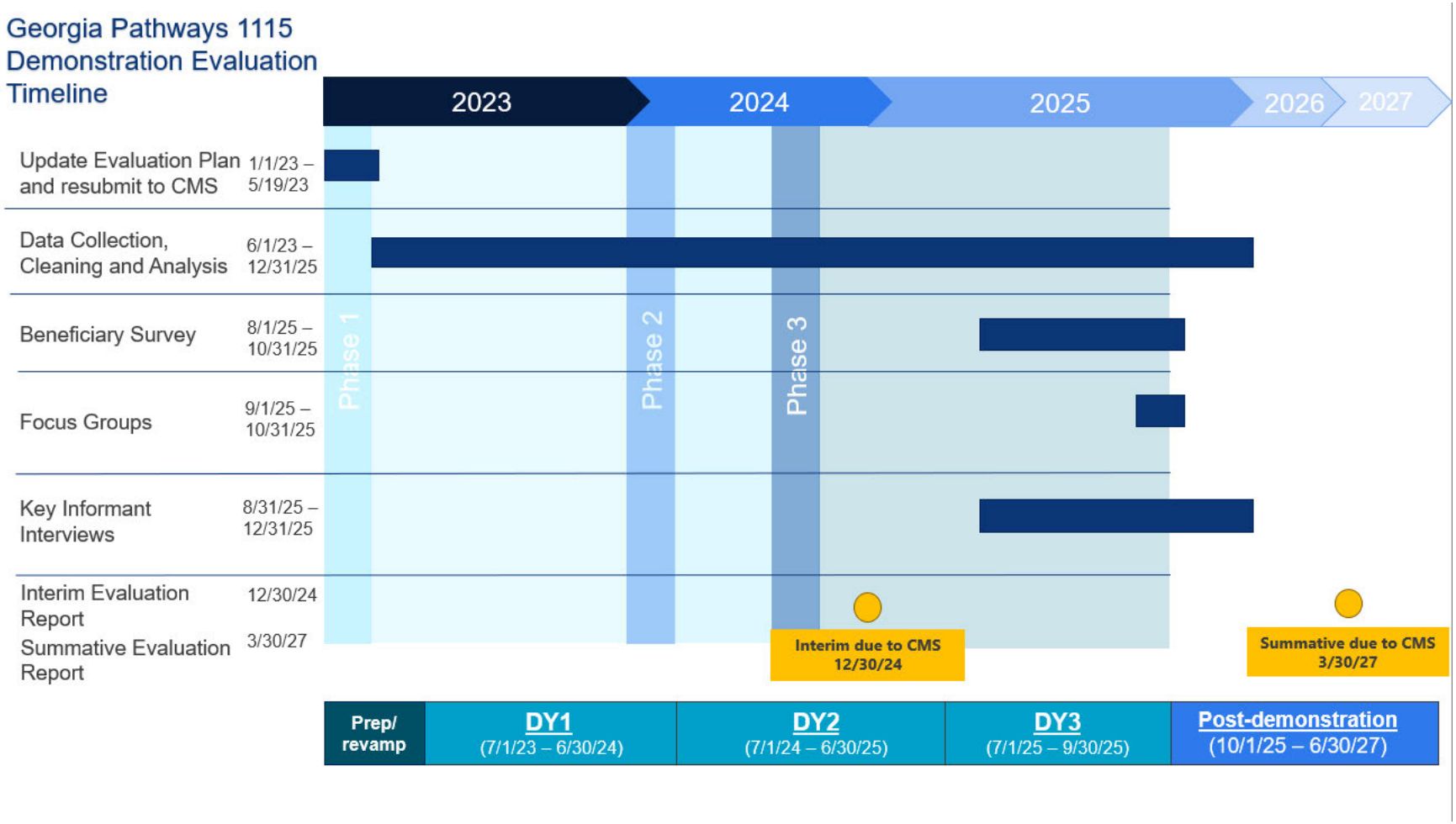
Consistent with the requirements of 42 CFR § 431.420, Georgia DCH selected and retained PCG as an independent evaluator to complete the independent evaluation of the demonstration required under 42 CFR § 431.424. DCH utilized the State of Georgia's procurement process to contract with this evaluator and promote an independent evaluation, through the general requirements for each state contractor as well as project-specific standards. DCH Procurement staff worked with the evaluator to identify and address concerns that might arise during the administration of the contract. By requiring initial satisfaction of these standards by the contracting party in order to be awarded the contract, as well as ongoing maintenance of the requirements during the term of service, DCH is in a position to receive an objective evaluation report that is the product of a fair, impartial, and conflict-free evaluation.

2.EVALUATION BUDGET

	Pre-Demonstration Dec 2020-6/30/23	DY1 7/1/23-6/30/24	DY2 7/1/24-6/30/25	DY3* 7/1/25-9/30/25	Post Demonstration 10/1/25-9/30/27	Total
Project Management	$ 45,149	$ 45,149	$ 45,149	$ 11,287	$ 67,723	$ 214,456
Evaluation Design Revised Design Due 5/19/23	$ 270,892					$ 270,892
Beneficiary & Provider Survey and Focus Groups			$ 120,000	$ 220,000	$ 77,000	$ 417,000
Key Informant Interviews			$ 90,297	$ -		$ 90,297
Quantitative Data Collection and Analysis		$ 225,743	$ 225,743	$ 225,743		$ 677,230
Interim Evaluation Report Due 12/30/24		$ 180,595	$ 45,149			$ 225,743
Summative Evaluation Report Due 3/30/27					$ 270,892	$ 361,189
Total	**$ 316,041**	**$ 451,486**	**$ 526,338**	**$ 547,328**	**$ 415,615**	**$ 2,256,807**

Note: * DY3 is not a full calendar year

3.TIMELINE AND MAJOR MILESTONES



The original demonstration period was scheduled to begin on July 1, 2021, but now will launch beginning July 1st, 2023, and will conclude September 30th, 2025. The first major milestone of the Georgia Pathways Demonstration is to Update to the Evaluation Design, which PCG will deliver to Georgia DCH on May 19th, 2023.

The Data Collection, Cleaning and Analysis phase will span the majority of the adjusted Demonstration period. The Beneficiary Survey and focus groups will take place around the close of the Demonstration.

Development of the Interim Evaluation Report, due to CMS December 30th, 2024, will begin as soon as data becomes available from DCH's vendor, which is anticipated to be in September 2023.[14] The Interim Evaluation Report will describe patterns of application, enrollment, suspension, continuance, and qualifying hours and activities in the first 13 months of the demonstration.

Data collection and analysis for the Summative Evaluation Report will begin in parallel, including preparations for beneficiary survey and focus groups, KIIs, and analysis of encounter data and national survey data. PCG will submit a full draft report to DCH at least four weeks prior to CMS deadline for internal review and comment period. Once the details of the report are endorsed by DCH, PCG will complete any final edits and return the final document for submission at least 14 days prior to the March 30, 2027, CMS deadline.

[14] The draft Interim Evaluation Report was initially due on September 30th, 2024. On July 18, 2024, CMS approved a three-month extension to the due date in response to the state's request for an additional three months to produce a more thorough and meaningful Interim Evaluation Report.

4. EVALUATION TABLE

TABLE 10 EVALUATION TABLE

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
Hypothesis 1: The demonstration will improve the health care access of low-income Georgians.						
Primary research question 1.1: Did the percent of adult members with a primary care or ambulatory visit in the last 12 months change?						
Pre-demonstration baseline	Claims/Encounter Data (MMIS)	Adults' Access to Preventative/Ambulatory Health Services (HEDIS AAP)	Percent of members who had an ambulatory or preventive care visit during the measurement year	Multiple linear regression; ANOVA/MANOVA; ITS; RDD	N	S
Pre-demonstration baseline	Claims/Encounter Data (MMIS)	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (HEDIS FUA)	Assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).	Multiple linear regression; ANOVA/MANOVA; ITS; RDD	N	S

[15] Where possible, we will include age, gender, race, ethnicity, and location (rural vs. urban) as subgroups. As discussed in Section D: Methodological Limitations, subgroup analysis may be limited by sample size, and it may not feasible to implement all analyses as intended.

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
			ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).			
Pre-demonstration baseline	Claims/Encounter Data (MMIS)	Follow-Up After Emergency Department Visit for Mental Illness (HEDIS FUM)	Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 and 30 days.	Multiple linear regression; ANOVA/MANOVA; ITS; RDD	N	S
Pre-demonstration baseline	Claims/Encounter Data (MMIS)	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS IET)	Percent with a new episode of alcohol or other drug dependence who: 1) initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis.	Multiple linear regression; ANOVA/MANOVA; ITS; RDD	N	S

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
			2) had two or more additional AOD services or MAT within 34 days of the Initiation visit.			
Primary research question 1.2: Did members' self-report of ability to obtain care change?						
N/a	Member Survey; Focus groups	Perceived Access	Member reports of ease of access to needed care	t-test; ANOVA/MANOVA; other descriptive statistics; qualitative analysis	Y	S
Primary research question 1.3: Did members' self-report of overall health status change?						
Comparison states; synthetic GA	BRFSS	Health-Related Quality of Life	Derived from healthy days questions: 1) Would you say that in general your health is excellent, very good, good, fair or poor?	Difference-in-differences; synthetic control model	N	S

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
			2) Now thinking about your physical health, which includes physical illness and injury, how many days during the past 30 days was your physical health not good?			
			3) Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good?			
			4) During the past 30 days, approximately how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?			

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Member Survey; Focus groups	Self-reported health	Self-rating of overall health	t-test, ANOVA/MANOVA, other descriptive statistics; qualitative analysis	Y	S
Primary research question 1.4: What was the outcome of redetermination for members who were identified during unwinding as possibly eligible for Pathways?						
N/a	Administrative Data	Outcome of redetermination	1) Percentage of individuals enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance and became enrolled in Pathways[9]	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	N	S
			2) Percentage of individuals enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance and became enrolled in Medicaid[9]			
			3) Percentage of individuals enrolled in			

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
			another Medicaid eligibility category who were either up for renewal or reported a change in circumstance and were found ineligible for Medicaid[9]			
			4) Percentage of individuals enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance and did not complete redetermination[9]			
			5) Percentage of individuals enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance and were denied Pathways due to unmet qualifying hours and activities requirement[9]			
			6) Percentage of individuals enrolled in another Medicaid eligibility category who were either up for			

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
			renewal or reported a change in circumstance and were denied Pathways due to other reasons[9]			
Primary research question 1.5: What was the outcome of new applications to Pathways?						
N/a	Administrative Data	Outcome of new applications	1) Percentage of new Medicaid applicants who became enrolled in Pathways[9]	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	N	S
			2) Percentage of new Medicaid applicants who became enrolled in Medicaid[9]			
			3) Percentage of new Medicaid applicants who were found ineligible for Medicaid[9]			
			4) Percentage of new Medicaid applicants who were denied Pathways due to unmet qualifying hours and activities requirement[9]			
			5) Percentage of new Medicaid applicants who were denied Pathways due to other reasons unrelated to the qualifying hours and activities requirement[9]			

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
Primary research question 1.6: Were Pathways members able to meet qualifying hours and activities (QHA) requirements and sustain coverage?						
N/a	Administrative Data	Outcome of qualifying hours and activities requirement	1) Percentage of Pathways members found exempt from reporting QHA after 6 months of reporting	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	N	S
			2) Percentage of Pathways members who verified QHA during an audit			
			3) Percentage of Pathways members who did not verify QHA during an audit			
			4) Percentage of Pathways members who requested an exception for good cause			
			5) Percentage of Pathways members who were approved for an exception			
			6) Percentage of individuals who requested reasonable modifications due to disability at application			
			7) Percentage of individuals granted reasonable modifications due to disability			

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
			8) Percentage of Pathways members suspended for noncompliance with the QHA requirement			
			9) Percentage of Pathways members disenrolled from the demonstration for noncompliance with the QHA requirement			
			10) Percentage of Pathways members reinstated after being in suspension status for noncompliance with the QHA requirement			
			11) Percentage of Pathways members re-enrolled in the demonstration after disenrollment for noncompliance with the QHA requirement			
Hypothesis 2: The demonstration will reduce the number of uninsured Georgia residents with incomes up to 100% of FPL.						
Primary research question 2.1: Did the number of uninsured adults aged 19-64 in GA change?						
Comparison states; synthetic GA	American Community Survey	Health Insurance Coverage (Variable name: HICOV)	Percent of Georgian adults aged 16-64 who are uninsured	Difference-in-differences; synthetic control model	N	S
Primary research questions 2.2: Did trends in the uninsured rate vary by geographic areas?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
Comparison states; synthetic GA	American Community Survey	Public Use Microdata Area code	American Community Survey geographic code (can be linked to counties, town and zip codes)	Difference-in-differences; synthetic control model	N	S
Primary research questions 2.3: Did trends in the uninsured rate vary by age group?						
Comparison states; synthetic GA	American Community Survey	Health Insurance Coverage (Variable name: HICOV)	Percent of uninsured	Difference-in-differences; synthetic control model	N	S
Primary research questions 2.4: Did trends in the uninsured rate vary by race/ethnicity group?						
Comparison states; synthetic GA	American Community Survey	Health Insurance Coverage (Variable name: HICOV)	Percent of uninsured	Difference-in-differences; synthetic control model	N	S
Hypothesis 3: The demonstration will increase the number of Georgia Pathways members who transition to commercial health insurance, including employer sponsored insurance and individual health insurance market coverage, after separating from Medicaid						
Primary research question 3.1: Did the number of members who lose eligibility due to gained income change?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
Subgroup comparison	Administrative Data	Percentage of members determined ineligible for Medicaid after state processes a beneficiary-reported change in circumstance	Percent of Pathways members who were enrolled in the demonstration and lost eligibility for Medicaid during the measurement period because they were determined ineligible after the state processed a change in circumstance, such as income or family household[9]	Trend over time; ANOVA/MANOVA	Y	S
Subgroup comparison	Administrative Data	Percentage of members determined ineligible for the demonstration at renewal, disenrolled from Medicaid	Percent of members enrolled in the demonstration and due for renewal during the measurement period who completed the renewal process and were determined ineligible for Medicaid[9]	Trend over time; ANOVA/MANOVA	Y	S
Subgroup comparison	Administrative Data	Percentage of members determined ineligible for the demonstration at renewal and transferred to another Medicaid eligibility category	Percent of members enrolled in the demonstration and due for renewal during the measurement period who completed the renewal process and moved from the demonstration to a	Trend over time; ANOVA/MANOVA	Y	S

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
			Medicaid eligibility group not included in the demonstration[9]			
Subgroup comparison	Administrative Data	Percentage of members who retained eligibility for the demonstration after completing renewal forms	Percent of members enrolled in the demonstration and due for renewal during the measurement period who remained enrolled in the demonstration after responding to renewal notices[9]	Trend over time; ANOVA/MANOVA	Y	S
Primary research question 3.2: Did the number of former Georgia Pathways members who successfully transitioned to commercial health insurance coverage change?						
Subgroup comparison	Administrative Data	Members who lost Medicaid eligibility due to mid-year change in circumstance, and transitioned to a qualified health plan offered in the Marketplace	Percent of members who lost eligibility for Medicaid during the measurement period due to a change in circumstance who transitioned to a qualified health plan offered in the	Trend over time; ANOVA/MANOVA	Y	S

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
			Marketplace (Health Insurance Exchange)[9]			
Subgroup comparison	Administrative Data	Members who lost Medicaid eligibility at renewal, and transitioned to a qualified health plan offered in the Marketplace	Percent of members who lost eligibility for Medicaid during the measurement period due to the outcome of eligibility renewal processes and transitioned to a qualified health plan offered in the Marketplace (Health Insurance Exchange)[9]	Trend over time; ANOVA/MANOVA	Y	S
Primary research question 3.3: What is the pattern of coverage of members who transition to ESI?						
N/a	Member Survey; Focus groups; Administrative Data	Patterns of ESI enrollment	Continuity and duration of ESI enrollment[9]	t-test, ANOVA/MANOVA, other descriptive statistics; qualitative analysis	N	S
			Transition from Pathways to ESI[9]			
			Transition from ESI to Pathways[9]			

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
			Disenrolled from ESI[9]			
Primary research question 3.4: What occupational or other characteristics are associated with transitioning to ESI?						
Demonstration members not enrolled in ESI	Member Survey; Focus groups	ESI enrollment	Occupation, job type, and demographic factors associated with transitioning to ESI from Georgia Pathways	t-test, ANOVA/MANOVA, other descriptive statistics; qualitative analysis	Y	S
Primary research question 3.5: What is the coverage status by payer type of former Georgia Pathways members after separating from Medicaid?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Member Survey; Focus groups	Post-Medicaid coverage	Former Pathways members coverage status and source (e.g. employer sponsored, marketplace, uninsured)	t-test, ANOVA/MANOVA, other descriptive statistics; qualitative analysis	Y	S
Hypothesis 4: The demonstration will increase member engagement in care.						
Primary research question 4.1: To what extent and in what ways did members feel more informed about their coverage and benefits, and more engaged in their own healthcare decisions?						
Subgroup comparison	Member Survey; Focus groups	Members' understanding of coverage and benefits, self-reported	Members' understanding of coverage and benefits, self-reported by member	t-test; ANOVA/MANOVA; other descriptive statistics; qualitative analysis	Y	S
Subgroup comparison	Member Survey; Focus groups	Members' engagement in their own healthcare decisions, self-reported	Members' engagement in their own healthcare decisions, self-reported by member	t-test, ANOVA/MANOVA; other descriptive statistics; qualitative analysis	Y	S

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
Hypothesis 5: The demonstration will increase the number of Georgia residents below and up to 100% of the FPL enrolled in employer sponsored insurance.						
Primary research question 5.1: Did the percentage of members enrolled in ESI through mandatory HIPP change?						
Subgroup comparison	Administrative Data	ESI enrollment	Percent of Pathways members who are enrolled in ESI through HIPP	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	Y	S
Primary research question 5.2: Did the percentage of premium paid for by premium assistance for qualifying ESI health plans change?						
Subgroup comparison	Administrative Data	Premium assistance	Average percentage of premium for HIPP members paid as premium assistance	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	Y	S
Hypothesis 6: The demonstration will increase the number of adults below and up to 100% of the FPL who are engaged in at least 80 hours a month of employment or employment related activities.						
Primary research question 6.1: Did the average hours worked by employed individuals change?						
Subgroup comparison	Administrative Data	Hours worked	Percent of uninsured; and then analysis by subgroup: Person's age (AGEP).	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	Y	S
Primary research question 6.2: Do members who initially participate in qualifying hours and activities other than employment gain employment within some defined time period (i.e., is there evidence of job-readiness progression?)						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
Subgroup comparison	Administrative Data	Qualifying hours and activities, as determined	Qualifying hours and activities, as determined during eligibility verification	t-test, ANOVA/MANOVA, other descriptive statistics	Y	S
Subgroup comparison	Member Survey; Focus groups	Qualifying hours and activities, self reported	Qualifying hours and activities, self reported by member	t-test, ANOVA/MANOVA, other descriptive statistics; qualitative analysis	Y	S
Primary research question 6.3: What are the characteristics of new jobs gained by qualifying hours and activities members?						
N/a	Administrative Data	Job characteristics, as determined	Occupation/industry categories, as determined with eligibility	t-test, ANOVA/MANOVA, other descriptive statistics	N	S
N/a	Member Survey; Focus groups	Job characteristics, self reported	Occupation/industry categories, self reported	t-test, ANOVA/MANOVA, other descriptive statistics; qualitative analysis	Y	S

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
Primary research question 6.4: Is employment among individuals subject to qualifying hours and activities requirements sustained over time?						
N/a	Member Survey; Focus groups	Employment duration	Self-reported duration of employment	t-test, ANOVA/MANOVA, other descriptive statistics; qualitative analysis	Y	S
Hypothesis 7: The demonstration will increase wage growth for those made eligible for Medicaid through the Demonstration.						
Primary research question 7.1: Did member earnings change at annual redetermination?						
Subgroup comparison	Administrative Data	Earned income	As determined during eligibility verification	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	Y	S
Hypothesis 8: The Georgia Pathways demonstration will improve the fiscal sustainability of the GA Medicaid program.						
Primary research question 8.1: Did the demonstration contain cost growth for Georgia Pathways members?[16]						
Pre-demonstration baseline	Claims/Encounter Data (MMIS)	Per capita expenditure	Per capita health expenditure for demonstration members derived from encounter data and average encounter costs.	Multiple linear regression; ANOVA/MANOVA	N	S

[16] While the state's STCs reference assessing uncompensated care costs, such analyses are likely to be of limited value for the Pathways demonstration as data on uncompensated care costs pertaining specifically to the Pathways enrollee population is unavailable.

