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

State Demonstrations Group

June 25, 2025

Kelly Cunningham
Medicaid Administrator
Illinois Department of Healthcare and Family Services
201 South Grand Ave. East
Springfield, IL 62763-0001

Dear Administrator Cunningham:

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 Illinois Continuity of Care and Administrative Simplification (Project Number 11-W-00341/5) 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 Illinois Continuity of Care and Administrative Simplification demonstration will transition to annual monitoring reporting effective June 25, 2025. The next annual monitoring report will be due on June 29, 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 24, "Monitoring Reports," monitoring reports "must follow the framework provided by CMS, which is subject to change as monitoring systems are developed / evolve and be provided in a structured manner that supports federal tracking and analysis." 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 27 "Monitoring Calls" describes, CMS may "convene periodic conference calls with the state," and the calls are intended "to discuss ongoing demonstration operation, to include (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 Illinois Continuity of Care and Administrative Simplification 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: Courtenay Savage, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER LIST

NUMBER: **11-W-00341/5**

TITLE: **Illinois Continuity of Care and Administrative Simplification**

AWARDEE: **Illinois Department of Healthcare and Family Services (HFS)**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project January 19, 2021 through December 31, 2025. In addition, this waiver may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waiver of state plan requirements contained in section 1902 of the Act is granted in order to enable the State of Illinois to carry out the Continuity of Care and Administrative Simplification section 1115 demonstration.

1. **Hospital Presumptive Eligibility (HPE)** **1902(a)(47)(B)**

   To the extent necessary, to enable the state to not implement a hospital presumptive eligibility program to permit hospitals to make presumptive eligibility determinations for individuals. The state will continue to operate Medicaid presumptive eligibility for children and pregnant women under the Medicaid state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: **11-W-00341/5**

TITLE: **Illinois Continuity of Care and Administrative Simplification**

AWARDEE: **Illinois Department of Healthcare and Family Services (HFS)**

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Illinois for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from April 12, 2021 through December 31, 2025, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The Secretary of Health and Human Services has determined that the Illinois Continuity of Care and Administrative Simplification section 1115 demonstration, including the granting of the expenditure authority described below, is likely to assist in promoting the objectives of title XIX of the Act.

The following expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Illinois to operate this section 1115(a) demonstration.

1. **Demonstration Operations for Automatic Reenrollment into the Managed Care Organization (MCO)**. Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Illinois managed care plans will be required to meet all requirements of section 1903(m) of the Act except the following:
    a. Section 1903(m)(2)(H), along with 42 CFR 438.56(g), to allow automatic re-enrollment into the enrollee's prior managed care organization when a Medicaid beneficiary loses Medicaid eligibility due to failure to complete the renewal process and is redetermined eligible, without a new application, if he/she submits redetermination paperwork documentation within 90 days after termination. This expenditure authority does not impact the requirements under 42 CFR 438.56(c)(2)(iii), which allows a beneficiary to request disenrollment if a temporary loss of eligibility caused the beneficiary to miss the annual disenrollment opportunity.

2. **Expenditures for Benefits for Postpartum Women**. Expenditures for Medicaid state plan benefits to extend the postpartum eligibility period from 60 days to 12 months, as described in the STC 16.

3. **Expenditures for Continuous Eligibility for Postpartum Benefits:** Expenditures for individuals enrolled in the Benefits for Postpartum Women group to be continuously eligible without regard to changes in income through the end of the 12 month extended postpartum eligibility period as set forth in STC 16.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00341/5**

TITLE: **Illinois Continuity of Care and Administrative Simplification**

AWARDEE: **Illinois Department of Healthcare and Family Services (HFS)**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Illinois Continuity of Care and Administrative Simplification section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Illinois Department of Healthcare and Family Services (HFS) (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act ("the Act"), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those state plan populations affected by the demonstration are effective from April 12, 2021 through December 31, 2025, unless otherwise specified.

The STCs have been arranged into the following subject areas:

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Interim and Summative Evaluation Reports
Attachment C: Evaluation Design (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

The objectives of the Illinois Continuity of Care and Administrative Simplification section 1115(a) demonstration is to provide quality care and improve health outcomes to Medicaid beneficiaries as well as reduce administrative burdens through care coordination and continuity of care initiatives. This amendment aims to increase and strengthen overall coverage and improve the health of certain new mothers in Illinois, as well as reduce the rate of maternal mortality in the state by addressing continuity of care for women postpartum.