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
Primary research question 8.2: Did the rate of hospitalization decrease for Georgia Pathways members?						
Pre-demonstration baseline	Claims/Encounter Data (MMIS)	Inpatient Days (HEDIS IPU)	Days as a hospital inpatient for demonstration members.	Multiple linear regression; ANOVA/MANOVA; ITS; RDD	N	S
Primary research question 8.3: Did enrollment of members in ESI reduce costs for the Medicaid program?						
Subgroup comparison	Administrative Data	Total Cost of Care	All costs (premium assistance and direct claims) for HIPP members compared to PMPM cost for non-demonstration Medicaid members.	Multiple linear regression; ANOVA/MANOVA	Y	S
Primary research question 8.4: What was the administrative cost of implementing and operating the demonstration?						
N/a	Administrative Data	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, health behavior incentives, premium assistance, community engagement requirements and/or retroactive eligibility waivers	Multiple linear regression; ANOVA/MANOVA	N	S
Exploratory Research Questions						
Primary research question 9: Was the demonstration implemented effectively?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Focus groups; Key Informant Interviews	Implementation	Narrative of implementation, including successes and challenges.	Qualitative analysis	N	S
Subsidiary research question 9a: How did the Public Health Emergency/Covid-19 pandemic impact implementation and evaluation of the demonstration?						
N/a	Focus groups; Key Informant Interviews	Pandemic effect	Narrative of perceived impact of the pandemic	Qualitative analysis	N	S
Primary research question 10: What barriers to meeting qualifying hours and activities requirements are experienced by demonstration participants and those interested in Pathways?						
N/a	Administrative Data	Members newly suspended for failure to complete QHA	The percent of demonstration members newly suspended, i.e., enrolled in the demonstration, but not actively receiving benefits, for noncompliance during the measurement period (if state has a suspension policy).	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	N	S
N/a	Administrative Data	Members newly disenrolled for failure to complete QHA	The percent of demonstration members newly disenrolled for noncompliance with QHA during the measurement period.	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	N	S

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Administrative Data	Total members whose benefits were reinstated after being in suspended status for noncompliance	The percent of demonstration members whose benefits were reinstated during the measurement period after suspension (i.e., enrolled in the demonstration, but not actively receiving benefits) in a prior month triggered by noncompliance with community engagement requirements, including those reinstated due to compliance, determination of exemption, successful appeal, or good cause circumstances.	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	N	S

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Administrative Data	Total members re-enrolling after disenrollment for noncompliance	Total percent of members re-enrolled in the demonstration during the measurement period after disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (depending on state policy), including those re-enrolling after being determined exempt or after successful appeal.	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	N	S
Subsidiary Research Question 10a: Do members understand the qualifying hours and activities requirements and how to satisfy them?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Member Survey; Focus groups	Comprehension of requirements	Percent of members who report clearly understanding the requirements of Georgia Pathways and how to meet them	Descriptive statistics; Qualitative analysis	Y	S
Subsidiary Research Question 10b: What are the common barriers to initial compliance with the qualifying hours and activities requirement as well as initial enrollment?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Member Survey; Focus groups	Barriers to initial compliance with QHA requirement	Narrative of barriers to complying with the QHA requirement, such as childcare, transportation hurdles, medical frailty, and administrative challenges	Descriptive statistics; Qualitative analysis	Y	S
Subsidiary Research Question 10c: What are the underlying reasons for post-enrollment noncompliance with the qualifying hours and activities requirement, potentially leading to suspensions and disenrollments from the demonstration?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Member Survey; Focus groups	Reasons for post-enrollment noncompliance with QHA	Narrative of reasons for post-enrollment noncompliance with the QHA requirement, such as childcare, transportation hurdles, medical frailty, and administrative challenges	Descriptive statistics; Qualitative analysis	Y	S
Subsidiary Research Question 10d: Did Pathways members utilize community supports and other services to satisfy the qualifying hours and activities requirement? Did the demonstration's intended, current and former participants perceive availability of such supports and services adequate?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Member Survey; Focus groups	Community supports to satisfy QHA requirement	Narrative of community supports and services that contributed to satisfying the QHA requirement	Descriptive statistics; Qualitative analysis	Y	S
Primary research question 11: What are the characteristics of members who meet or fail to meet qualifying hours and activities requirements? Do these characteristics change over time? How do the characteristics change over time?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Focus groups	Characteristics of members	The percent of members enrolled in the demonstration who were subject to and met the community engagement requirement, and were self-employed or employed in subsidized and/or unsubsidized settings. Includes those who must report their hours to the state and those "deemed" compliant by the state because they are working more than the percent of required hours.	Qualitative analysis	N	S
Primary research question 11a: What are the characteristics of individuals who experience coverage suspension or disenrolled due to not meeting qualifying hours and activities requirement?						
Subgroup comparison	Administrative Data	Characteristics of members	Characteristics of individuals who experience coverage suspension or disenrollment due to unmet QHA requirements	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	Y	S
Primary research question 11b: What is the average duration of coverage gap for individuals who experience coverage suspension or disenrollments?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
Subgroup comparison	Administrative Data	Average duration of coverage gap	Average duration of coverage gap for individuals experiencing suspension/disenrollments	Multiple linear regression; ANOVA/MANOVA; descriptive statistics	Y	S
Primary research question 12: Did members not eligible for NEMT experience any challenges with accessing care because of lack of transportation*?*						
N/a	Member Survey; Focus groups	Challenges of access without NEMT	Narrative of health care access challenges as a result of not having NEMT	Descriptive statistics; Qualitative analysis	Y	S
Primary research question 12a: Do Pathways members over 21 report missing appointments due to lack of transportation?						
N/a	Member Survey; Focus groups	Appointments missed due to lack of transportation	Narrative of transportation challenges causing missed appointments	Descriptive statistics; Qualitative analysis	Y	S
Primary research question 12b: Do Pathways members over 21 report that they would use NEMT if it were available?						

Comparison strategy	Data Source	Measure Name	Measure Description	Analytic Approach	Subgroup Analysis (Y/N)[15]	Reporting (I = Interim Evaluation Report, S = Summative Evaluation Report)
N/a	Member Survey; Focus groups	Use of NEMT if available	Narrative of non-emergency medical transportation use	Descriptive statistics; Qualitative analysis	Y	S
Primary research question 12c: Do Pathways members who are 21 or younger, or who were previously eligible for NEMT (due to being under 21, or having been traditional Medicaid members previously), report using NEMT to access services?						
N/a	Member Survey; Focus groups	Youth eligible (age < 21) NEMT use	Narrative of non-emergency medical transportation use for those under the age of 21 (or those who recently aged out of NEMT use)	Descriptive statistics; Qualitative analysis	Y	S

Attachment D: Implementation Plan

Overview: This implementation plan template contains a structured layout to help document the state's approach to implementing its Medicaid section 1115 demonstration eligibility and coverage policies. The implementation plan also helps establish information that will be important for the state to consider as it embarks on the monitoring protocol, and ultimately what the state will include in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard Centers for Medicare & Medicaid Services (CMS) approval processes and documentation, such as advance planning documents, verification plans, or state plan amendments. Each state with an approved eligibility and coverage demonstration should complete one Implementation Plan Template that encompasses every eligibility and coverage policy in its demonstration and the demonstration overall, as outlined in the state's special terms and conditions (STC).

The eligibility and coverage implementation plan has three sections. Section 1 is the title page. Section 2 contains implementation questions that the state should answer, organized by eligibility and coverage policy and then by reporting topic. In Section 3, the state should provide policy-specific information not captured in Section 2, and may submit additional supporting documents.

This state-specific template consolidates CMS's available implementation plan templates for the eligibility and coverage policies that are included in the Georgia Pathways to Coverage section 1115 demonstration: premiums or account payments, and qualifying hours and activities requirements. For other eligibility and coverage policies that that are in the state's demonstration but do not have a CMS implementation plan template, such as incentives for healthy behaviors, non-applicability of retroactive eligibility, copayments for the non-emergent use of the emergency department, and non-applicability of hospital presumptive eligibility and non- emergency medical transportation (NEMT), the state should follow the guidance in the STCs and use Section 3 of this template to provide additional applicable information.

1. Title page for the state's eligibility and coverage demonstration or eligibility and coverage policy components of the broader demonstration

The state should complete this title page as part of its eligibility and coverage implementation plan. This section collects information on the approval features of the state's section 1115 demonstration overall, followed by information for each eligibility and coverage policy. Definitions for certain rows are provided below the table.

Overall section 1115 demonstration	
State	*Georgia*
Demonstration name	*Georgia Pathways to Coverage*
Approval period for section 1115 demonstration	*10/15/2020 – 09/30/2025*
Qualifying hours and activities requirement	
Qualifying hours and activities requirement start date	*10/15/2020*
Implementation date, if different from qualifying hours and activities requirement start date	*07/01/2023*
Premiums or account payments	
Premiums or account payments start date[a]	*10/15/2020*
Implementation date, if different from premiums or account payments start date[b]	*07/01/2024*

[a] **Eligibility and coverage demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the effective date listed in the state's STCs at time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of policy:** The date of implementation for each eligibility and coverage policy in the state's demonstration.

Georgia Pathways to Coverage goes live on July 1, 2023, and the earliest someone can apply for Georgia Pathways is July 1, 2023. The standard of promptness for making an eligibility determination is 45 days. If an individual applies on July 1, 2023, and it takes 45 days to determine eligibility, that determination will be made around August 15, 2023. Coverage in Georgia Pathways is prospective- meaning coverage begins the first of the month following an eligibility determination. In our example, coverage for this individual who was determined eligible on August 15, 2023, begins September 1, 2023. The individual reports qualifying hours and activities by September 3, 2023, with a final reporting deadline of September 17, 2023. The individual will report hours completed from the previous month, which in this case is August, to maintain coverage in October. To accommodate members who may have a lag in documentation, a member's reporting period may overlap with the end of the previous month or the start of the next month. In our example, if a member reports on September 3rd, they may not have a pay stub

for four weeks in August, so would be able to include the final week in July.

If the individual's eligibility determination is made within the month of July (e.g., applied July 1 and is determined eligible July 20), coverage begins August 1. The individual reports qualifying hours and activities in August, with a final reporting deadline of August 17. The individual will report hours completed in July to maintain coverage in September.

Individuals may apply for the program at any time during a given month. At application, an individual must report at least 80 hours of engagement in a qualifying activity or activities and provide documentation for verification that they meet the hours and activities threshold for the most recent four weeks available within the eight weeks prior to application submission date. Given the standard of promptness for making an eligibility determination is 45 days, there is likely a month after application submission and prior to coverage beginning in which the member does not need to report hours because the application is being process and their coverage has not yet begun. An individual will not be required to report hours while his or her application is being reviewed. After initially reporting hours during the application process, an individual will next be required to report only after coverage begins.

2

2. Required implementation information, by eligibility and coverage policy and reporting topic

Provide information about implementation of the eligibility and coverage policies by responding to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (that is, government or nongovernment entities). If a prompt does not pertain to the state's demonstration, enter "N.A." in the "State response" cell for that prompt. Responses should provide details beyond the information in the state's demonstration STCs. Responses should be concise but provide enough information to fully answer the question, and adequately address the items in the "Required key points" column. The required key points are meant to guide state responses, but the state should not check the boxes in the "Required key points" column. CMS will use this column to review the completeness of the state's implementation plan submission.

Prompts	State response
Qualifying hours and activities requirement	
CE.Mod_1. Specify qualifying hours and activities requirement policies	
Intent: To describe in more detail the qualifying hours and activities requirement policies outlined in the state's STCs	
1.1 Describe how the state will define exempt populations, including additional details about how these exemptions are defined and how long exemptions will last if applicable: 1.1.i Full-time student status	N.A. Pathways creates a new category of Medicaid for individuals that meet the eligibility criteria. Qualifying hours and activities are a requirement for eligibility. As such, there are no exempt populations included in the demonstration design and the State has therefore indicated "N.A" in all sub-sections of this module. Pathways applicants will be evaluated for other categories of Medicaid prior to being determined eligible for Pathways. Many of the populations in this section would be eligible for other categories of Medical Assistance. Full-time students are considered eligible for Pathways as long as they meet other eligibility criteria. Enrollment in an institution of higher education or vocational educational training is a qualifying activity. Qualifying activity hours earned will vary based on course load. • An individual with a current course-load of at least 11.5 credit hours will be considered to have fully met the qualifying activities threshold and will be granted 80 hours per month of a qualifying activity. • An individual with a current course-load between 5.50 and 11.49 credit hours will be granted 40 hours per month of a qualifying activity. • An individual with a current course-load between 0.01 and 5.49 credit hours will be granted 20 hours per month of a qualifying activity. Credit hours must be obtained through an accredited educational institution or program.

Prompts	State response
1.1.ii Medical frailty and other medical conditions	N.A. Individuals considered medically frail could be eligible for other categories of Medicaid or state programs. Pathways members may request good cause exceptions if they have a temporary impairment which prevents them from meeting the qualifying activities requirement. Reasonable modifications and reasonable accommodations are also available to individuals in the Pathways program. Refer to Questions 2.8-2.11 for additional details. As outlined in STC 36, the State will consider granting good cause for a beneficiary who has been compliant with the qualifying hours and activities requirement e if the beneficiary demonstrates a need for the good cause as a result for failing to meet or report the qualifying hours and activities requirement for that month. Any of the following could be circumstances giving rise to good cause exceptions: • The beneficiary or an immediate family member experiences a hospitalization or a serious illness and as a result, is unable to fulfill the qualifying hours and activities • The beneficiary experiences a short-term injury or illness and as a result, is unable to fulfill the qualifying hours and activities • The beneficiary experiences the birth, adoption, or death, of an immediate family member • The beneficiary has a family emergency or other life event (e.g., divorce, civil legal matter, or is a victim of domestic violence) and as a result, is unable to fulfill the hours and activities requirements • The beneficiary is quarantining in response to having COVID-19 symptoms, a COVID19 diagnosis, or exposure to COVID-19, or because of a closure of the place(s) where the beneficiary was meeting the hours requirement related to COVID-19 and as a result, is unable to fulfill the hours and activities requirement • Other good cause reason(s) as defined and approved by the state. Good cause "other" can be used if the individual does not feel like one of the pre-populated options best describes the reason for their request. The "other" option is intentionally undefined, as it is meant to give the member the opportunity to request good cause hours for a reason other than those defined. Once the State understands the "other" good cause reasons being requested by members, public facing documents will be updated and adjustments will be made to the online Customer Portal.
1.1.iii Pregnancy	N.A. Pregnant women up to 100% of FPL and those postpartum up to 12 months are eligible for another category of Medicaid. The State is aligning with the approved SPA, which allows for 12 months of postpartum coverage. If a woman is in her 12-month postpartum period, she will remain in the pregnancy category of assistance for the duration of that 12-month period. If an individual is covered under Pathways and becomes pregnant, she can report a change in circumstance, indicating that she is pregnant. Once a change in circumstance is reported, the individual will be run through the eligibility cascade and moved from the Pathways category of assistance into pregnancy Medicaid.

Prompts	State response
1.1.iv Acute medical condition	N.A. Individuals with acute medical conditions would likely be eligible for other categories of Medicaid or state programs. Pathways members may request good cause exceptions if they have a temporary impairment which prevents them from meeting the qualifying activities requirement. Reasonable modifications and reasonable accommodations are also available to individuals in the Pathways program. Refer to Questions 2.8-2.11 for additional details. The State provides a variety of categories of assistance today that cover individuals who could have an acute medical condition. The new Georgia Pathways category of assistance will be last in the Georgia Gateway eligibility rules cascade logic. This means that in order to be determined eligible for Pathways, an individual would have to be "denied" for all other categories of assistance available. Individuals who have an acute medical condition are not precluded from Georgia Pathways, but based upon their circumstance, it is possible that the cascade logic could deem them eligible for another category of assistance.
1.1.v Former foster care youth	N.A. The State is not making changes to its former foster care youth category of Medicaid, and therefore they are not part of the demonstration.
1.1.vi Beneficiaries in substance use disorder treatment	N.A. Substance use disorder (SUD) treatment is considered an allowable activity under the job readiness qualifying activity. Job readiness consists of activities directly related to preparation for employment, including life-skills training, GED class time, resume building, and habilitation or rehabilitation activities, including SUD treatment. Hours spent on job readiness activities count towards the 80 hour minimum monthly requirement. Refer to Question 1.2 for additional details on how qualifying hours are counted for SUD treatment. The State would include the following services as SUD treatment for a qualifying activity: • Addictive Disease Support Service • Peer Support (group) • Peer Support (individual) • Ambulatory Detox • Opioid Maintenance
1.1.vii Beneficiaries who are homeless	N.A.
1.1.viii Beneficiaries who were incarcerated within the last six months	N.A.

Prompts	State response
1.1.ix Beneficiaries receiving unemployment benefits	N.A. Individuals who apply for Pathways and Pathways members enrolled in the program may satisfy the qualifying hours and activities requirement through a variety of activities beyond employment. *Refer to Question 1.2 for additional details on the Pathways qualifying activities.*
1.1.x Enrollment in the state's Medicaid employer premium assistance program	N.A. Individuals enrolled in the Pathways Mandatory HIPP program must meet the qualifying hours and activities requirement but are exempt from monthly reporting so long as they remain in Mandatory HIPP. Reporting will be required if the HIPP member is not the employee that has ESI access (i.e., if the HIPP member has access to ESI through their spouse).
1.1.xi Caregiver of a dependent	N.A.
1.1.xii Beneficiaries exempt from TANF/SNAP requirements	N.A. If a member is enrolled in Pathways, and TANF and/or SNAP ABAWD, then the qualifying activities completed by the individual for the purposes of TANF or SNAP ABAWD compliance will also count towards the qualifying activities and hours for Pathways as long as the activity is a qualifying activity for Pathways. However, if a member is exempt from work requirements for SNAP/TANF, they will still be required to meet the qualifying activities for Pathways to maintain ongoing eligibility.
1.1.xiii Other (by specific exempt status)	N.A.
1.2 Provide additional details about qualifying activities and the number of required qualifying hours. 1.2.i Hour requirements	Pathways members are required to engage in a minimum of 80 hours of qualifying activities per month to maintain eligibility for Pathways. Members may satisfy their qualifying hours and activities requirement through participation in one or a combination of the following activities: (a) Subsidized or unsubsidized public or private sector employment, including self- employment and employment as an independent contractor; (b) On-the-job-training in the public or private sector; (c) Participation in job readiness activities directly related to the preparation for employment, including habilitation and rehabilitation activities, including SUD treatment, and GED programs; (d) Community service with public or non- profit organizations participating in projects that serve the community; (e) Vocational Educational Training limited to 12 months in a beneficiary's lifetime, unless a beneficiary is enrolled in vocational education for a highly sought- after trade through the Technical College System of Georgia High Demand Career Initiative (in this instance, vocational education training may count as a qualifying activity for the duration of the vocational education program); (f) Enrollment in an institution of higher education, (qualifying activity hours earned will vary based on course load); and (g) Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program, as long as the individual has been determined eligible for GVRA services For most of the qualifying activities above, members report the number of hours engaged each month to maintain eligibility. *Refer to Question 1.2.iv for additional details on reporting frequency and hours measurement.*

Prompts	State response
	If a Pathways member is engaged in any of the below qualifying activities, they are exempt from the monthly reporting requirement as long as they meet the criteria listed below: **Higher Education and Vocational Education:** Members enrolled in and earning course credit at a college, university, or other institution of higher learning and vocational education will be considered as meeting the qualifying activities and hours requirement for each month of a term of enrollment as follows: a) A member with a current course-load of at least 11.5 credit hours will be considered to have fully met the qualifying activities threshold and will be determined as meeting the 80 hours per month of a qualifying activities. b) A member with a current course-load between 5.5 and 11.49 credit hours will be granted 40 hours per month of a qualifying activity. They will be required to engage in other activities for at least 40 hours per month to maintain Pathways eligibility. c) A member with a current course-load between .1 and 5.49 credit hours will be granted 20 hours per month of a qualifying activity. They will be required to engage in other activities for at least 60 hours per month to maintain Pathways eligibility. **GVRA Vocational Rehabilitation Program:** Members who are enrolled in the GVRA Vocational Rehabilitation programs are considered to be meeting the qualifying hours requirement for each month they remain active clients of the GVRA program provided this can be validated by an interface or other means. *Refer to Question 3.12 for additional details.* There are vocational schools in Georgia that are not part of the Technical College System of Georgia (TCSG). TCSG includes 22 colleges, 88 campuses, and online learning with over 600 program options. TCSG and the high demand career initiative (HDCI) is specifically mentioned because it is a state-funded apprenticeship initiative that represents a historic investment by the State in registered apprenticeships. The State wants to incentivize individuals to enter into industries and career fields with high-demand, thus achieving higher wages, and upward mobility within their employer and industry. The same credit hour / qualifying hours allocation will apply to those enrolled in a program through TCSG.
1.2.ii Extra hours policy	The demonstration does not allow extra hours to count toward other periods.
1.2.iii Grace period	The demonstration does not have a grace period for qualifying hours and activities.

Prompts	State response
1.2.iv Reporting frequency and hours measurement	Members required to report qualifying hours and activities must report qualifying hours and activities for the previous month by the 17th of the reporting month in order to maintain coverage for the following month. Once a member reports qualifying hours and activities timely for six consecutive months of enrollment in Pathways, they will no longer be required to report monthly for the remainder of their current certification period in Pathways until their redetermination. Members will be required to report any changes in circumstance that may impact their Pathways eligibility. Members may report qualifying hours and activities using a mobile application (when mobile application becomes available), online through the Customer Portal, via paper/mail, in-person, and telephonically. Reporting will include an individual's self-attestation of activity hours, accompanied by supporting documentation for verification. All Pathways members are required to report qualifying hours and activities **except** in the following cases: a) If the applicant is determined eligible for Pathways and provides verification of completing a minimum of 80 hours total (not on average) of employment during the most recent six consecutive months prior to application for which verification is available, then the individual will be considered in compliance with the Pathways qualifying activities requirement and will be exempt from reporting monthly for the duration of their Pathways certification. b) All Pathways members enrolled in ESI are considered in compliance with the qualifying activities requirement and are n o t required to report monthly. However, reporting will be required if the HIPP member is not the employee that has ESI access (i.e., if the HIPP member has access to ESI through their spouse). c) Members enrolled full-time in higher education or vocational education programs are deemed in compliance with the qualifying activities requirement and are not required to report monthly. They will only be required to report enrollment for the most recent term in which they are enrolled for as long as the member is enrolled as a full-time student. Once the school term ends, the student will be required to submit verification for the new school term if enrolled full-time or will be required to submit monthly qualifying activities reporting. d) All members who are enrolled in the GVRA Vocational Rehabilitation are deemed in compliance with the qualifying activities requirement and are not required to report monthly provided this can be validated by an interface or other means. *Refer to Question 3.12 for additional details.* The State updated the reporting timelines based on feedback received regarding notice of adverse action. The cutoff date for reporting is now the 17th, which allows for 10 days' notice of adverse action. The State made provisions for retroactive coverage / retroactive reinstatement for instances when the information is postmarked by the 17th but arrives after the final reporting deadline. On the occasion the 17th falls on the weekend, and the member still needs to report, they can provide their reporting form and documentation to the State using the drop boxes which are located at every DFCS county office. In addition, the member is able to utilize other means to report, such as online through the Customer Portal or through the mobile application. The State projects the mobile application will be available July 1, 2023.
1.3 Provide additional details on how the state will: 1.3.i Define the circumstances that give rise to good cause	Members may submit a good cause exception request for continued coverage if they failed to meet the qualifying hours and activities threshold for their reporting month. Good cause exception requests are not allowable at application for Pathways. Members may request up to 120 hours total of good cause exception hours for each certification year. Per the STCs, the State considers the following circumstances as meriting good cause: a) A family emergency or live event: The individual or a member of their immediate family was a victim of/involved in domestic violence, divorce, legal proceeding, legal matter, or temporary incarceration during the reporting period; or the individual was confirmed to serve jury duty during the reporting period. b) The birth, adoption, foster placement, or death of an immediate family member: A member of the individual's immediate family was born, was adopted, or died during the reporting period. The individual received a placement of a foster child in the home, including those in kinship during the reporting period. c) A temporary illness/short-term injury: The individual experienced a temporary illness or short-term injury that resulted in an inability to work, attend school, or perform other regular daily activities for over three consecutive calendar days during the reporting period.

Prompts	State response
	d) A serious illness of hospitalization of the member, or an immediate family member: The individual or a member of the individual's immediate family was hospitalized or otherwise incapacitated during the reporting period due to illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility; or continuing treatment by a health care provider. e) A natural or human-caused disaster: The individual was a victim of a natural or human-caused disaster, such as a flood, storm, earthquake, serious fire, industrial accident, shooting, act of terrorism, incidents of mass violence, or other declared incident of mass trauma during the reporting period. f) Temporary homelessness: The individual was evicted from their home or became homeless during the reporting period. g) COVID-19: The individual is unable to fulfill the hours and activities requirements because the individual was quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, or exposure to COVID-19, or because of a closure of the place(s) related to COVID-19 where the individual was meeting the hours requirement. h) Other: Other good cause reason as defined and approved by the State. Members will request a good cause exception using the same channels as they do to report qualifying hours and activities (mobile application when available), online through the Customer Portal, via paper/mail, in-person, and telephonically. If a member reports hours or credit-hour equivalent that do not meet or exceed the 80-hour threshold in Customer Portal, they will be automatically prompted to make a good cause exception request for the remaining hours. Good cause exception requests will be granted automatically by the system and will not require worker approval if the member still has remaining good cause hours, selects a reason for the good cause from the pre-defined list, provides a brief description, and provides supporting verification. If the member chooses the "Other" option for requesting good cause, a task will be created in the Georgia Gateway IES for a worker in a new Specialized Unit created for Pathways to review and approve. Guidance for approval and denial of these good cause exception request types will be documented. Members will retain coverage until the Specialized Unit has completed review of the request of type "Other." Good cause exception requests will be subject to program audit. The "other" category will be based on case-by-case circumstances, depending on what a member submits. Some examples of "other" may be religious holidays observed by the individual, voting, or an employer driven reduction in work schedule. Acceptable documentation for each good cause exception request type is defined in section 3.8 in the CE module. If an individual is covered under Pathways and becomes pregnant, she can report a change in circumstance, indicating that she is pregnant. Once a change in circumstance is reported, the individual will be run through the eligibility cascade and moved from the Pathways category of assistance into pregnancy Medicaid A woman will remain in pregnancy Medicaid for her 12-month postpartum period Once that 12 months expires, she will be run through the eligibility cascade to determine eligibility of other categories of assistance, including Pathways, which remains at the bottom of the eligibility cascade. Individuals who are still employed and are utilizing benefits available to them under federal / state laws such as FMLA are still meeting a qualifying activity. The individual can report a change in circumstance and indicate that they have reasonable accommodation that limits the number of hours they can engage in a qualifying activity from an employer or supervisor.
1.3.ii Review additional circumstances that fall outside the defined list of circumstances	☐A) The state clearly defines the process for how the state will review additional good circumstances that fall outside the defined list The Specialized Unit has been created. If a member chooses the "other" category as the reason for the good cause request, a task will be created and routed to the specialized unit to review and approve or deny the request. The specialized unit will catalog the request and the action (approval / denial) to ensure there is consistency in these decisions. A unique circumstance is one in which the specialized unit does not feel they can decide. If the specialized unit does not feel they can make a decision, the request will be reviewed with the DCH Policy Director.

Prompts	State response
1.3.iii Determine how long individual good cause circumstances will apply	Good cause exceptions are applied in hourly increments, up to 120 hours. Good cause hours are only applied for the month in which it was requested. The individual must request a certain number of hours.
1.4 Provide additional details on how the state will define the following compliance actions: 1.4.i Opportunity to cure/grace periods	The state demonstration does not include opportunities to cure/grace periods.
1.4.ii Suspension	A member who fails to report qualifying hours and activities by the 17th of the reporting month or reports insufficient hours without submitting a good cause exception request will enter a 90-day suspension period. *Refer to Question 1.2i for additional details on the hours requirement, and Question 1.2.iv for additional details on the reporting frequency requirements.* The suspension period will begin the first day of the calendar month immediately following the month in which the qualifying activities report was required. While in suspension, the member's claims are not paid, capitation rates are not paid, and the member is not eligible for Medicaid coverage during the suspension period. Due to the new timelines, a person must request a good cause exception by the 17th of the reporting month to avoid the suspension period. The individual must report a total of 80 hours, which can include a combination of qualifying activities and good cause exception hours. Documentation must be postmarked by the 17th. The period between the final reporting deadline and the end of the month will be reported in the following month. For example, a member must report their qualifying hours and activities by September 17. The hours the member is reporting by September 17 are the qualifying hours and activities completed during the month of August. Any qualifying hours and activities completed during the month of September (including the time period from September 17 to the end of the month) will be due during the month of October. The State will provide at least 10 days advance notice of the suspension.
1.4.iii Termination	If a member fails to report their qualifying hours and activities by the 17th of the third month of their suspension period, the member will be terminated from Pathways beginning the following month and must reapply for coverage. Disenrollment from Medicaid will only occur after the State determined the member is ineligible for all other classes of assistance. If the member is terminated, they may reapply for coverage at any time. Documentation needs to be postmarked by the 17th. The period between the final reporting deadline and the end of the month will be reported in the following month. For example, a member must report their qualifying hours and activities by September 17. The hours the member is reporting by September 17 are the qualifying hours and activities completed during the month of August. Any qualifying hours and activities completed during the month of September (including the time period from September 17 to the end of the month) will be due during the month of October. The State will provide at least 10 days advance notice of the suspension.

Prompts	State response
1.4.iv Non-eligibility period	The State does not apply non-eligibility periods to members who do not comply with qualifying hours and activities requirements.
1.4.v Other compliance actions	The State demonstration does not include any other compliance actions. There may be future implications on the status of a member's MRA while a member is in suspension. The State will provide additional details in an updated implementation plan when available. The State anticipates a Phase 3 implementation date of July 1, 2024. We understand this requires an approved Implementation Plan and will work with CMS to identify a date for submission when more information about the development and design of these elements are available.

Prompts	State response
CE.Mod_2. Establish beneficiary supports and modifications	
Intent: To describe how states will provide supports to beneficiaries to ensure that they are able to meet qualifying hours and activities requirements	
Specific supports	
2.1 Describe planned transportation supports and how the state will connect beneficiaries with those supports.	Highlighted below are some available options to support Pathways members with transportation supports. CMOs are expected to help their Pathways members understand and stay compliant with the requirements of the Pathways program. CMOs may assist their members in finding qualifying activity options that do not require transport (e.g., online training, online education) or offer transportation supports as a value-added benefit. Pathways members will most likely be eligible for, and many already receiving, Supplemental Nutrition Assistance Program (SNAP) benefits. All SNAP recipients may voluntarily participate in SNAP Employment & Training (E&T), which offers transportation support for work -related activities. Eligibility Specialists who serve Pathways applicants and members will also be trained in SNAP and will provide information on SNAP for Pathways applicants and members who are not currently enrolled. In addition, various counties across Georgia offer local transportation resources to residents. Pathways members will be made aware of and referred to these resources as applicable when they contact their local Medicaid office. The State is not planning on providing any additional resources for transportation beyond those described.
2.2 Describe planned child care supports and how the state will connect beneficiaries to those supports.	The State will continue to provide information for child care support for Pathways applicants and members as it does today for other Medicaid applicants and members. This includes but is not limited to referrals and information on local county resources, as well as how to apply for child care support provided through the Georgia's Department of Early Care and Learning (DECAL). The child care support application is included within the State's Georgia Gateway IES. Individuals applying for Medical Assistance or any benefit program through Gateway will see the option to apply for child care supports with DECAL. As part of the Medical Assistance application, individuals applying may respond to the childcare screener and receive a determination to see if they are eligible for certain child care supports. Individuals may also apply for certain child care supports with DECAL using a paper application or by telephone. **Georgia Department of Early Care and Learning (DECAL):** DECAL is responsible for meeting the child care and early education needs of Georgia's children and their families. DECAL administers the Childcare and Parent Services (CAPS) program, the Supporting Onsite Learning for Virtual Education Program (SOLVE) program, as well as other programs which assists no to low income families with the cost of child care. **Childcare and Parent Services (CAPS):** CAPS is Georgia's subsidized child care program. CAPS assists low-income families with the cost of child care in order to support Georgia's school readiness goals. CAPS is available in all 159 counties within Georgia. CAPS provides scholarships to families who need financial assistance with paying for the cost of child care. Individuals can apply for the CAPS Program through the Georgia Gateway portal when applying for Medical Assistance or other benefits, or by telephone or paper application. To be eligible to benefit from the CAPS Program, a family must meet the following criteria and provide verifying documentation: a) Be a resident of Georgia b) Be able to verify its identity c) Meet income requirements d) Be involved in a CAPS-approved activity Georgia recognizes two types of licensed child care settings, and CAPS offers scholarships to both types: Child Care Learning Centers and Family Child Care Learning

Prompts	State response
	Homes. Families are free to select the type of child care setting that is best for their children. **Supporting Onsite Learning for Virtual Education Program (SOLVE):** SOLVE provides scholarships for families with students enrolled in a Georgia public school system offering only a virtual learning model. Scholarships support working families with children ages 5-12 (kindergarten and up), and up to age 22 for children with disabilities, by paying for care, supervision, and support during the school day while students are engaged in virtual learning. Individuals can apply for the SOLVE program through the Georgia Gateway portal when applying for Medical Assistance or other benefits. To be eligible to benefit from the SOLVE Program, a family must meet the following criteria: a) The family's income may not exceed 85% of the state median income (SMI) b) The child must be enrolled in a Georgia public school, state charter commission school, or locally approved charter school that is primarily offering virtual learning (50% or more of classroom instruction is virtual for any grade level kindergarten- 7th) c) The child must be 5-12 years of age and enrolled in a kindergarten or higher classroom, or up to age 22 if the child has a disability d) The parents must be attending work, school, or a combination of the two SOLVE will provide financial assistance to qualifying families in the form of a "SOLVE Scholarship." SOLVE Scholarships can be used at licensed child care learning centers, family child care learning homes, and providers with an approved day camp exemption. **Other Child Services Administered by DECAL:** DECAL administers other early childhood care and education programs which are available to no to low income families, such as Georgia's Pre-K Program, child nutrition, Quality Rated (Georgia's tiered quality rating and improvement system), child care licensing, and the Head Start State Collaboration.
2.3 Describe planned language support services for non–English- speaking beneficiaries and how the state will connect beneficiaries with those supports.	The State will continue to provide the language support services for non-English speaking Pathways applicants and members as it does for other Medicaid applicants and members. The State, through a third-party vendor, operates a language line, which provides telephonic and in- person interpretation services for members requiring language assistance. Members can access interpreter services by making a request to a case worker, who will arrange for a live interpreter to come to an appointment or for services to be provided telephonically. Interpretation services are available in more than 300 languages. Additionally, the State, through a third-party vendor, provides translation services for all written materials upon request. Members may request translation services through a case worker by providing the document to be translated and the requested language. The document will be returned to the member in the requested language, Translation services are available in 15 different languages, including the most prevalent language spoken in the State. A Notice can be translated in a few business days. If a member receives their "Qualifying Activities Incomplete Notice," there would be time for the member to request a translated notice. In addition, the State operates a Language Line which is available for language assistance. The customer portal is available in Spanish. Additionally, the customer portal landing page includes 14 additional languages, which directs the member to a paper application that is translated into the selected language. If the member seeks support through one of the mentioned 14 languages or needs support in a different language, they can call into the Call Center and can get assistance completing an Application Telephonically. The agent can use the Language Line to complete the application/renewal on the behalf of the customer. Once the agent has completed with the member then submission looks just like a Customer Portal application. The State will provide oral interpretation services at the time of application to individuals with limited English proficiency. There are qualifying hours and activity opportunities available to those with LEP.