The programs within this demonstration promote Medicaid objectives by:

- This demonstration will assist Illinois in providing continuity of care to beneficiaries whose coverage was terminated for failure to return their renewal form or other required information at renewal by automatically enrolling them in the same managed care plan they were previously enrolled in as long as the beneficiary submits their Medicaid redetermination paperwork within 90 days from the date of termination;

- This demonstration will enable Illinois to focus its administrative resources on processing full Medicaid applications and redeterminations rather than spending administrative resources on implementing a hospital presumptive eligibility program; and

- This demonstration will provide Medicaid coverage to women for 12 months inclusive of the 60-day postpartum period under the state plan, even if they no longer meet the applicable income standards during any portion of that period. This coverage aims to increase and strengthen overall coverage and improve the health of certain new mothers in Illinois, as well as reduce the rate of maternal mortality in the state by addressing continuity of care for women postpartum.

Under the Illinois Continuity of Care and Administrative Simplification section 1115(a) demonstration, the state will have the authority to allow beneficiaries whose coverage was terminated for failure to complete the renewal process to automatically reenroll into their prior Medicaid managed care plans (MCO) without requiring a new application if the individual subsequently returns their redetermination paperwork within 90 days of their date of termination as well as the authority to waive Hospital Presumptive Eligibility (HPE) requirements to test the efficacy of doing so. Under the postpartum amendment, the demonstration provides Medicaid coverage to women for 12 months inclusive of the 60-day postpartum period. This coverage aims to increase and strengthen overall coverage and improve the health of certain mothers.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes**. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (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 Patient Protection and Affordable Care Act (Section 1557).

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy**. All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulations, and Policy**. The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP 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 as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business 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 necessary to comply with such change, as well as a modified allotment neutrality worksheet 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 earlier of 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 or XXI state plan amendment (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is

affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

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 MCS 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 or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. 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 which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    d. An up-to-date CHIP allotment worksheet, if necessary;

    e. The state must provide updates to existing demonstration reporting and 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 of the state in accordance with the requirements of 42 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 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 the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

   b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, 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 calendar days after CMS approval of the transition and phase-out plan.

   d. Transition and Phase-out Procedures: The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all

applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition,

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. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must 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 waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. **Adequacy of Infrastructure.** The state will 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 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 funds 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 must 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 or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS 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 46.104(d)(5).

IV. ELIGIBILITY AND BENEFITS

16. **Eligibility Groups Affected by the Demonstration.** The state will extend the postpartum eligibility period from 60 days to 12 months for:

    a. Women enrolled in the Medicaid pregnant women group whose 60-day postpartum period is ending; and

    b. Women enrolled in any Medicaid eligibility group (other than the pregnant women group) who have household income up to 208 percent of the FPL and whose 60-day postpartum period is ending.

    The state of Illinois will transition or enroll eligible postpartum women into the Benefits for Postpartum Women demonstration group until the end of the month in which the 12-month period after the end of the pregnancy ends. The women will remain enrolled continuously regardless of changes in income through the duration of the extended postpartum period

    The state will integrate eligibility, verification, and redetermination processes for the Benefits for Postpartum Women demonstration group into the state's eligibility and

enrollment system in accordance with section 1943 of the Act.

At the end of the extended postpartum eligibility period for individuals enrolled in the demonstration, the state will complete any required renewal or redetermination due to a change in circumstance in order to redetermine Medicaid eligibility, including on all other bases prior to determining the individual ineligible and terminating coverage, consistent with 42 CFR 435.916.

17. **Waiver of Hospital Presumptive Eligibility (HPE).** This demonstration provides a waiver of the HPE requirement under section 1902(a)(47)(B) to promote continuity of care by encouraging timely submission of full benefit Medicaid applications, and reducing processing times by avoiding the administrative complexities involved with the implementation of an HPE program.

V. COST SHARING

18. **Cost Sharing.** This demonstration does not change the Medicaid benefit package design. There is no new cost sharing, copayments, or coinsurance for any benefit provided under this demonstration. State plan benefits will continue to be applied in accordance with the state plan and all eligibility groups will continue to receive all state plan benefits.

VI. DELIVERY SYSTEMS

19. **Delivery System**. The demonstration delivery system does not differ from the Medicaid and/or CHIP plan, except as discussed below.