Prompts	State response
2.4 Describe if the state will provide or connect beneficiaries to any other supports, including assistance from other agencies and entities complementing Medicaid efforts.	The State will continue to provide information and referrals for Pathways applicants and members for support services as it does for other Medicaid applicants and members. Available community resources vary from county to county. Eligibility specialists in each county often provide information on Section 8 housing or prescription assistance programs that may be available to members. Additionally, specialists across local counties maintain local resource lists with available partnerships and programs within their communities. Resource lists may contain information on food banks, clothing pantries, resources for veterans, utility assistance, and low or no cost health or dental clinics. Upon a member's request, eligibility specialists provide referrals to community organizations available in the area.
Ensure that qualifying activities are available and accessible	
2.5 Describe the state's strategy for ensuring training opportunities, including job search training, on- the-job training, and job skills training, are available and accessible to beneficiaries. Describe the training opportunities available, requirements that must be met in order for beneficiaries to qualify for the opportunities, and how beneficiaries will be able to access them.	Training opportunities will be available for Pathways applicants and members through multiple channels. Pathways members will likely be eligible for, and many enrolled in, SNAP. All SNAP recipients may voluntarily participate in SNAP E&T. The SNAP E&T Program manages and sponsors many qualifying activities, including training opportunities and provides related support to ensuring those activities are available and accessible to members. Pathway members may also be aided in finding training opportunities by their CMOs. CMOs will help their members remain in compliance with the qualifying hours and activities threshold by providing information, program instruction (such as how to report hours and activities), and on- going support – acting effectively as a case manager and advocate for the participant to succeed in the program and maintain their Pathways eligibility. The State is actively working with CMOs to help them provide support to their members related to qualifying activities. Pathways members also will be able to pursue training and job opportunities via Job Centers operated by local Workforce Investment Boards. The State will maintain a list of resources and partners such as the Department of Community Affairs, Goodwill Industries, and the United Way, that are available to potential Pathways eligible individuals and Pathways members on the dedicated Pathways webpage and from workers across counties Requirements may be dependent on the individual training opportunity. Individual training programs might have requirements. However, there is no requirement that individuals must meet to access the library of training opportunities or list of resources and partners. The State is requiring each CMO to develop and implement an engagement plan for its Pathways members, which will include helping members identify training opportunities. In addition, the State's evaluation vendor will be conducting a member survey and focus groups as part of their evaluation and will include questions related to accessibility to training opportunities.

Prompts	State response
2.6 Describe public programs that the state Medicaid agency will partner with to leverage existing employment and training supports. Describe how the arrangements will work and indicate if these supports will be available to all demonstration beneficiaries subject to qualifying hours and activities requirements or if other qualifying restrictions will apply. Describe how the state will fund such employment and training supports.	The Department of Community Health (DCH) will partner with several agencies to provide information and referrals for Pathways applicants and members on available employment and training support across the State. DCH collaborates on an ongoing basis with The Division of Family and Child Services (DFCS), within DHS, which administers eligibility for Medicaid as well as the SNAP program. Pathways members will likely be eligible for, and many enrolled in, SNAP. All SNAP recipients may voluntarily participate in E&T. The State will partner with the SNAP E&T program and leverage the existing work activity opportunities and supports already available to SNAP E&T participants to make them available to SNAP E&T participants who are also Pathways members. In addition, Able-Bodied Adults Without Dependents (ABAWDS) receiving SNAP are also required to engage in work or education a minimum of 80 hours per month. Eligibility Specialists who serve Pathways applicants and members will also be trained in SNAP and will provide information on SNAP for Pathways applicants and members who are not currently enrolled. In addition, the DCH will coordinate with the Department of Labor and Department of Economic Development to provide referral information for Pathways applicants and members on job search and training opportunities for Pathways participants within their communities. The State will maintain a list of resources and partners such as the Department of Community Affairs, Goodwill Industries, and the United Way, that are available to potential Pathways eligible individuals and Pathways members on the dedicated Pathways webpage and from workers across counties. The State is not aware of any specific program restrictions that would limit enrollment.
2.7 Describe how the state will modify qualifying hours and activities requirements in areas with few qualifying activities opportunities and how often these adjustments will be reviewed.	The State is not modifying the qualifying hours and activities requirement based upon a member's physical location. There are a variety of activities which satisfy the qualifying hours and activities requirement, which may be performed in person or virtually, and is not dependent on local employment opportunities. Refer to Question 1.2 for additional details on the Pathways qualifying activities. The State will make referrals to select transportation supports which are available to individuals to allow for in-person participation in qualifying activities. *Refer to Question 2.1 for additional details on transportation supports available for Pathways members.* Per the STCs, the State will assess areas that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with a lack of public transportation to determine whether there should be further good cause exceptions from the qualifying hours and activities requirement and/or additional mitigation strategies, so that the qualifying hours and activities requirement will not be unreasonably burdensome for applicants and beneficiaries to meet. *Refer to Question 6.8 for additional details on monitoring.* The State will assess the current unemployment rate, assess areas with limited economic and / or educational opportunities and transportation on an annual basis.
Reasonable modifications for individuals with disabilities (in compliance with all applicable federal laws, including the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act, and the Age Discrimination Act)	
2.8 Describe the planned modifications to qualifying hours and activities requirements available to beneficiaries with disabilities.	All the reasonable modifications available today to Medicaid applicants and members with disabilities will also be available for Pathways applicants and members. For the qualifying hours and activities requirements, the following reasonable modifications are available for **Pathways applicants** with disabilities: • The State will pend a Pathways application up to an additional 90 days to allow the customer who indicates they have a disability to provide verification of engagement in a qualifying activity prior to making a determination of eligibility • The State will pend a Pathways application for additional time upon referral of an individual to GVRA and provide a referral to the GVRA Vocational Rehabilitation Program if the individual with a disability indicates they need support to get engaged with qualifying activities or find employment. For the qualifying hours and activities requirements, the following reasonable modification is available for **Pathways members** who incur a disability after enrollment in Pathways:

Prompts	State response
	• Allowing a member to maintain Pathways coverage if they can no longer work/engage in a qualifying activity due to a disability while they are referred to GVRA for support. The only circumstance in which the State needs to be informed about a reasonable accommodation made between the employer/institution and the Pathways member is if the member has reduced work/engagement hours and will be unable to meet the minimum of 80 hours/month required for Pathways eligibility. • In this circumstance, State **will modify the minimum number of qualifying hours** in order to maintain Pathways eligibility below 80 hours per month if the individual has an agreement from their employer or organization that indicates that due to the Pathway member's disability they are unable to work/engage beyond a maximum threshold which is less than 80 hours per month (this is termed a reasonable accommodation provided by the employer/organization). For the qualifying hours and activities requirements, the **following qualifying activity is for Pathways members with disabilities**: • Enrollment and active participation in GVRA is deemed as a qualifying activity, regardless of how many hours the Pathways member is engaged with the Vocational Rehabilitation Program on a monthly basis. The State will pend an application for those who have a disability and request the modification. If an individual has a disability and is meeting the 80 qualifying hours and activities requirement at application, they will undergo an eligibility determination. Their application will not be pended.
2.9 Describe the state's process for assessing and providing modifications to qualifying hours and activities requirements available to beneficiaries with disabilities.	The State is establishing a Specialized Unit of Eligibility Specialists who are trained in ABD Medicaid, Family Medicaid, and Pathways which will review and process applications, changes, and renewals for Pathways applicants and members requiring a reasonable modification to the qualifying hours and activities requirement due to a disability. The eligibility system is being updated for Release 1 to collect additional information from applicants and members and task routing to the Specialized Unit. **Pathways Applicants:** Medical Assistance applicants who are identified by the eligibility system as potentially eligible for Pathways (i.e., reported income is less than 100% FPL and they have affirmed they want to be assessed for Pathways) and have reported that they have a disability on the application will be prompted to answer a question regarding their need for assistance in completing the qualifying hours and activities. Responding yes to this question routes the application to an Eligibility Specialist in the Specialized Unit. After being assessed for all other categories of Medicaid and determined potentially eligible for Pathways, the Specialized Unit will conduct outreach to the applicant to conduct an interview to discuss their options for meeting the qualifying activities requirement. The individual will be provided options such as receiving an additional 90 days to get engaged on their own in an activity and provide verification to the State, or receiving a referral to the GVRA Vocational Rehabilitation program. The Specialized Unit will provide these options without needing to verify the disability or provide additional information or verification documentation. Once the individual is either enrolled and actively engaged with GVRA, or reporting qualifying hours and verification of meeting the 80 hours minimum, the Specialized Unit will approve their Pathways eligibility. An individual is able to request a reasonable accommodation in person. **Pathways Members**: Pathways members will be able to request a reasonable modification for Pathways through reported changes by phone, paper, or online through the Customer Portal. • Members are able to report having an established agreement (reasonable accommodation) with their employer or organization which reduces their hours below the 80 hours required to maintain Pathways eligibility. This change will be routed to the Specialized Unit to review and process the reduction in hours request. Once the member provides verification of the agreement, the Specialized Unit will adjust their required hours ongoing in the IES to maintain eligibility for Pathways. The member does not need to provide verification of the disability nor does the Specialized Unit make a determination of the number of hours the individual is able to engage. • It is a signed agreement between the member and their employer that documents a reduction in hours. This document must specify the rationale for a reduction in hours and indicate why a reduction in hours is necessary for the individual to participate in the qualifying activity. The request must also indicate the start date and end date for the arrangement. There is no template, as each member's circumstances will be different. • Eligibility specialists will be available to answer questions on what type of document might be sufficient and what information is needed. Individuals can contact eligibility specialists through the call center or in-person at their local DFCS office.

Prompts	State response
	• Members are able to report that they are no longer able to engage in a qualifying activity due to a disability and need assistance. This change task is routed by the IES to the Specialized Unit for review and to provide the individual with a referral to GVRA for assistance. In addition, the Specialized Unit will approve good cause exception requests marked as "Other" category by Pathways members and conducting audits on other good cause exceptions. If it is discovered that someone requested good cause hours for a reason that would actually warrant a long-term reasonable modification for Pathways, the Specialized Unit will conduct outreach to the member to provide them with options.

Prompts	State response
2.10 Describe how the state will connect beneficiaries with disabilities to needed supports and services.	Pathways applicants and members will be afforded the same access to reasonable modifications that are available for all categories of Medicaid. Applicants and members are able to request a reasonable modification during application, changes, and renewals. These requests may be made online via the Customer Portal, by mail, by phone, or in person at a local office (when possible). All staff are trained in how to provide the following reasonable modifications: • Sign language interpreter • Cued speech interpreter • Oral interpreter • Tactile interpreter • Email • Face to face interview • Electronic communication • Teletypewriter (TTY) • Braille • Large print • Video Relay • Telephonic signature • Telephonic apps/renewals • Telephone call reminder of deadlines "Other"
2.11 Describe any additional steps the state will take to ensure compliance with all applicable federal laws related to people with disabilities.	The State has ADA coordinators responsible for ensuring compliance with applicable federal laws for Medicaid applications, changes, and renewals for individuals with disabilities. In addition, the State conducts annual staff training of compliance rules and regulations. The State also recently updated the online Customer Portal screens to enhance ADA accessibility, which was implemented in November 2020. Among these enhancements, an applicant may request one or more of the 13 example reasonable modification and communication assistance types. When individuals apply for benefits, there is a question that asks if the individual has a disability that will require a reasonable modification or communication assistance. The question is also asked for the Authorized Representative. The question includes the listed options to the right. It also asks if the reasonable modification / communication assistance is a one time or ongoing request. The reasonable modification / communication assistance will be confirmed and provided to the individual and/or Authorized Representative when requested. If a person is not able to apply on the Customer Portal, the question for reasonable modification / communication assistance is provided on the paper application which is either downloadable on the website or can be requested at a local DFCS office. A reasonable modification request / communication assistance request can also be made on the DFCS Nondiscrimination and Disability webpage where the individual can either make the request using an online form or using a downloadable form which can be emailed to DHS/DFCS. There is also a tagline on the Customer Portal landing page which will notify anyone with a disability for requesting communication assistance. The tagline states: "If you have trouble while using Georgia Gateway, please call the Online Services hotline at 1-877-423-4746. If you have a hearing impairment, call GA Relay at 1-800-255-0135. The services are free." A tagline is also located on top of the paper application form: "If you need help reading this information or communicating with us, ask us or call 1-877-423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay)."

Prompts	State response

Prompts	State response
CE.Mod_3. Establish procedures for enrollment, verification, and reporting	
Intent: To describe modifications to enrollment processes as well as verification and reporting of activities and exemptions	
Modifications to application, enrollment, and renewal procedures	
3.1 Describe any planned changes to the state's application(s) and application/enrollment processes to identify beneficiaries subject to or exempt from qualifying hours and activities requirements.	The State's online, paper, and telephonic applications will be updated to include questions to determine Pathways eligibility. Pathways creates a new category of Medicaid for individuals that meet the eligibility criteria. As such, there are no exempt populations included in the demonstration design. New information will be collected from the State's Medicaid application in order to determine Pathways eligibility. Individuals will be provided the opportunity to sign a Pathways contract indicating their awareness of the terms of coverage, agreeing to comply with the premium payment (if applicable) and the qualifying activities reporting requirement, that they may be subject to random and periodic audits, and awareness their employer may be contacted to gather additional information on their ESI plan (if applicable). Individuals will be provided the opportunity to submit their participation and hours spent engaged in a qualifying activity or activities in order to make an eligibility determination. Individuals will also be provided the opportunity to upload or send specific documentation for verification of participation in each of their reported qualifying activities. Finally, the individual will be provided the opportunity to answer one question about use of tobacco or tobacco products. The Pathways contract is a contract between the applicant and the State wherein the applicant agrees to indicating their awareness of the terms of coverage, agrees to comply with the premium payment (if applicable) and qualifying activities reporting requirements, that they may be subject to random and periodic audits, and awareness that their or their spouse's employer may be contacted to gather additional information on their ESI plan (if applicable). If an individual does not fulfill the terms of the contract, and thus the elements of the program, then the member will be suspended and could be terminated. If a member is terminated from Pathways, they must reapply for Medical Assistance. If the individual reapplies for Medical Assistance, they must sign the Pathways contract as part of the application process. If an individual does not submit the required documentation for verification at application, they will be issued a Verification Checklist (VCL). The individual will have 14 days to respond to the VCL and provide the outstanding documents and / or information needed to complete the application. The State will update its online application in order to collect the above information using dynamic logic. The State will also update its paper application for Medical Assistance to collect the same information. A new attachment, Attachment D, will be added as an addendum to the paper application to capture information needed for Pathways eligibility. The existing attachment that collects information on access to health coverage, Attachment A, will be updated to capture information needed for access to employer sponsored insurance necessary for the Mandatory HIPP program. The State plans for the updated application to be available online and in paper by the Pathways implementation date of July 1, 2023 Staff will also be trained to receive applications telephonically and in-person by this date. The period between the final reporting deadline and the end of the month will be reported in the following month. For example, a member must report their qualifying hours and activities by September 17. The hours the member is reporting by September 17 are the qualifying hours and activities completed during the month of August. Any qualifying hours and activities completed during the month of September (including the time period from September 17 to the end of the month) will be due during the month of October.
3.2 Describe any planned changes to the state's renewal processes for the qualifying hours and activities demonstration population. For example, will the state update any pre-populated renewal forms to capture information on qualifying hours and activities requirements compliance or exemptions?	At renewal, a member must report their hours and activities and provide documentation for verification to maintain ongoing Pathways eligibility. The State will pre-populate the online renewal submission with the qualifying hours and activities that the member last reported for the member to update and provide verification. If a member requests a paper renewal packet the State will include a renewal attachment to capture qualifying hours and activities data needed for the renewal. Qualifying hours are not verified monthly, but members must report their qualifying hours monthly and upload documentation. There are some electronic sources, such as the interface with TCSG or GVRA, that can be leveraged in place of a member's monthly reporting. These electronic sources will report monthly on behalf of the member as to their continued engagement in the qualifying activity. Additional electronic sources will be added in future releases. The State will implement changes to renewal processes by go-live of July 1, 2023.
3.3 Describe any other planned modifications to the state's	The State intends to use its existing Family Medicaid and ABD eligibility staff to process Pathways Medical Assistance applications. The State's existing Family Medicaid and ABD eligibility staff will be trained on the Pathways program, including the qualifying hours and activities.

Prompts	State response
eligibility determination and enrollment processes and operations as a result of implementation of qualifying hours and activities requirements. For example, will applications for beneficiaries who may be subject to qualifying hours and activities requirements be funneled to a specific unit for processing? Describe any impact that this may have on processing time for applications.	Applications for individuals who are potentially eligible for Pathways who indicate they have a disability will be routed to a new Specialized Unit. This Specialized Unit will consist of staff trained in both Family Medicaid and ABD Medicaid. The State will increase eligibility staff in order to handle additional volume across the Family Medicaid and Specialized Unit and in order for applications to be processed timely. There will be approximately 70 staff added. Hiring is underway and is anticipated to be complete by the end of May 2023.
Procedures for beneficiaries to report qualifying hours and activities	
3.4 Describe how beneficiaries will report compliance with qualifying hours and activities requirements. Describe the modalities to report hours and their availability. Describe the deadlines for reporting compliance, and any limitation to reporting that might affect beneficiary compliance. For example, are beneficiaries only able to report by phone during regular business hours?	Members who are subject to the monthly reporting requirement can report qualifying hours and activities using a mobile application (once mobile application becomes available), online through the Customer Portal, paper/mail, in-person, and telephonically. The online Customer Portal will be available for members to report compliance 24/7. Online reporting may be limited for members with restricted computer or internet access, which can affect their ability to report hours and to scan or attach supporting documentation for verification. The State will have paper forms available for members to report and submit documentation for their qualifying hours and activities in-person and by mail. In addition, members will be able to report qualifying hours and activities telephonically. When subject to the qualifying hours and activities reporting requirement, members must report qualifying hours and activities from the previous month by the 17th of the reporting month in order to maintain coverage for the following month. Once a member reports qualifying hours and activities timely for six consecutive months of enrollment in Pathways, they will no longer be required to report monthly for the remainder of their current enrollment in Pathways except at annual renewal. Members will have an affirmative responsibility to inform the State of any changes in circumstance. The State does not intend to review and verify a member's monthly reporting. Rather, the system will ensure that the member's total hours sum to at least 80 and that for each individual qualifying activity reported, there is documentation uploaded. Once an individual meets the six consecutive months of timely reporting, the individual must only report and provide documentation for verification at annual redetermination. The individual does not need to report for six months each certification period. An individual will be able to report hours and activities telephonically from 8:00am to 5:00pm. The period between the final reporting deadline and the end of the month will be reported in the following month. For example, a member must report their qualifying hours and activities by September 17. The hours the member is reporting by September 17 are the qualifying hours and activities completed during the month of August. Any qualifying hours and activities completed during the month of September (including the time period from September 17 to the end of the month) will be due during the month of October.
3.5 If the state has a waiver that allows the state to limit reporting modalities to only allow online reporting, describe any reporting modifications available to beneficiaries without Internet access.	The State does not have a waiver allowing only online reporting.
Procedures for entities to report qualifying hours and activities	
3.6 Describe if the state plans to	The State is not planning to allow entities to report activities.

Prompts	State response
develop capacities so that employers, volunteer supervisors, schools, and other representatives can report qualifying hours and activities on behalf of beneficiaries. Describe the procedures for entities to report qualifying hours and activities.	
Procedures for beneficiaries to report or file for an exemption	
3.7 Describe the procedures for beneficiaries to report standard exemptions as defined in section 1.1 (e.g., pregnancy, full time student status, homelessness). Describe how and to whom beneficiaries can report exemptions, how often they need to demonstrate continued eligibility for an exemption, and what documentation is required, if any. Note what reporting modalities are required, and whether specific exemptions must be reported differently.	N.A. Pathways creates a new category of Medicaid for individuals that meet the eligibility criteria. Qualifying hours and activities are a requirement for eligibility. As such, there are no exempt populations included in the demonstration design. *Refer to Question 1.1 for additional details.*
3.8 Describe the procedures for beneficiaries to file for good cause as defined in section 1.3 and what documentation is required, if any.	Members may submit a good cause exception request to the State when reporting their qualifying hours and activities. The request may be filed through the same channels used to report qualifying hours and activities: mobile application (once mobile application becomes available), online through the Customer Portal, via paper/mail, in-person, and telephonically. In order to make a request for good cause, a member must select a reason for the good cause exception, provide a written explanation of the circumstance, indicate the number of hours being requested for good cause, and submit documentation to support the request. If by the 3rd of the month a member does not report their hours or reports insufficient hours (any amount less than 80), and does not submit a good cause exception request by this date, then they will be sent a notice on the 8th of the month with instructions on the good cause exception request process. A member must submit any good cause exception requests by the 17th of the month for the following month of coverage. Members may make a good cause exception request for the following one month of coverage if they fail to meet the threshold of 80 hours in the prior month, provided they have good cause hours remaining out of the 120 hours allowable per certification year. Any remaining good cause hours at the end of a member's certification year do not roll over into the next certification year. Acceptable documentation for each good cause exception request type is defined as follows: a) Family emergency or life event a. Client Statement with Collateral Contact b. Clinician's Note c. Court Papers/Legal Papers d. Police Report/Domestic disturbance report e. Jury Duty Selection Notice b) Birth, adoption, foster placement, or death of an immediate family member a. Birth certificate b. Birth announcement c. Adoption papers

Prompts	State response
	d. Obituary e. Death certificate f. Caregiver Placement Passport (for foster placement) c) Temporary illness/short term injury a. Clinician's Note b. Employer/Supervisor Statement d) Serious illness or hospitalization of member or immediate family member a. Clinician's Note b. Employer/Supervisor Statement e) Natural or human-caused disaster a. Client Statement with Collateral Contact b. State-issued executive order c. Federally declared disaster f) Temporary homelessness a. Client Statement b. Landlord letter c. Lease document g) COVID-19 a. Client Statement with Collateral Contact b. Clinician's Note c. Employer/Supervisor Statement h) Other a. Client Statement with Collateral Contact The state does not make a distinction as to the type or duration of homelessness. Good cause is limited to 120 hours per certification year. An attestation is sufficient for homelessness, as noted by "client statement." Documentation of a state or federally declared disaster will not be required if the declaration applies to the entire state. If there is a disaster that does not apply to the entire state (e.g. a fire that only impacts a limited number of counties), an individual will need to request good cause hours, write a brief statements, and upload a document. When an individual requests one of the pre-defined good cause reasons, an eligibility worker will not verify the request. Rather, the individual must select the reason for good cause, write a brief statement, and upload a document. The good cause will be automatically granted. All good cause requests are subject to audit.
State verification of qualifying activities and exemptions	
3.9 Describe how the state will verify beneficiaries' compliance with qualifying hours and activities requirements. For example, note whether the state will accept self-attestation of beneficiary-reported hours or verify hours through use of data from other sources. Specify how periodic audits will be conducted, if applicable.	To remain eligible for Medicaid coverage through Pathways, a member must report and provide documentation for verification of their qualifying hours and activities monthly while subject to the monthly reporting requirement. Members will report the number of activity hours for each qualifying activity type and submit documentation for verification for each qualifying activity type. The documentation needed for verification will be communicated to the applicant at application via help text, which is available on the online Customer Portal. There is also language on the paper application that includes all of the qualifying activities and the associated documents. In addition, communications materials such as FAQs and the Pathways website will include this information. Per the STCs, to the maximum extent practicable, the State will utilize system interfaces with other entities to verify compliance with the qualifying hours and activities requirements. *Refer to Question 3.12 for additional details on the data sources that will be used to identify and verify compliance.*

Prompts	State response
	The State will consider that a member has fulfilled the qualifying activities requirement as long as the member has reported timely adequate activity hours and/or good cause hours in accordance with the member's hours threshold and remaining good cause hours and submitted adequate documentation for verification of each qualify activity reported and/or good cause. The State will continue to follow the established policies and processes for audits of Family Medicaid classes of assistance including Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) audits. Random and periodic program audits will be established for Pathways to verify compliance with the qualifying hours and activities. All Pathways members will be subject to program audits, and the State will use defined criteria and sampling methodology to identify members at higher risk of non- compliance. High-risk case types include those with qualifying hours and activities from self-employment, from volunteering, or those who used all 120 good cause hours during their certification period. Randomly sampled audits will occur monthly. Program audits for the Pathways program will begin in Release 2 of implementation in January 2024. From Release 1 beginning July 1, 2023, random audits will be conducted for high- risk case types and the Pathways population will be incorporated into existing audit samples for Family Medicaid classes of assistance The period between the final reporting deadline and the end of the month will be reported in the following month. For example, a member must report their qualifying hours and activities by September 17. The hours the member is reporting by September 17 are the qualifying hours and activities completed during the month of August. Any qualifying hours and activities completed during the month of September (including the time period from September 17 to the end of the month) will be due during the month of October.
3.10 Describe how the state will verify exemptions as defined in section 1.1, if applicable.	N.A. Pathways creates a new category of Medicaid for individuals that meet the eligibility criteria. Qualifying hours and activities are a requirement for eligibility. As such, there are no exempt populations included in the demonstration design. *Refer to Question 1.1 for additional details.*
3.11 Describe whether and how the state will use data from SNAP and TANF. Describe the process for identifying beneficiaries enrolled in SNAP/TANF and exempt from or meeting qualifying hours and activities requirements for those programs. Describe how the state will ensure that those beneficiaries are also counted as meeting or exempt from Medicaid qualifying hours and activities requirements, as applicable.	If a member is enrolled in Pathways, and TANF and/or SNAP, then the work activities completed by the individual for the purposes of TANF or SNAP ABAWD compliance will also count towards the qualifying hours and activities for Pathways, if the activities are allowable for Pathways and the member has met or exceeded the Pathways hours requirement as verified by the SNAP or ABAWD verification documents. The State does not currently utilize electronic reporting of hours for SNAP ABAWD compliance. A case worker indicates after verification whether an individual met or did not meet the monthly requirement. A new Specialized Unit will be established within the State with cross-trained ABAWD and Pathways Medicaid staff to promote consistency of activity review and workers will be trained that every time reports are completed on a SNAP ABAWD to report and validate whether the hours are allowable and sufficient for Pathways. However, if a member is enrolled in Pathways and exempt from meeting the community engagement requirements for SNAP/TANF, they will still be required to meet the qualifying activities requirement for Pathways. Likewise, Pathways reporting exceptions do not apply to the SNAP/TANF population completing work requirements. Electronic verification with SNAP/TANF is not yet established. This functionality will be included in a later release.

Prompts	State response	
3.12 Describe whether and how the state will use additional data sources or leverage other entities to verify compliance with or identify potential exemptions from qualifying hours and activities requirements (e.g., state wage data, unemployment, managed care organizations [MCO]).	The State will utilize system interfaces with other entities to verify compliance with the qualifying hours and activities requirements. The State is planning to create interfaces with GVRA to receive automated reports from the agency. The State is also planning for automated verification of a member's qualifying activity monthly reporting through interfaces such as Work Number, and Technical College System of Georgia (TCSG). **GVRA:** The State's interface with GVRA will confirm enrollment and monthly compliance with the program. Members enrolled in GVRA do not need to report their qualifying hours and activities monthly as long as they are validated as enrolled and compliant with GVRA. **TCSG:** The State's interface with TCSG will confirm the member's enrollment, term start date, term end date, total number of credit hours enrolled, and whether the program is a HOPE/High Demand Career Initiative Program. Members enrolled in a TCSG program will not have to report monthly qualifying hours and activities as long as they are enrolled full time in a TCSG program. **Work Number:** The State's interface with Work Number will serve to verify hours where possible. Members engaged in employment still need to report their qualifying hours monthly unless six months of consecutive employment are verified at application in which case the member will have a reporting exception. There are no exempt populations included in the demonstration design. Automated verification of a member's qualifying activities through GVRA and TCSG will be implemented by July 1, 2023. The Work Number interface is already available. If the interface confirms 80 hours of qualifying hours and activities, the member does not need to self-report any hours. A change notice will be sent to the member to let them know there is a change in their reporting requirement. Qualifying hours are not verified monthly, but members must report their qualifying hours monthly and upload documentation. There are some electronic sources, such as the interface with TCSG or GVRA, that can be leveraged in place of a member's monthly reporting. These electronic sources will report monthly on behalf of the member as to their continued engagement in the qualifying activity. Additional electronic sources will be added in future releases. The member must report their monthly hours and upload documentation, but the State is not planning to verify every member's monthly submission.	**CMS Comment:** Under the special terms and conditions (STCs) of the demonstration, the state is required to comply with verification requirements at 42 CFR 435.952(c). These regulations provide that an individual must not be required to provide additional information or documentation unless the information cannot be obtained electronically, or the information obtained electronically is not reasonably compatible. CMS expects that the state will not deny, suspend, or terminate initial and ongoing eligibility of applicants and beneficiaries for failure to provide documentation on meeting the qualifying hours and activities requirement where electronic data sources that can be used to verify an individual's attested information are available. CMS has discussed with the state the option to use Quarterly Wage Data (QWD) as an additional electronic data source for verifying qualifying work hours beyond the interfaces listed in this section of the Implementation Plan, in alignment with the requirements of 42 CFR 435.952(c). For the state to leverage QWD to electronically verify hours worked, this would require a change to the state's Medicaid application and post-enrollment monthly reporting form to enable individuals to provide their hourly wage in addition to hours worked. To demonstrate compliance with 42 CFR 435.952(c), the state would need to accept self-attestation of hours worked for all individuals whose hours of work with an employer are not verified electronically beginning at program launch until the state can leverage the use of QWD to attempt electronic verification of attested qualifying work hours prior to requiring paper documentation. Additionally, the state confirmed that it has an established interface connection with Work Number to verify hours worked and will establish electronic verification for individuals enrolled in an institution of higher education by January 2024. For individuals for whom Work Number returns earnings information, but not hours of work, the state would need to implement a process to calculate the hours of work using attested hourly wage, if provided. Until the state has revised the application or contract to request attestation of hourly wage, to demonstrate compliance with 42 CFR 435.952(c), the state would need to accept attestation of work hours with an employer that participates in Work Number if Work Number does not return hours worked. Similarly, until electronic verification of higher education qualifying hours is established, the state will need to accept attestation of student enrollment and course load. The state implemented the Pathways program on July 1st without allowing for self-attestation as verification of qualifying work hours for applicants or beneficiaries who meet the work requirement through employment. The state's current implementation of the Pathways program is non-compliant with CMS verification requirements at 42 CFR 435.952(c) due to not allowing self-attestation for beneficiaries who meet the work requirement through employment. The state will be expected to provide substantive updates to CMS documenting verification and enrollment processes consistent with federal requirements, and an expected timeline of progress towards compliance through

Prompts	State response	
		both monitoring calls and Quarterly Monitoring Reports.

Prompts	State response
CE.Mod_4. Operationalize strategies for noncompliance	
Intent: To describe how states will implement the policies for beneficiaries who do not comply with qualifying hours and activities requirements	
Strategies for beneficiaries at risk of noncompliance	
4.1 Describe how the state will identify beneficiaries at risk of noncompliance.	Members who have not reached six months of consecutive reporting and are still reporting their hours and activities must do so by the 3rd of each month in order to maintain coverage for the following month. If a member does not report their hours and activities by the 3rd , or if the member reports insufficient hours, the State will send the member a notice on the 4th of the month. This notice will remind the member that the deadline for late reporting of qualifying activities and/or good cause exception from the prior month is the 17th of the current month, will state that failure to report qualifying activities and/or good cause exception will result in suspension, and will include information on how to report qualifying activities and/or good cause exception. Using an example, a member must report their qualifying hours and activities by September 3. The hours and activities the member is reporting during the month of September are those the member completed in the month of August. If the member does not report by the 3rd, the State will send a Qualifying Activities Incomplete notice. The member has until the 17th to report qualifying hours and activities. If the member does not report, the State will send a Suspension Notice. The member will be suspended starting October 1. The member reports in September the hours and activities completed in August for coverage in October.
4.2 Describe what strategies the state will use to assist beneficiaries at risk of noncompliance in meeting the requirements.	*Refer to Question 4.1 for additional details.* Care Management Organizations (CMOs) are tasked with documenting their approach to conducting outreach and providing services and supports to Pathways members to help them remain compliant with their qualifying hours and activities. The CMOs are expected to provide qualifying activity support to their members by monitoring their engagement in qualifying activities, identifying who needs supports, and implementing strategies to aid these individuals in avoiding potential suspension or termination. The CMOs will be required to provide reports and qualitative updates, along with metrics, that will help measure the effectiveness of the engagement plan. The CMOs will also be expected to meet monthly with the State to present their findings.
4.3 Describe how the state will implement the following compliance actions, including what processes the state will implement to identify and track beneficiaries in these statuses: 4.3.i Suspension	The State will identify and track suspended members using a new status code in the Georgia Gateway IES to indicate suspension. The new code will be implemented by July 1, 2023.
4.3.ii Termination	Once a member is terminated, their termination record becomes part of their overall benefits record. The benefits record is maintained in Gateway. The State is anticipating collecting key performance metrics related to termination. Those metrics include: • Total number of members terminated from Pathways (number of members terminated as of the last day of the reporting month and cumulative members terminated to date) • Total number of members terminated, by termination reason (number of members terminated as of the last day of the reporting month by termination reason and cumulative members terminated to date by termination reason)
4.3.iii Non-eligibility period	The State does not apply non-eligibility periods to members who do not comply with qualifying hours and activities requirements. An individual may reapply for Medical Assistance at any time following disenrollment.

Prompts	State response
4.3.iv Other compliance actions (e.g., grace periods/ opportunity to cure)	The State does not plan to implement other compliance actions.
4.4 Provide details on the state's plan, if applicable, to provide advance notice to beneficiaries at risk of suspension or disenrollment for noncompliance. Include when the state will notify beneficiaries and how many notices or other communications (e.g., calls) each beneficiary will receive.	The State will communicate to all members about their suspension or disenrollment for noncompliance through member notices. Member notices will be sent via paper or electronically, based on the member's stated preference. The State will send any member who does not report their hours and activities by the 3rd of the month or who reports insufficient hours, a notice on the 4th of the month. This notice will state that failure to report hours and activities will result in suspension and includes appeal language. The State will send any member who does not report their hours by the 17th of the month or who reports insufficient hours, a suspension notice on the 18th of the month. This notice will state that the member is in suspension effective the first of the following month and will include appeal language. *Refer to Question 4.1 for additional details on these notices.* On the 18th of the second month of suspension, the State will send a termination warning notice to any member who does not report qualifying activities/good cause by the 17th of the second month of suspension or who reports insufficient hours. This notice includes information on the consequences of non-reporting and includes appeal language. On the 18th of the month, the State will send a termination notice to any member who does not report qualifying activities/good cause by the 17th of the third month of suspension or who reports insufficient hours. This notice will state that the member will be terminated effective the first of the following month. It will also include appeal language. This provides a 10-day notice for adverse action, taking into account the shortest month of the year, February.
4.5 Describe the state's process for benefit reactivation (from suspension) and/or re-enrollment (from termination) once qualifying hours and activities requirements are met. Describe the state's process to get beneficiaries re- enrolled into a managed care plan, if applicable.	If a member is in suspension for non-compliance with the qualifying hours and activities requirement, a member must report qualifying activities/good cause by the 17th of the month in order for coverage to be prospectively reactivated for the first of the following month. If a member does not report qualifying activities/good cause by the 17th of the 3rd month of suspension, the member will be terminated by the last day of that month and must reapply for coverage. The termination notice will include information on how to reapply for Medical Assistance. In order to be eligible for Pathways, the individual must report qualifying hours and activities at application. Reactivated members will be assigned to a Care Management Organization (CMO), using the State's existing auto-reenrollment assignment processes. If a member is in suspension and does report qualifying activities/good cause, the member will be reinstated. The member will receive a notice, informing the member of their change in status. This notice will also include information on the monthly qualifying activities reporting requirement needed to maintain eligibility.
4.6 Describe the process by which a beneficiary who is about to be suspended or disenrolled will be screened for other Medicaid eligibility groups or exemptions (e.g., by sending form to potentially eligible beneficiaries to capture additional information).	Prior to being suspended for failing to meet qualifying activity monthly reporting criteria, a member will be run through the cascade for all classes of Medical Assistance. If a member is eligible for any other class of Medical Assistance that is higher on the cascade than Pathways, the member will be approved for that class of Medical Assistance. If the member is not eligible for any other class of assistance that is higher on the cascade, the member will be suspended. Prior to being terminated from Pathways, a member will be run through the cascade for all classes of assistance. If a member is eligible for any other class of assistance that is higher on the cascade than Pathways, the member will be automatically enrolled into that class. If the member is not eligible for any other class of assistance that is higher on the cascade, the member will be evaluated for a class of assistance that is lower on the cascade. If the member is not eligible for any other class of assistance, the member will be terminated. There are no state-only funded programs for which individuals may be eligible. Denied individuals will be referred to the Marketplace electronically.