20. **Managed Care Reinstatement when a Medicaid Beneficiary Submits Late Paperwork within 90 Day.** The demonstration allows the state to reinstate a beneficiary into their previous managed care plan if the beneficiary submits his/her Medicaid redetermination paperwork within 90 days of a loss in Medicaid eligibility.

VII. GENERAL REPORTING REQUIREMENTS

21. **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 singly 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 current demonstration period. 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 submissions 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 plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of 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 with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

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

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

23. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

24. Monitoring Reports. The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual 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 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 provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. The operational updates will focus on progress toward meeting the demonstration's milestones. 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 goals, and must cover all key policies under this demonstration. This should include, but not be limited to, data related to the waiver of hospital presumptive eligibility and metrics related to beneficiary re-enrollment into prior managed care plans under this demonstration. The performance metrics will also reflect all other components of the state's demonstration. 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, and grievances and appeals. The monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 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 should be reported separately.

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.

25. Corrective Action Plan Related to Monitoring. 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 and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. 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.

26. 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 close-out report must comply with the most current guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the close-out report.

c. The state must take into consideration CMS's 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'S 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 21.

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

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

28. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must 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 Monitoring Report.

VIII. EVALUATION OF THE DEMONSTRATION

29. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 21.

30. 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 accordance with the CMS-approved Evaluation Design. The independent party will also support the state in the development of the 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.

31. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after the approval of the demonstration. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs, and any

applicable CMS technical assistance on applying robust evaluation approaches, including establishing appropriate comparison groups and assuring causal inferences in demonstration evaluations.

32. **Evaluation Budget.** A budget for the evaluations must 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 evaluations 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 designs are not sufficiently developed, or if the estimates appear to be excessive.

33. **Evaluation Design Approval and Updates.** The state must submit the revised draft Evaluation Designs within sixty (60) calendar days after receipt of CMS's comments. Upon CMS approval of the draft Evaluation Designs, the documents will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the evaluation designs and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

34. **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. The evaluation design must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and also its effectiveness in achieving the goals. The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation and Medicaid health service expenditures

    The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF). Hypotheses for waiver of hospital presumptive eligibility must relate to enrollment and enrollment continuity, and hypotheses for re-enrollment into a prior managed care plan must relate to continuity of coverage and care, and health outcomes.

35. Interim Evaluation Report. The state must submit an Interim Evaluation Report for each evaluation design, as applicable, and 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 Reports 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 a description of how the design was adapted should be included. If the state is not requesting a renewal for the demonstration, the 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 a revised Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website.

e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

36. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs. The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within eighteen (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 must submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.

b. Upon approval from CMS, the final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

37. 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 and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. 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.

38. **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.

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

40. **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. 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 on 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.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

41. **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.[1]

42. **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 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

[1] For a description of CMS's current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

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 thirty (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.

43. 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 X:

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.

44. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that the non-federal share is obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that such funds must not be used to match any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, CMS reserves the right to prohibit the use of any sources of non-federal share funding that it determines impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to fund the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

45. 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.

46. Financial Integrity for Managed Care and Other Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR §438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74.

b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR §447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

47. Requirements for health care related taxes and provider donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All health care-related taxes as defined by Section 1903 (w)(3)(A) of the Social Security Act and 42 CFR § 433.55 are broad-based as defined by Section 1903 (w)(3)(B) of the Social Security Act and 42 CFR § 433.68 (c).

b. All health care-related taxes are uniform as defined by Section 1903 (w)(3)(C) of the Social Security Act and 42 CFR § 433.68 (d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903 (w)(3)(E)(i) of the Social Security Act and 42 CFR § 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903 (w)(4) of the Social Security Act and 42 CFR § 433.68 (f).

e. All provider related-donations as defined by 42 CFR § 433.52 are bona fide as defined by Section 1903 (w)(2)(B) of the Social Security Act, 42 CFR § 433.66, and 42 CFR § 433.54.

48. 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.

49. 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 Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart

MEG	To Which BN Test	WOW Per Capita	WOW Aggregate	WW	Brief Description

Table 2: Master MEG Chart					
	Does This Apply?				
Benefits for Postpartum Women	Hypo 1	X		X	See Expenditure Authority #1
ADM	N/A	N/A	N/A	N/A	Additional administrative costs that are directly attributable to the demonstration

50. 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-00341/5). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (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 demonstration year will be offset against expenditures incurred in the demonstration year 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 Master MEG Chart table, 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 VIII, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting 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 1: MEG Detail for Expenditure 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
Benefits for Postpartum Women	The expenditures associated with Benefits for Postpartum Women 10-months beyond the	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Yes	4/12/2021	12/31/2025

	60-day postpartum period.							
ADM	Additional administrative costs that are directly attributable to the demonstration	N/A	Follow CMS-64.10Base Category of Service Definitions	Date of payment	ADM	No	1/1/2021	12/31/2025

51. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 2: Demonstration Years

Demonstration Year	Start Date	End Date
DY 1	April 12, 2021	December 31, 2021
DY 2	January 1, 2022	December 31, 2022
DY 3	January 1, 2023	December 31, 2023
DY 4	January 1, 2024	December 31, 2024
DY 5	January 1, 2025	December 31, 2025

52. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months 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 X. CMS will provide technical assistance, upon request.[2]

[2] 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 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.

53. 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. **54. 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 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 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. The state certifies that the data it provided to establish the budget neutrality expenditure limit 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. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

55. 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.

56. 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 demonstration 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.

57. 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 project 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.

58. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

59. 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, as a part of this demonstration approval. 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.

a. **Hypothetical Budget Neutrality Test 1: Benefits for Postpartum Women** 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.

Demonstration Eligibility Group (PMPM Costs)	Trend Rate	DY1	DY2	DY3	DY4	DY5
Benefits for Postpartum Women	5.4 %	$390.85	$411.96	$434.21	$457.66	$482.37

60. 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 Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

61. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from April 12, 2021 to December 31, 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.

62. 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 6: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	**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

63. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Due Date	Deliverable	STC
30 calendar days after approval date	State acceptance of demonstration waiver, expenditure authority, and STCs	Approval letter
180 calendar days from the demonstration approval date	Draft Evaluation Design	STC 31
60 calendar days after receipt of CMS comments on the Draft Evaluation Design	Revised Draft Evaluation Design	STC 33
30 calendar days after CMS Approval	Approved Evaluation Design published to state's website	STC 33
December 31, 2025 or With renewal application	Draft Interim Evaluation Report	STC 35
60 calendar days after receipt of CMS comments on the Draft Interim Evaluation Report	Revised Interim Evaluation Report	STC 35
Within 18 months after December 31, 2025	Draft Summative Evaluation Report	STC 36

60 calendar days after receipt of CMS comments on the Draft Summative Evaluation Report	Revised Summative Evaluation Report	STC 36
Monthly Deliverables	Monitoring Call	STC 27
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports and Quarterly Expenditure Reports	STC 24
Annual monitoring reports due 90 calendar days after the end of each 4th quarter	Annual Monitoring Reports	STC 24

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.

CMS expects evaluation designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html. If the state needs technical assistance using this outline or developing the evaluation design, the state should contact its demonstration team.

Expectations for Evaluation Designs

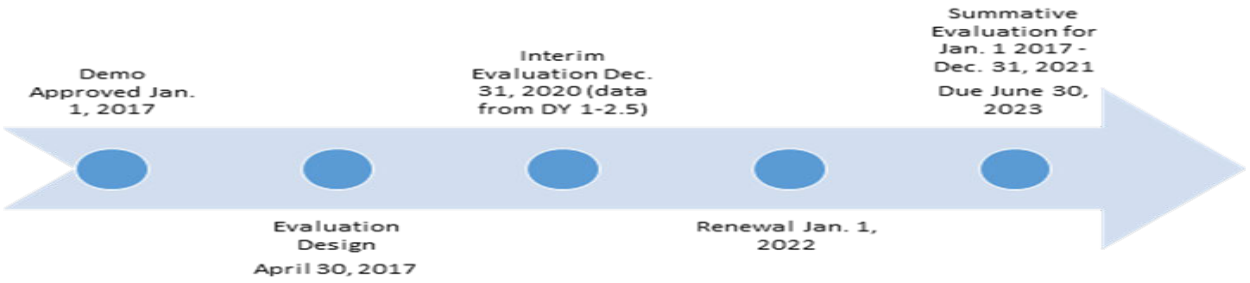
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, 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 for a 5-year demonstration). 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 thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

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

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

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

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

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

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

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

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

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

    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
    b. Qualitative analysis methods may be used, and must be described in detail.
    c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

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

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

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

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

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	-Patient survey	Descriptive statistics

		services within the last 6 months)		
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.