Prompts	State response
4.7 Describe any differences/modifications from the current renewal process, including changes for beneficiaries in suspension status due to noncompliance with qualifying hours and activities requirements.	The State is not implementing any modifications to its current renewal process. Members will still receive renewal notices and information while in suspension. The existing timelines for timely renewals will apply to members in suspension.
Stopping payments to managed care	
4.8 Describe procedures to stop capitation payment to MCOs when a beneficiary's eligibility is suspended or terminated due to failure to comply with qualifying hours and activities requirements.	At the end of every month, the IES will run eligibility for all Pathways members and perform its monthly closeout. The State's IES electronically delivers a monthly file to the State's Medicaid Management Information System (MMIS) on the first of the month, which includes all Pathways members and whether their status is active or closed. The file is processed by MMIS the evening it is received. When MMIS processes the file to run capitation payments, the system will make payments to the CMOs for those members who are identified as active in the system. If there is no eligibility for that month on a member, no capitation payment will be made to the CMO on behalf of the member. The process for stopping capitation payments to CMOs is the same for members in a suspended status and members who were terminated from Pathways. CMOs will receive an audit file from the State each month with a list of their active members only.
4.9 Describe whether and how beneficiaries will be made aware of ways to access primary and preventive care at low or no cost after disenrollment or during a suspension.	The State will insert language in notices that provides information on how to access low or no cost care. This language will also include the Department of Community Health's website, which provides information on Federally Health Qualified Centers and Community Health Centers throughout the State. The website also includes a feature to "find the nearest center" so an individual can locate and visit the center nearest to their location.

Prompts	State response
Re-enrollment after disenrollment for noncompliance	
4.10 Describe what beneficiaries will need to do to re-enroll following disenrollment or suspension for failure to comply with qualifying hours and activities requirements.	If a member is in suspension for non-compliance with the qualifying hours and activities requirement, a member must report qualifying activities/good cause by the 17th of the month in order for coverage to be prospectively reinstated for the first of the following month. If a member does not report qualifying activities/good cause by the 17th of the 3rd month of suspension, the member will be terminated and must reapply for coverage. The member may reapply for coverage at any time by completing a Medical Assistance application. In order to be eligible for Pathways, the individual must report qualifying hours and activities at application. If the individual is approved for Pathways, coverage will begin the first of the month following the eligibility determination.
4.11 Describe actions the state will need to take to re-enroll or reactivate beneficiaries following disenrollment or suspension. Describe how the state will process new applications for individuals who were disenrolled for noncompliance if it differs from the state's standard application processes.	The State's processes will not differ from its standard application processes. Members can reapply for Medical Assistance at any time and must fill out the application in entirety.
4.12 Describe how the state will handle applications for individuals who reapply for coverage but are still in suspended status or non- eligibility period, if applicable. For example, will the state process those applications with a prospective eligibility date or will the state deny those applications until individuals are eligible.	If a member is in a suspended status, their program status for Medical Assistance is considered approved. Therefore, in the online Customer Portal, a member in suspension status would be unable to submit a new application. The member would instead be directed to submit a change report. If a member submits a new paper application while in a suspended status, the paper application would be withdrawn upon processing and reviewed as a change report. If a member in suspended status and reports qualifying hours and activities on the paper application, the member could exit suspension status if the qualifying hours and activities meet the threshold and the member provides documentation for verification. There are no non-eligibility periods in the Pathways program design.
Appeals processes	
4.13 Describe any modifications to the appeals processes for beneficiaries enrolled in the qualifying hours and activities requirements demonstration, including appeals for: 4.13.i Suspensions or disenrollment for noncompliance; 4.13.ii Denials of exemption or good cause requests Describe what happens to the beneficiary while the case is pending or in the appeals/fair hearing process, if it differs from the current process.	The State is not making any modifications to the appeals process. All fair hearings staff will be included in both policy training and processing training, provided by the Education and Training team beginning in May. The functions needed for Pathways are already encompassed in the current processes of filing fair hearings, so the training will be focused on understanding the Pathways-specific reasons that would allow the filing of a fair hearing. In addition, the State plans to produce a report of the number of adverse action letters, reviewed to determine whether the adverse action letters were properly issued; and thereafter a review of continued services for those who asked for the same pending the outcome of any hearing requested; and finally, the review of proper action after the court's decision. In this context, appeals refers to the fair hearing process operated by the State.

Prompts	State response
CE.Mod_5. Develop comprehensive communications strategy	
Intent: To describe how the state will communicate qualifying hours and activities requirements policies and procedures (as necessary) to internal and external stakeholders (beneficiaries, partners, staff/other internal entities)	
Beneficiary communication	
5.1 Provide details on the state's plan to communicate to current beneficiaries and new applicants/beneficiaries about **general qualifying hours and activities requirements policies**, including when qualifying hours and activities requirements will commence, the number of required qualifying hours and frequency of completion, how to report compliance and on what frequency, specific activities that may be used to satisfy qualifying hours and activities requirements, and information about resources that will facilitate compliance such as the availability of transportation and child care. Include details such as how often the state plans to communicate with beneficiaries and through what modes of communication, including what information will be distributed using formal notices.	The State will communicate to all members about general qualifying hours and activities requirements policies through member notices. Member notices will be sent via paper or electronically, based on the member's stated preference. The State does not have information about the proportion of the demonstration population who are computer savvy and have stable internet access. The State does provide the option for individuals to "go green" and receive electronic communications / notices, but paper communications are always available. The State will use multiple modalities to facilitate communication including paper and electronic options. In addition, all DFCS county offices will have Pathways information sheets, which include information regarding the qualifying hours and activities policies. A member's approval notice will include information about general qualifying hours and activities requirements policies including how to report hours and activities, the reporting deadlines for hours and activities, the consequences for missing ongoing reporting, how to request a good cause exception, and the waiver for ongoing reporting once six consecutive months of reporting are met. *Refer to Question 1.2.iv for additional details on reporting frequency and hours measurement.* The State will also issue a Pathways information sheet, which includes information regarding the qualifying hours and activities policies. This information sheet will be distributed both electronically and in paper to other State agencies and community partners such as Rural Health Centers and Federally Qualified Health Centers. The State will communicate to stakeholders, including active members and applicants, through a dedicated, comprehensive Pathways website. This website will host all information related to Pathways including information sheets, frequently asked questions, and applicable forms. This website will include information on the general qualifying hours and activities requirements policies.
5.2 Provide details on the state's plan to communicate to beneficiaries about **exempt populations and good cause circumstances.** Include details such as how often the state plans to communicate with beneficiaries and through what modes of communication, including what information will be distributed using formal notices.	The State will communicate to all members about good cause exceptions through member notices. Member notices will be sent via paper or electronically, based on the member's stated preference. A member's approval notice will include information about how to request a good cause exception and what those good cause exception reasons are. If a member does not report their qualifying activities and/or good cause by the 3rd o f the month, or if the member reports insufficient hours, the State will send the member a notice. This notice will include information on how to request a good cause exception. The State will communicate to stakeholders, including active members and applicants, through a dedicated, comprehensive Pathways website. This website will host all information related to Pathways including information sheets, frequently asked questions, and applicable forms. This website will include information on good cause circumstances and how to request good cause.

Prompts	State response
5.3 Provide details on the state's plan to communicate to beneficiaries about **suspension or disenrollment for noncompliance.** Include details such as how often the state plans to communicate with beneficiaries, through what modes of communication, including what information will be distributed using formal notices.	The State will communicate to all members about their suspension or disenrollment for noncompliance through member notices. Member notices will be sent via paper or electronically, based on the member's stated preference. If a member does not report qualifying activities and/or good cause by the 3rd of the month, or if the member reports insufficient hours, the State will send the member a notice. This notice will remind the member of the deadline for late reporting of hours, will state that failure to report hours and activities will result in suspension, and will include information on how to request a good cause exception. If the member does not report their hours by the 17th of the month, or if the member reports insufficient hours, the State will send the member a suspension notice. This notice will inform the member that they will lose coverage at the end of the month and will enter a 90-day suspension period. It will also inform the member that they can regain coverage prospectively by reporting qualifying hours and activities for one month. *Refer to Question 4.1 for additional details on this notice.* If a member does not report qualifying activities/good cause by the 17th of the second month of suspension, the member will receive a termination warning notice. This notice will inform the member that they will lose coverage at the end of the next month if they do not report qualifying hours and will need to reapply for Medical Assistance. If a member does not report qualifying activities/good cause by the 17th of the third month of suspension, the member will receive a termination notice. This notice will inform the member that their coverage will end at the end of the month and they will need to reapply for Medical Assistance. The State will communicate to stakeholders, including active members and applicants, through a dedicated, comprehensive Pathways website. This website will host all information related to Pathways including information sheets, frequently asked questions, and applicable forms. This website will include information on suspension, disenrollment for non-compliance, and how to file an appeal.
5.4 Provide details on the state's plan to communicate to beneficiaries about **reactivation following suspension or re-entry after disenrollment for noncompliance.** Include details such as how often the state plans to communicate with beneficiaries, through what modes of communication, including what information will be distributed using formal notices.	The State will communicate to all members about reactivation/reentry policies through member notices. Member notices will be sent via paper or electronically, based on the member's stated preference. If the member does not report their hours by the late deadline of 17th of the month, or if the member reports insufficient hours, the State will send the member a suspension notice. This notice will inform the member that they will lose coverage at the end of the month and will also inform the member that they can regain coverage while in suspension by reporting qualifying hours and activities for one month. If a member does not report qualifying hours and activities by the 17th of the second month of suspension, the member will receive a termination warning notice. This notice will inform the member that they will lose coverage at the end of the next month if they do not report qualifying hours and activities and will need to reapply for Medical Assistance. If a member does not report qualifying hours and activities by the 17th of the third month of suspension, the member will receive a termination notice. This notice will inform the member that their coverage will end at the end of the month and they will need to reapply for Medical Assistance.

Prompts	State response
5.5 Describe the state's plan for communicating to beneficiaries about changes in requirements. For example, how will beneficiaries be notified of differences in the requirements they need to meet if they transition off SNAP/TANF but remain subject to qualifying hours and activities requirements.	The State will communicate to all members about changes in requirements through member notices. Member notices will be sent via paper or electronically, based on the member's stated preference. Members are made aware of the qualifying hours and activities and the associated reporting requirements in their initial approval notice. *Refer to Question 5.2 for additional details on this notice.* If a member completes six consecutive months of reporting, or if a member reports a change that leads to a change in reporting, the member will receive communication on a change in reporting requirements. Instances in which a member will receive notice about a change in reporting requirements include: • Member completes six consecutive months of reporting • Member becomes enrolled in an institution of higher education or TSCG full-time • Member becomes enrolled and actively engaged in GVRA • Member is no longer enrolled in an institution of higher education or TSCG full-time • Member is no longer enrolled and actively engaged in GVRA • Member is enrolled in Mandatory HIPP program (unless the HIPP member is not the employee that has ESI access) The State will communicate changes in reporting requirements the month in which the change occurs, which will provide sufficient time for the member to ensure proper reporting, if applicable, for compliance.
5.6 Describe any plans to use qualifying hours and activities requirements partners, such as qualified health plans, managed care organizations, providers, or community organizations to communicate to beneficiaries and conduct outreach, such as delivering education and ensuring compliance with qualifying hours and activities requirements.	The State will engage partners in a multi-step participant outreach and communications effort to promote engagement and compliance with the qualifying hours and activities requirements of Pathways. The State will launch a public information campaign about Pathways prior to the program's go-live date of July 1, 2023. This campaign will include disseminating information about the program, including the qualifying hours and activities requirement and targeting those potentially interested in Pathways prior to program enrollment. The State will provide information to partners including but not limited to community health centers, hospitals, provider groups, CMOs, public assistance offices, job centers, community agencies, and advocacy organizations throughout the State. These partners will be provided materials, enabling them to increase awareness of Pathways to the clients they serve and provide accurate information to help interested individuals meet the qualifying activity requirements prior to application. The State will establish a dedicated statewide call center number specific for answering Pathways questions, enabling any interested individual to speak with a representative who can answer specific questions and help callers better understand the Pathways program requirements. The statewide call center is equipped to communicate with non-English speakers. The State will also create a dedicated webpage which will be kept up to date with information and application resources on the new Pathways program. Once enrolled in Pathways, the CMOs will be responsible for supporting their members in understanding the ongoing program requirements. CMOs will help their members remain engaged in and compliant with the qualifying hours and activities requirement, will encourage their members to report accurately and timely, and will provide needed support to their members to be successful and maintain coverage. The State is actively working with CMOs to help them provide support to their members related to qualifying activities. As defined in the CMO Contract between DCH and the State, at a minimum, CMOs are required to outreach to members at two different points. The first outreach is within 7 days of enrollment to provide newly enrolled Pathways members with Pathways-specific information, including how to maintain coverage. The second outreach is within 30 days of enrollment where CMOs make an outreach phone call to newly enrolled Pathways members to explain the requirements of the program as well as explain the support services available. Outside of these requirements, CMOs will be required to demonstrate additional outreach to members as part of their engagement plans submitted to the State. Information will be provided to partners via e-mails and e-newsletters as well as information and materials, such as one-pagers, in paper form.

Prompts	State response
5.7 Describe how the state will ensure that materials or communications are accessible to beneficiaries with limited English proficiency, low literacy, disabilities, in rural areas, and other diverse groups. Describe the process for testing beneficiary notices for reading level and comprehension.	The State provides translation services for written materials. Translation is available in 15 different languages, so members with limited English proficiency can request any communication be translated into their language of choice. Information is provided in non-English languages informing people that language services are available and how to access them. Materials and communications are reviewed by policy staff at the Division of Family and Children Services (DFCS) and the General Counsel to make sure the language used is plain and simple for all members and that the documents are easy to read and comprehend. The State offers reasonable modifications and communication assistance to members who need such assistance. Available options for communication assistance include: • Sign language interpreter • Cued speech interpreter • Oral interpreter • Tactile interpreter • Email • Face to face interview • Electronic communication • Teletypewriter (TTY) • Braille • Large print • Video Relay • Telephonic signature • Telephonic apps/renewals • Telephone call reminder of deadlines The State will provide materials, such as applications and information sheets to all counties, which are located in both rural and urban counties. The State will also communicate to stakeholders, including active members and applicants, through a dedicated, comprehensive Pathways website. This website will host all information related to Pathways including information sheets, frequently asked questions, and applicable forms. The State currently provides references on all notices and its website about the availability of language services. All county offices include prominently displayed posters that describe the language services available and information on requesting those services. Staff in all county offices are aware of the services and are able to provide in-person assistance or by telephone, if requested. Key documents such as the application and renewal forms are available in large print, Spanish, and large print Spanish on the State's website. The posters contain a tagline that is translated in 20+ non-English languages. The State will have an inventory of materials and communications available in Spanish. If a member requires a material or communication to be translated, they may request translation services through a case worker by providing the document to be translated and the requested language. The document will be returned to the member in the requested language. Translation services are available in 15 different languages, including the most prevalent languages spoken in the State. Translation of notices occurs within 24- 48 hours of the request. An individual can receive free interpretation services over the phone or in their local DFCS office. An individual can contact the Call Center or visit their local DFCS office.

Prompts	State response
	The Call Center has an IVR system that provides options for 7 languages (Vietnamese, Korean, Nepali Burmese, Portuguese, English, and Spanish). If they are requesting a language that is excluded from that list, they can reach an agent who will provide translation services for other languages. The six non-English languages are representative of the top languages requested through the language line.
5.8 Describe the state's plans for translating beneficiary notices into languages other than English, and note what other languages will be available.	The State will translate all member notices into Spanish. The State also provides translation services for all written materials upon request. Members may request translation services through a case worker by providing the document to be translated and the requested language. The document will be returned to the member in the requested language, Translation services are available in 15 different languages, including the most prevalent languages spoken in the State. The State will use a third-party vendor for all translation services. Translation of notices occurs within 24- 48 hours of the request. A member can request translation services through case workers as well as call center agents.
5.9 Describe the state's plan to communicate modifications of qualifying hours and activities requirements to beneficiaries with disabilities.	At application, individuals who attest to having a disability and are not currently meeting the qualifying hours and activities threshold can request assistance in meeting the qualifying hours and activities requirement. If an individual requests assistance, an eligibility specialist from the Specialized Unit will conduct telephonic outreach to the member. The eligibility specialist will discuss the qualifying hours and activities requirements with the individual. If the individual thinks they can meet the requirements, they will have 90 days to meet the requirements. If the individual states that they need help meeting the requirements, the eligibility specialist will offer to refer the individual to GVRA and explain that enrollment in and compliance with the program satisfied the qualifying hours and activities requirement for Pathways. *Refer to Questions 2.8-2.11 for additional details.*
Partner communications	
5.10 Describe the state's plan to conduct outreach to partner organizations.	The State will conduct outreach to a number of partner organizations and trade associations including but not limited to: • Division of Family and Children Services • The State's Care Management Organizations • Georgia Vocational Rehabilitation Agency • Department of Behavioral Health and Developmental Disabilities • Federally Qualified Health Centers

Prompts	State response
	• Workforce Development Boards • Rural Health Centers • Technical College System of Georgia • Georgia Board of Regents Outreach to partner organizations and trade associations will begin in February 2023. Outreach will be conducted on an ongoing basis via e-mail correspondence, social media channels, and a quarterly newsletter. The State will host a dedicated Pathways inbox, where all inquiries from stakeholders, including partner organizations and trade associations, can be sent. The State will also communicate to partner organizations and trade associations through the Medicaid Fair, an event the Department of Community Health holds quarterly. Additionally, the State will provide information to partner organizations and trade associations, through a dedicated, comprehensive Pathways website. This website will host all information related to Pathways including information sheets, frequently asked questions, and applicable forms
5.11 Describe how the state plans to keep partner organizations informed and engaged, including all forms of communication that the state plans will use to engage partner organizations.	The State will actively communicate to a number of partner organizations and trade associations throughout the demonstration including but not limited to: • Division of Family and Children Services • The State's Care Management Organizations • Georgia Vocational Rehabilitation Agency • Department of Behavioral Health and Developmental Disabilities • Federally Qualified Health Centers • Workforce Development Boards • Rural Health Centers • Technical College System of Georgia • Georgia Board of Regents Outreach will be conducted via e-mail correspondence, social media channels, and a quarterly newsletter. The State will host a dedicated Pathways inbox, where all inquiries from stakeholders, including partner organizations and trade associations, can be sent. The State will also communicate to partner organizations and trade associations at through the Medicaid Fair, an event DCH holds quarterly. Additionally, the State will provide information to partner organizations and trade associations, through a dedicated, comprehensive Pathways website. This website will host all information related to Pathways including information sheets, frequently asked questions, and applicable forms. The State will communicate to partner organizations and trade associations regularly and on an as needed basis.
Staff/internal communications	
5.12 Describe internal staff trainings that the state is planning to conduct, such as trainings for call center representatives.	Internal staff trainings will be conducted with staff across DFCS and DCH. Division of Family & Children Services (DFCS) Training: DFCS will conduct field and call center staff trainings on systems and programmatic topics related to Pathways with all MAGI and non- MAGI Medicaid eligibility staff, including eligibility workers across Family Medicaid, ABD, and Quality Assurance. All field staff and call center staff will also be trained. Lobby staff and telephone staff will be provided with a training or review of information for awareness on the Pathways program. The contents of this training will consist of both systems and programmatic topics related to Pathways. The State expects to conduct all trainings virtually. Training will be delivered through online modules and virtual instructor-led trainings.

Prompts	State response
	Trainings will begin with DFCS staff no later than June 1, 2023. Department of Community Health (DCH) Training: DCH will conduct staff trainings on policy topics for all policy staff who will be responsible for answering questions or providing oversight for the Pathways program. The contents of this training will consist of an overview of the Pathways policy. Trainings will be delivered using pre-recorded virtual modules in the Learning Management System (LMS). These modules will be available to be shared broadly with staff in DCH, DFCS, and the Georgia Department of Human Services (DHS). Trainings will begin with DCH staff in April 2023 Fair hearings staff will be trained beginning in May. Training will consist of a combination of online self-guided modules and instructor facilitated virtual courses. The types of fair hearing requests expected include appeals for suspension or terminations and denial of good cause.
5.13 Describe any internal materials that the state is planning to develop for staff, such as manuals or reference guides.	Internal materials across DCH and DFCS will be updated with the policies and procedures of the Pathways program. Based on a series of policy memos issued by DCH to DFCS, DFCS will update the Online Directives Information System (ODIS) of DHS, which is centralized electronic warehouse of the policies and manuals of the programs and services provided by the DHS. In addition, internal training materials will be developed by DFCS for MAGI and non-MAGI staff on the implementation of the Pathways program. Existing curriculum will be updated to include the Pathways program in order to train new or existing staff. Training materials for the IES will be updated to instruct workers on how to process cases in Gateway. The training materials developed will be incorporated into online training, policies and procedures, instructor-led trainings, and tip sheets or hand-outs required to support training sessions. Frequently Asked Questions (FAQs) will be developed during training or after trainings are delivered. These will be distributed to staff prior to the Pathways Go-Live. Materials will be developed by mid-April 2023 and finalized by mid-May 2023 for distribution.

Prompts	State response
CE.Mod_6. Establish continuous monitoring	
Intent: To describe the state's process for conducting process and quality improvement for the qualifying hours and activities requirements	
6.1 Describe any analyses that the state is planning to conduct to inform its monitoring beyond the CMS required quarterly and annual monitoring reports. Describe the state's process for determining whether changes are needed for the following: 6.1.i Beneficiaries exempt from qualifying hours and activities requirements 6.1.ii Qualifying activities and required hours 6.1.iii Reporting frequency and hours measurement 6.1.iv Situations that give rise to good cause 6.1.v Compliance actions 6.1.vi Other policy changes	While CMS has mandated extensive quarterly monitoring and reporting including approximately 80 different measures, the State plans on developing additional metrics that will be analyzed on a monthly basis. These measures will reflect a combination of enrollment, disenrollment, suspension, qualifying activity types, and other program elements. Georgia Medicaid leadership will use the data and information provided through all forms of monitoring to evaluate overall program implementation and performance. Any potential changes will be made on an as needed basis dependent on the unique circumstances of each issue. The State will work with CMS, as necessary, on any modifications that would require CMS approval. Given that there are no exemptions in the Pathways program analysis will not be conducted on that issue. Qualifying activities and required hours, reporting frequency, and good cause will all be evaluated by looking at the data to identify trends and potential areas of concern. These issues will be elevated as necessary to Georgia Medicaid leadership so that appropriate actions can be taken. The State shared a list of proposed monthly metrics with CMS. The State started the development process for those monthly reports. The reports are scheduled to go into production by June 30, 2023.
6.2 Describe any actions needed to ensure that the state can capture and report required quarterly and annual monitoring metrics. Describe any necessary structural or process changes (i.e. data sharing systems/agreements with MCOs) that the state must make in order to capture and report required quarterly and annual monitoring metrics. IT changes need only be discussed in section 7.	The State is leveraging a cross divisional monitoring and evaluation implementation team that is focused on measure development and tracking. The team has identified the measures, data sources, system modifications and is developing the reports that will be in place for go live on July 1, 2023. This team will continue to meet over the next several months and report out through the Leadership Steering Committee that all necessary tasks are being completed timely to ensure that the first monitoring report will go to CMS 60 days at the end of the quarter period ending September 30, 2023. The State has identified the data sources for the majority of required monitoring metrics, which will largely come from the Georgia Gateway Integrated Eligibility System (IES). The State has identified metrics that would be received from other sources, including CMO Encounters, and from the Member Rewards Account (MRA) vendor. Since the MRA implementation will not be occurring until Phase 3 with a targeted implementation date of July 1, 2024, the State is still working through various system design issues. The State is aware that any vendor selected to administer the MRA will need to have appropriate reporting expectations included in the contract. The State has not identified any risk areas.

Prompts	State response
6.3 Describe how the state will assess the availability of accessible transportation supports by region and how the state will address gaps in supports. Note the frequency with which the state will assess the availability of transit and transportation supports.	Transportation supports are not provided by the State for Pathways members. *Refer to Question 2.1 for additional details.* There are no additional eligibility requirements or qualifications to access value-add services. Each care management organization offers value-added services to its members. The transportation service is dependent on what the individual care management organization offers to its members.
6.4 Describe how the state will assess the availability of child care supports by region and how it will address gaps in supports. Note the frequency with which the state will assess the availability of child care supports.	Child care supports are available for Pathways members across all regions. *Refer to Question 2.2 for additional details.* The State can assess availability of child care supports through data that is available in the IES. Reports can be generated in order to understand member participation in available child care supports across regions. The State may initiate conversations with county DFCS offices, the Department of Early Care & Learning (DECAL), and community support providers to determine the feasibility of filling gaps in available supports or member participation. The State updates and reviews the use of child care supports on a weekly basis as part of workload management, to assess the health of our program, and to make data driven policy, process, and workload decisions. The State keeps a very close watch on data through weekly productivity and metrics reports that the reporting and data team produces. This data is reviewed on a bi-weekly basis with Child Care and Parent Services (CAPS) leadership team.
6.5 Describe how the state will assess the availability of language access services by region and address gaps in supports. Note the frequency with which the state will assess the availability of language access services.	Language support services for non-English speaking Pathways applicants and members are available upon request across all regions. The State can assess member participation in available language access services across regions by requesting information from county DFCS offices and DFCS administrators responsible for coordinating translation and interpretation services. The State may initiate conversations with county DFCS offices to determine the feasibility of filling gaps in available supports or member participation.
6.6 Describe how the state will assess the availability of other supports, including assistance from other agencies and entities complementing Medicaid efforts, by region and address gaps in supports. Note the frequency with which the state will assess the availability of other supports.	The State will continue to provide information and referrals for Pathways applicants and members for support services as it does for other Medicaid applicants and members. Available community resources vary from county to county. The State can assess member participation in other supports across regions by requesting information from county DFCS offices. The State does not keep track of the referrals or resources shared with individuals or the utilization of those supports and resources by individuals. The State may initiate conversations with county DFCS offices to determine the feasibility of filling gaps in available supports or member participation.

Prompts	State response
6.7 Describe how the state will assess whether qualifying activities are available during a range of times, through a variety of means, and throughout the year. Describe any additional analysis that the state is planning to conduct to verify the available qualifying activities opportunities.	The State has offered a wide range of qualifying activities to potential enrollees. The State is establishing an audit infrastructure to evaluate a number of factors. The State will look to add an analysis to the audit team to ensure that qualifying activities are captured correctly and that beneficiaries are availing themselves of the many different qualifying activities. *Refer to Question 1.2 for additional details on the Pathways qualifying activities.* If the audit team identifies any major gaps, the issue can be elevated to Georgia Medicaid leadership. Any course of action is dependent on the issue and the ability of the State to influence change. Any data generated by the audit team can be reviewed on a regular basis. The State will evaluate the different types of qualifying activities being reported (employment, community service, etc). The State will look at the distribution of those qualifying activity types by region across the state to understand and assess where there may be gaps or hardships. The State will also collect information from the CMOs as part of the execution of their Pathways engagement plans. Information will also be collected through the Evaluation Vendor's survey and focus groups.
6.8 Describe how the state will identify geographic areas with high unemployment and limited economic and/or educational opportunities. Describe how the state will adjust qualifying hours and activities requirements in areas with few qualifying activities opportunities and how often those adjustments will be reviewed.	The data sources will include looking at application data and if necessary, conducting some random analysis on the types of qualifying activities included and denial rates within certain geographic areas. If there appears to be certain areas that are disproportionately reflected in the data as having lower approval rates, the State can evaluate through more granular analysis the types of activities available in that geographical region. The State will review unemployment data, broken down by current CMO geographic region, on an annual basis. In addition, the evaluation vendor, in the interim evaluation report, will assess member experience in accessing qualifying activities. Based on those reviews, the State will evaluate any changes needed to its approach to qualifying hours and activities requirements of the Pathways program.
6.9 Describe how the state will assess reasonable modifications and the availability of supports for beneficiaries with disabilities by region. Describe how the state will address gaps in supports. Note the frequency with which the state will assess reasonable modifications and the availability of supports.	All the reasonable modifications available to Medicaid applicants and members today with disabilities will also be available for Pathways applicants and members. As part of the eligibility process, the State will ensure that these standard practices regarding reasonable modifications will be available to all applications and followed by all eligibility staff regardless of region. *Refer to Questions 2.8-2.11 for additional details.* The State is establishing a new Specialized Unit of Eligibility Specialists who are trained in ABD Medicaid, Family Medicaid, and Pathways which will review and process applications, changes, and renewals for Pathways members requiring a reasonable modification to the qualifying hours and activities requirement due to a disability. This Specialized Unit will follow practices regarding reasonable modifications for all members with disabilities regardless of region. If the State identifies gaps when reviewing the operations of the Specialized Unit in how members are supported it will work to improve the operations of this unit through training, process improvement, and other actions as necessary. The State will work with the Georgia Vocational Rehabilitation Agency quarterly to understand utilization of services by each of its eight regions. The State will also be able to access data on referrals to GVRA and data on denials from GVRA.

Prompts	State response
CE.Mod_7. Develop, modify, and maintain systems	
Intent: To describe any system changes needed to implement qualifying hours and activities requirement policies and meet reporting requirements	
7.1 Describe whether the state is planning to enhance its eligibility and enrollment systems to determine eligibility for the qualifying hours and activities requirements demonstration population. Note specific systems changes that will be made and, when the state will submit an APD if one has not been submitted already. Include the projected timeline for making the changes if not included in the APD or if an APD has not been submitted.	The State plans to enhance current eligibility and enrollment system capabilities to identify members in the system who are required to comply with qualifying activity requirements. The Georgia IES will determine that a Pathways member is required to comply with qualifying activity requirements unless the Pathways member meets a Pathways reporting exception. The system will support flagging Pathways members who have a reporting exception due to: (1) having met the requirement for six consecutive months of reporting within the period of eligibility; (2) being actively enrolled in a current term for Vocational Education; (3) being actively enrolled in a current term for Higher Education (4) having an active referral to GVRA; or (5) being actively enrolled and engaged with GVRA. The system will implement a monthly automated batch process that will redetermine eligibility for the qualifying activities requirement population and for the population with an exception to report qualifying activities to assess any change to the reporting status. Members who have a change in their reporting requirement status for qualifying activities will be notified through a new system notice. These system updates will be implemented as of the Release 1 Go-Live date of July 1, 2023 according to the timeline included in the APD. There have been no changes to key milestone dates at this time.
7.2 Describe whether the state is planning to develop or enhance systems capacities so that beneficiaries can report qualifying hours. If the state is planning to do this, describe: 7.2.i The system(s) that will be used for beneficiaries to report qualifying hours and for the state to track hours 7.2.ii Any specific systems changes the state is planning 7.2.iii Whether information on qualifying hours will be transferred to other systems 7.2.iv The projected timeline for implementation of system enhancements, if not included in the APD or if an APD has not been submitted. Provide the timeframe for APD submission if one has not been submitted already.	The State will enhance system capabilities so that members can report qualifying activity hours electronically through the Customer Portal or mobile application (once mobile application becomes available). The system will allow members to log into the Customer Portal or mobile application and link their active Pathways case. The system will support a report of monthly hours for qualifying activities, a request of good cause for the month, and a request of reasonable modification to meet Pathways reporting requirements through Customer Portal. The system will also be developed to support verification upload for qualifying activities and good cause through the Customer Portal and mobile application. **Reporting qualifying hours and activities:** The Customer Portal and Georgia Mobile Solution are the systems that will be used for members to report qualifying hours. The IES Worker Portal will be enhanced to support worker tracking of qualifying activities and good cause report through the qualifying activities "timeclock" available for worker review and validation in the Data Collection module of the application. **Systems changes:** The State is planning to enable a report of qualifying activity hours and verification in the Customer Portal through the Apply for Benefits, Report my Changes, and Renew my Benefits modules. The State will also support Federally-Facilitated Marketplace (FFM) application referral customers with notification to report qualifying activity hours through the Gateway Customer Portal to support application processing. **Information transfer:** The volume of qualifying activity hours will not be transferred to other systems. **Projected Timeline:** These system updates will be implemented as of the Release 1 Go-Live date of July 1, 2023 according to the timeline included in the APD. There have been no changes to key milestone dates at this time.

Prompts	State response
7.3 Describe whether the state is planning to develop or enhance systems capacities so that entities, such as employers, volunteer supervisors, schools, and other institutions, can automatically report qualifying activities completed by beneficiaries. If the state is planning to do this, describe: 7.3.i The system(s) that will be used for CE entities to report qualifying hours and for the state to track hours 7.3.ii Any specific systems changes the state is planning 7.3.iii Whether information on qualifying hours will be transferred to other systems 7.3.iv The projected timeline for implementation of system enhancements, if not included in the APD or if an APD has not been submitted. Provide the timeframe for APD submission if one has not been submitted already.	The State is planning to create interfaces with GVRA to receive automated reports from the agency when a Pathways member becomes enrolled and actively engaged in the GVRA program, thus satisfying the qualifying activities monthly requirement and determining a reporting exception for members who are enrolled. The State also intends that the GVRA agency will send information when a Pathways member's enrollment terminates in GVRA such that the member's qualifying activity reporting eligibility may be redetermined. The State is also planning automated verification of a member's qualifying activity monthly reporting through interfaces with Work Number, and TCSG. *Refer to Question 3.12 for additional details on interfaces for qualifying activities.* The State is not intending that entities can report monthly qualifying activity hours on behalf of a member. These system updates are scheduled to be implemented as close to the Release 1 Go-Live date of July 1, 2023 as possible.

Prompts	State response
7.4 Describe whether the state is planning to develop or enhance systems capacities to integrate data from other public programs, such as SNAP and TANF. For each external data source listed in 3.11, describe: 7.4.i The data source(s) the state will need to access, including which agencies the data is coming from 7.4.ii System(s) that the data will be stored in 7.4.iii Whether and how the state needs to modify system capacities to integrate data for each source 7.4.iv Whether the necessary data matching agreements are in place The projected timeline for implementation of system enhancements, if not included in the APD or if an APD has not been submitted. Provide the timeframe for APD submission if one has not been submitted already.	The State is not planning system enhancements to integrate data from other public programs such as SNAP and TANF because its current systems can implement the qualifying hours and activities requirements. If a member is enrolled in Pathways and TANF and/or SNAP, then the work activities completed by the individual for the purposes of TANF or SNAP ABAWD compliance will also count towards the qualifying activities and hours for Pathways if they overlap with Pathways requirements. *Refer to Question 3.11 for additional details.* The system will support the worker to enter the activity met by the member in the TANF and/or SNAP time clock, and will also support the worker to enter the Pathways required data elements in the appropriate modules of the Worker Portal for Pathways qualifying activities. **Data sources:** The data source for TANF and SNAP time clocks is Gateway. **Data storage:**. The data for the TANF and SNAP activities are stored in Gateway. **Systems modifications:** The State is not planning to modify system capabilities to integrate data. **Data matching agreement:** No additional data sharing agreements are required for workers to review the TANF and SNAP activities data as the information may support Pathways eligibility. an individual can receive free interpretation services over the phone or in their local DFCS office. **Projected Timeline:** These system updates will be implemented as of the Release 1 Go-Live date of July 1, 2023 according to the timeline included in the APD. There have been no changes to key milestone dates at this time.
7.5 Describe any systems modifications that the state is planning to operationalize the suspension of benefits and/or termination of eligibility, including: 7.5.i Changes to the determination of eligibility, including changes to the MMIS eligibility module to indicate someone is in a suspended status 7.5.ii How systems will be used to implement suspension of benefits and/or termination of eligibility 7.5.iii Specific system modifications the state needs to implement to operationalize suspension of benefits 7.5.iv The level of automation or manual intervention needed 7.5.v Changes to how the system(s) will need to process terminations	The State is planning to extend the Medical Assistance eligibility determination rules engine to determine a suspension of benefits and termination of eligibility for the Pathways class of Medical Assistance. **Changes to determination of eligibility:** Modifications will be made to the eligibility system to determine that a member for Pathways is suspended from Medical Assistance due to failure to meet the qualifying activity reporting requirement. The eligibility system will send a termination record to the MMIS system when a Pathways member is determined as suspended. The MMIS system will indicate that a member is terminated from receiving Medical Assistance services. **Determination of suspension and termination:** The system will determine a suspension of Pathways benefits if the member has not met the Pathways qualifying activity requirements. The system will count with a suspension counter each sequential month in which a beneficiary fails to meet the Pathways qualifying activity requirements. The system will determine an eligibility status of terminated for a member whose suspension counter exceeds 3 consecutive months. The system will reset the suspension counter to 0 if the beneficiary complies with qualifying activity reporting requirements in a month prior to the suspension counter exceeding 3. **Systems modifications for suspension:** The State will develop an automated batch process that runs monthly to determine that a Pathways member is suspended due to not meeting the qualifying activity requirements. **Automation**: The monthly automated batch process described above will determine suspension and termination eligibility status results for Pathways members. If a member reports qualifying activities online and submits associated verification that the policy allows to be accepted as automated in the system, then the system will also restore eligibility from a suspended status in the monthly batch process. A worker may also input qualifying activity information for a member who was non-compliant with qualifying activities to restore eligibility from a suspended status. **Systems modifications for termination:** No additional system changes are required to support terminations beyond what is stated in the aforementioned requirements. **Information transfer:** Suspension or termination information will be shared with the MMIS system.

Prompts	State response
7.5.vi Whether and how this information will be transferred to other systems or contractors The projected timeline, and the timeframe for APD submission if one has not been submitted already	**Projected Timeline:** These system updates will be implemented as of the Release 1 Go-Live date of according to the timeline included in ☐ the APD. There have been no changes to key milestone dates at this time.
7.6 Describe any systems modifications that the state is planning to operationalize benefit reactivation and/or re-enrollment once qualifying hours and activities requirements are met, including: 7.6.i Changes states will implement to prevent enrollment during non-eligibility periods, if applicable 7.6.ii How systems will be used to operationalize benefit reactivation and/or re- enrollment 7.6.iii Specific system modifications the state needs to implement to operationalize suspension of benefits 7.6.iv The level of automation or manual intervention needed 7.6.v Whether and how this information will be transferred to other systems or Contractors 7.6.vi The projected timeline, and the timeframe for APD submission if one has not been submitted already	If a Pathways member is suspended from Pathways coverage due to failure to comply with qualifying activity requirements, the member will be able to report compliance for qualifying activities which will be accepted via automated batch process by the system or accepted via worker review. Monthly, the system will re- determine eligibility status of members required to report qualifying activities, including all individuals who are suspended for failure to comply with qualifying activity requirements; if a suspended member has complied, then the Pathways category of assistance will be reactivated as approved. A worker can also redetermine eligibility if the worker entered the qualifying activity hours in order to reactivate an approval for the Pathways category of assistance. **Changes to prevent enrollment:** There are no system requirements to prevent enrollment during non-eligibility periods as no non-eligibility periods are defined for the Pathways category of assistance. **Benefit reactivation:** The system will operationalize benefit reactivation by allowing members to report qualifying activity hours during a suspended period, by enabling entry and validation of the qualifying activity report during the suspended period, and by configuring the eligibility determination logic to determine Pathways eligibility as approved for a member who complies with the qualifying activity reporting requirement during their suspension period. **Systems modifications for suspension:** *Refer to Question 7.5.*
7.7 Describe any other significant systems modifications the state is planning to operationalize qualifying hours and activities requirements. Include the timeline for implementing system changes and modifications.	The State is not planning to make other significant changes and modifications.

Prompts	State response
Premiums and account payments	
PR.Mod_1. Eligibility and payment amounts	
Intent: To describe in more detail how the state determines (1) eligibility for and exemptions from the premiums policy, and (2) payment amounts	
1.1 Describe which beneficiaries are subject to the premiums or account payments policy.	Pathways members with incomes between 50% and up to 100% of the Federal Poverty Level (FPL) who are not enrolled in the Mandatory Health Insurance Premium Payment (HIPP) program or enrolled in vocational education programs of highly sought-after trades through the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant programs, will be required to pay monthly premiums. *Refer to Questions 1.2.vii and 1.3 for additional details on how the State will exempt HIPP and TCSG members from premium payment.*
1.2 Describe how the state will determine whether beneficiaries are exempt from premiums or account payments and if those exemptions go beyond what is required in statue.	Pathways applicants will be screened / assessed for other categories of Medicaid prior to being made eligible for Pathways. Most of the populations in this section would be eligible for other categories of Medicaid. The State anticipates a Phase 3 implementation date of July 1, 2024. We understand this requires an approved Implementation Plan and will work with CMS to identify a date for submission when more information about the development and design of these elements are available.
Mandatory populations: 1.2.i Pregnant women	Pregnant women up to 100% of the FPL and those postpartum up to 60 days are eligible for another category of Medicaid and therefore would not be considered for Pathways. The State anticipates a Phase 3 implementation date of July 1, 2024. We understand this requires an approved Implementation Plan and will work with CMS to identify a date for submission when more information about the development and design of these elements are available.
1.2.ii American Indians/Alaska Natives (AI/AN)	The State is exempting American Indians/Alaska Natives from premium payments as required by federal regulation.
Optional exemptions: 1.2.iii Beneficiaries with exceptional health care needs	The State is not exempting beneficiaries who may be unable to comply because of exceptional health care needs
1.2.iv Medically frail	The State is not exempting beneficiaries who are medically frail and have serious medical conditions.
1.2.v Beneficiaries eligible for Medicare	The State is not exempting beneficiaries eligible for Medicare.

Prompts	State response
1.2.vi Former foster care youth	The State is not exempting former foster care youth.
1.2.vii Other (by specific exempt status)	The State is exempting from premium payments members enrolled in the Mandatory HIPP program. The exemption on premium payments lasts while the member is enrolled in the Mandatory HIPP program. If a member is no longer enrolled in the Mandatory HIPP program, and enrolls in Pathways, the member will be subject to premium payments if their income is between 50% and up to 100% of the FPL. The State is also exempting from premium payments members enrolled in vocational education programs of highly sought-after trades through the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant programs. The exemption on premium payments will last for the duration of the member's enrollment and for two months following graduation from the program. After the two months post-graduation period concludes, members will be subject to premium payments if their income is between 50% and up to 100% of the FPL. The State anticipates a Phase 3 implementation date of July 1, 2024. We understand this requires an approved Implementation Plan and will work with CMS to identify a date for submission when more information about the development and design of these elements are available The trades that are considered highly sought-after are available on the Technical College System of Georgia's High-Demand Career Initiative website, which can be accessed here: https://www.tcsg.edu/hdci/
1.3 Describe the state's process for exempting beneficiaries from premiums or account payments. Note whether specific exemptions must be reported differently.	Members are not required to claim an exemption. Eligibility for premium exemptions will be captured by the Georgia Gateway Integrated Eligibility System (IES) at application, when there is a reported change, and at redetermination. An indicator in the eligibility system will designate exemption from premium payment if the individual is part of an exempt population group. Members enrolled in the Mandatory HIPP program are not subject to premium payments. Mandatory HIPP members who have access to employer sponsored insurance (ESI) and were determined by the State to be cost-effective at application will be enrolled in their employer's coverage. An indicator in the State's IES will indicate exemption from premium payment for members enrolled in the Mandatory HIPP program. Mandatory HIPP members do not have to claim an exemption from premium payments so long as they are enrolled in the Mandatory HIPP program. Members enrolled in vocational education programs of highly sought-after trades through the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant programs are not subject to premium payments. An indicator in the State's IES will indicate exemption from premium payment for Pathways members who are engaged in this qualifying activity type if reported and verified. Members enrolled in this program do not have to claim an exemption from premium payments so long as they remain enrolled in the vocational program. The State anticipates a Phase 3 implementation date of July 1, 2024. We understand this requires an approved Implementation Plan and will work with CMS to identify a date for submission when more information about the development and design of these elements are available.
1.4 Describe the state's payment requirements and compliance actions, including when payment is due before the beneficiary is subject to adverse actions.	Pathways members that are required to make monthly premium payments as a condition of ongoing eligibility will be required to pay their premium by the 7th of each calendar month. If the member does not pay by the 7th, they will be sent a notice of late payment on the 8th of the month and be instructed to submit payment by the 23rd of a calendar month. If a member does not submit their premium payment by the 23rd of the calendar month, they will enter a grace period. Members are allowed up to two grace months per

Prompts	State response
	certification period in which they will maintain their Medicaid coverage even if they did not pay their premium. A member who fails to submit a monthly premium payment for three months, either consecutively or cumulatively within a certification period, will enter a 90-day suspension period the following month. During suspension, the member's Medicaid coverage is suspended, their medical claims will not be paid, and a capitation payment will not be made. The member may come out of suspension by making a premium payment within the 90 days. If a member does not make a premium payment during the 90-day suspension period, the member ☐ will be terminated from Pathways and must reapply for coverage.
1.5 If prepayment is required, describe the process, including whether the beneficiary is required to pay the full monthly payment to initiate coverage or if there is an alternative payment amount, the timeframe required for payment, and what compliance actions will result from noncompliance	Individuals subject to premiums will be required to make an initial premium payment prior to coverage initiation. Coverage begins on the first of the month following payment. Individuals with incomes from 50% up to 85% of the FPL will pay a monthly premium of $7.00. Individuals with incomes from 85% up to 100% of the FPL will pay a monthly premium of $11.00. A tobacco surcharge of $3.00 for individuals with incomes from 50% up to 85% of the FPL or $5.00 for individuals with incomes from 85% up to 100% of the FPL, will be added to member's premiums if they self-attest to using tobacco or tobacco-related products at application. There is no alternative premium payment amount to initiate coverage. An individual will have 90 days from the date of eligibility determination to make their initial premium payment. If an individual does not make a premium payment within 90 days following their eligibility determination, their application will be closed. The individual will receive a denial notice and will be required to re-apply for Medical Assistance in order to receive coverage.
1.6 Describe how the state will determine whether beneficiaries are subject to premiums or account payments but exempt from compliance actions, and what documentation is required (if applicable). Describe the type of compliance actions that might result from noncompliance.	Based on the State's demonstration design, no beneficiaries will be subject to premiums or account payments but exempt from compliance actions.
1.7 Describe how beneficiaries subject to premiums or account payments can claim financial hardship and what documentation is required (if applicable).	Based on the State's demonstration design, no beneficiaries can claim financial hardship.
1.8 Describe how the state will determine the premium or account contribution amount beneficiaries will pay, including whether amounts will change over time or be	Premium payments will be tiered based on income. A member's income is calculated and verified using the State's current Modified Adjusted Gross Income (MAGI) methodology. Individuals with incomes from 50% up to 85% of the FPL will pay a monthly premium of $7.00. Individuals with incomes from 85% up to 100% of the FPL will pay a monthly premium of $11.00. A tobacco surcharge of $3.00 for individuals with incomes from 50% up to 85% of the FPL or $5.00 for individuals with incomes from 85% up to 100% of the FPL, tiered for income, will be added to member's premiums if they self-attest to using tobacco or tobacco-related products at application, reported

Prompts	State response
recalculated for any reason. Provide information beyond what is provided in the STCs.	change, or renewal. A member's ongoing premium payment may change during a certification year or at redetermination due to a member's change in income or attestation of completion of a tobacco cessation program. A member's premium payment may also change during their annual renewal if income has changed.
1.9 Describe how the state will determine that beneficiaries have reached the aggregate cap specified in the STCs.	☒ The State is limiting the required premium payments of $7.00 and $11.00 monthly to 2% of an individual's annual income. This 2% calculation was made using the lowest level FPL in the band (50% and 85%) as the basis for the premium payments. There are no other out-of-pocket expenses that Pathways members must incur because copayments will be deducted from the Member Reward Account (MRA) and the account balance can run negative with no financial liability for the member. Members will therefore not reach the aggregate cap. Given this, a process for tracking when members reach the 5% spending cap is not necessary. The State anticipates a Phase 3 implementation date of July 1, 2024. We understand this requires an approved Implementation Plan and will work with CMS to identify a date for submission when more information about the development and design of these elements are available.

Prompts	State response
PR.Mod_2. Beneficiary account operations (if applicable)	
Intent: To describe how the state will develop and administer beneficiary accounts.	
2.1 Describe the state's plan for effectuating beneficiary health accounts, including who administers accounts and the roles of vendors.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available.
2.2 Describe the mechanisms for how health accounts work, including how the state makes payments to beneficiary health accounts.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
2.3 Describe whether a beneficiary's premium contribution counts towards the beneficiary account balance.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
2.4 Describe how beneficiary accounts are drawn down to pay for health care services.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
2.5 Describe whether beneficiary account balances roll over from one enrollment year to the next, and if accounts with balances rolled over reduce monthly contribution amounts.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available.

Prompts	State response
2.6 Describe whether and how the state will return account funds to beneficiaries after separation from Medicaid.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available

Prompts	State response
PR.Mod_3. Invoicing and payments	
Intent: To describe how the state will issue invoices and how beneficiaries can make account payments	
3.1 Describe the timing of payment invoicing, beneficiary payments, and grace periods, and deadlines for reporting a change in circumstance that would affect premium liability. Describe the invoicing mode and the number of times an unpaid invoice will be resent.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
3.2 Describe the procedures for beneficiaries to pay premiums or account payments.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
3.3 Describe third parties that can make payments on behalf of beneficiaries, and the process by which they can make payments on behalf of beneficiaries (if applicable).	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available

Prompts	State response
PR.Mod_4. Reduction to premiums for non-income related reasons	
Intent: To describe how the state will implement rewards for account payment	
4.1 Describe whether and how the state will implement incentives or rewards related to premium or account payments (if applicable).	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available

Prompts	State response
PR.Mod_5. Operationalize strategies for noncompliance	
Intent: To describe how states will implement the policies for beneficiaries who do not comply with the premiums policy	
5.1 Describe how the state will implement compliance actions, including what processes it will use to identify and track beneficiaries in grace periods, non-eligibility periods, and/or other statuses.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
5.2 Provide details on the state's plan to provide advance notice to beneficiaries at risk of suspension or disenrollment for noncompliance. Include when the state will notify beneficiaries and how many notices or other communications (e.g., calls) each beneficiary will receive.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
5.3 Describe the process by which the state will track and pursue collectible debts (if applicable).	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
5.4 Describe the process by which beneficiaries who are about to be disenrolled for nonpayment will be screened for other Medicaid eligibility groups or exemptions (e.g., by sending a form to potentially eligible beneficiaries to capture additional information).	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
5.5 Describe any modifications to the appeals processes for beneficiaries subject to premium requirements, including appeals for compliance actions and denials of hardship requests. Describe what happens to the beneficiary while the case is pending or in the appeals/fair hearing process, if it differs from the current process.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
5.6 Describe the actions that an individual needs to take to re-enroll after a non-eligibility period ends, including any modifications from the current application process.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available

Prompts	State response
5.7 Describe how the state will process applications from individuals who were disenrolled due to a non-eligibility period, if it differs from the state's standard application processes.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
5.8 Describe how the state will handle applications from individuals who reapply for coverage before the end of their non-eligibility period. Explain whether the state will process applications with a prospective eligibility date or deny applications until individuals are eligible.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
5.9 Describe how the state will handle applications from individuals who reapply for coverage while they are in suspended status.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available

Prompts	State response
PR.Mod_6. Develop comprehensive communications strategy	
Intent: To describe how the state will communicate premiums policy and procedures to internal and external stakeholders (beneficiaries, partners, staff/other internal entities)	
6.1 Provide details on the state's plan to communicate to beneficiaries about **the invoicing schedule, the basis for payment amounts, the payment process, non-eligibility periods, and rewards for payment (if any)**. Describe the information provided on beneficiary invoices, including the amount owed and the basis for that amount. For account statements, describe additional information on service use, costs of care, and account withdrawals. Include details such as how often the state plans to communicate with beneficiaries and through what modes of communication, including what information will be distributed using formal notices.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available

Prompts	State response
6.2 Provide details on the state's plan to communicate to beneficiaries about **processes for reporting changes in income, making hardship claims, and filing appeals.** Include details such as how often the state plans to communicate with beneficiaries and through what modes of communication, including what information will be distributed using formal notices.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
6.3 Provide details on the state's plan to communicate to beneficiaries about **making the first payment to initiate coverage.** Include details such as how often the state plans to communicate with beneficiaries and through what modes of communication, including what information will be distributed through formal notices	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
6.4 Provide details on the state's plan to communicate to beneficiaries about the **consequences of nonpayment.** Include details such as how often the state plans to communicate with beneficiaries and through what modes of communication, including what information will be distributed	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
6.5 Describe the state's plan for communicating to beneficiaries about changes in requirements. For example, describe if beneficiaries will be notified of changes in payment amounts when amounts are time-varying or otherwise recalculated.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
6.6 Describe any plans to use partners, such as managed care organizations or other contractors, to communicate to beneficiaries and conduct outreach on payment requirements.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
6.7 Describe how the state will ensure that materials or communications are accessible to beneficiaries with limited English proficiency, with low literacy, and in rural areas, and other diverse groups. Describe the process for testing beneficiary notices for reading level	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available

Prompts	State response
and comprehension.	
6.8 Describe the state's plan for translating beneficiary notices into languages other than English, and note what other languages will be available.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available

Prompts	State response
PR.Mod_7. Develop and modify systems	
Intent: To describe any system changes needed to implement premiums policies and meet reporting requirements	
7.1 Describe whether the state is planning to develop or enhance systems capabilities to accept and track premiums or account payments. If the state is using beneficiary accounts, describe systems changes needed to establish accounts.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available.
7.2 Describe any systems modifications that the state is planning in order to operationalize compliance actions.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available
7.3 Describe any other significant systems modifications the state is planning to operationalize premium or account contribution requirements.	The State is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available

3. Relevant documents

Please provide any additional documentation or information that the state deems relevant to plans for the successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

In addition, the state should use this section to provide additional details not captured in the STCs regarding implementation of the other demonstration policies, such as incentives for healthy behaviors, non-applicability of retroactive eligibility, copayments for the non-emergent use of the emergency department, and non-applicability of hospital presumptive eligibility and non-emergency medical transportation (NEMT).

Other Eligibility and Coverage Policies	
Policy areas	**State response**
Section_3.1. Healthy Behavior Incentives	The state is still working on details of this element which is part of the Phase 3 release on July 1, 2024. The State will provide additional details in an updated implementation plan when available.
Section_3.2. Non-applicability of Retroactive Eligibility	Coverage in Pathways is prospective only and begins with the first day of CMO enrollment. No retroactive coverage or assistance in paying prior months' medical bills will be provided to individuals enrolling in Pathways.
Section_3.3. Copayments for Non-Emergent Use of the Emergency Department (ED)	The State will not charge copays to Pathways members until the Phase 3 release on July 1, 2024, when the MRA is implemented. Members enrolled in Pathways will be subject to copayments. Copayments will not be assessed at the point of service and will not be collected by providers. Instead, copayments will be assessed retrospectively for services already received and will be deducted from the MRA. Individuals enrolled in the Mandatory HIPP program will have their cost-sharing obligations, including copayments and deductibles, made on their behalf by the State. Copayments for Non- Emergent Use of the Emergency Department (ED) will follow the same process as other copayments. Once subject to copayments, Pathways members will be noticed of the copayment amount incurred due to Non-Emergent Use of the ED and of their right to appeal the copayment deduction in their CMO Welcome Packet. No payment will be made by the member at the point of service in the ED. This deduction will be waived for any beneficiary who contacts their CMO's 24-hour nurse hotline 48 hours prior to utilizing the hospital ED. The hospital will bill the CMO for the visit and will be paid according to their contract with no

Other Eligibility and Coverage Policies	
Policy areas	**State response**
	copayment deduction. The CMO/MRA vendor will debit the MRA for the Non-Emergent Use of the ED copayment. A non-emergent visit will be defined using the 99281 CPT code. ER codes range from 99281 through 99285, with 99281 being the least intensive. Once a non-emergent visit is identified, notice will be sent to the member, noting that the visit was identified as non-emergent and stating that the member will have appeal rights to indicate the emergency nature of the visit. If a member appeals the decision and indicates that they were not counseled at the hospital at the time of the visit regarding non-emergent use, this will be grounds for a successful appeal.
Section_3.4. Non-Applicability of Hospital Presumptive Eligibility and Non-Emergency Medical Transportation (NEMT)	Per the STCs, the State will waive hospital presumptive eligibility for Pathways members. Eligibility in Pathways is prospective and has a qualifying activities requirement, which is not practicable for hospitals to evaluate. The State will maintain the State Plan benefits for Pathways members, except for NEMT. Members enrolled in the Mandatory HIPP program will have a different benefit package based on the insurance offered by their employer.

Attachment E:
Monitoring Protocol (reserved)