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

1. When the demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

G. Attachments

1. Independent Evaluator. This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.
2. Evaluation Budget. A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently

cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3. Timeline and Major Milestones. Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation Report in the timeline. 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 Interim and Summative Evaluation Reports

Introduction

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

Expectations for Evaluation 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

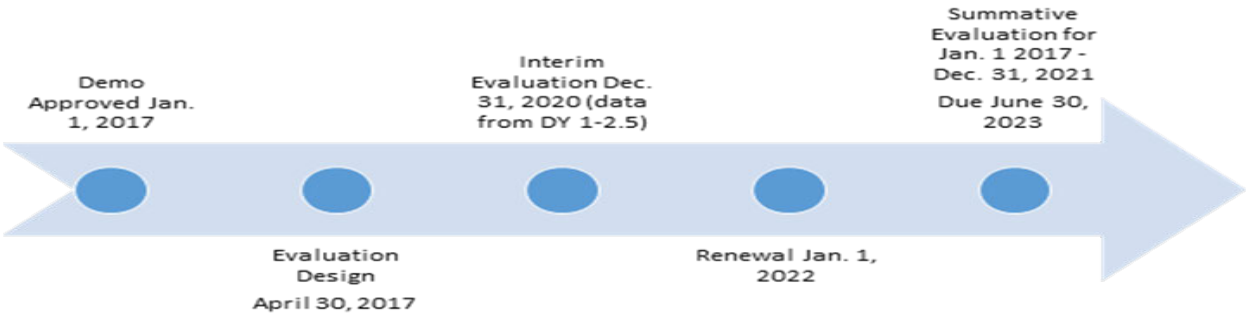
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved 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 for a 5-year demonstration). 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 Reports 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 evaluation 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 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 that may be interested in implementing a similar approach?

F. Attachment(s)

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

Attachment C: Evaluation Design (Reserved)

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

November 3, 2022

Theresa Eagleson
Director
Department of Healthcare and Family Services
201 South Grand Ave. East
Springfield, IL 62763-0002

Dear Ms. Eagleson:

On March 13, 2020, the President of the United States issued a proclamation that the Coronavirus Disease 2019 (COVID-19) outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (the Act) as amended (42 U.S.C. 1320b-5). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6:00 PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020.

In response to the section 1115(a) demonstration opportunity announced to states on March 22, 2020, in State Medicaid Director Letter (SMDL) #20-002,[1] and the guidance in State Health Official Letter (SHO) #22-001[2] as published on March 3, 2022, Illinois submitted a request for an amendment to the Illinois Continuity of Care and Administrative Simplification

[1] See SMDL #20-002, "COVID-19 Public Health Emergency Section 1115(a) Opportunity for States," available at https://www medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx.
[2] See SMDL #20-001, "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency," available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

section 1115(a) demonstration (Project Number 11-W-00341/5) to address the COVID-19 public health emergency (PHE) and to promote continuity of coverage during the unwinding of the COVID-19 PHE. CMS determined that the state's application is complete, consistent with the exemptions and flexibilities outlined in 42 CFR 431.416(e)(2) and 431.416(g).[3] CMS expects that states will offer, in good faith and in a prudent manner, a post-submission public notice process, including tribal consultation as applicable, to the extent circumstances permit. This letter serves as a time-limited approval of the state's requests, which will be approved as an amendment to the Illinois Continuity of Care and Administrative Simplification demonstration and which is hereby authorized retroactively from March 1, 2020, through the end of the COVID-19 PHE unwinding period or until all redeterminations are conducted during the unwinding period as discussed in SHO #22-001.

CMS has determined that the COVID-19 PHE amendment to the Illinois Continuity of Care and Administrative Simplification demonstration – including the Medicaid expenditure authority detailed below and in Attachment D – is necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE and to ensure renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage at the end of the COVID-19 PHE. The demonstration amendment is likely to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals who may be affected by COVID-19. This approval allows the state to align its policies for young adults in Medicaid and CHIP, and prevent gaps in coverage during the PHE. Additionally, this amendment ensures that the state can mitigate churn for eligible beneficiaries and smoothly transition individuals between coverage programs during the COVID-19 PHE unwinding period.

In addition, in light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President's declaration detailed above – and in consequence of the time-limited nature of this demonstration amendment – CMS did not require the state to submit budget neutrality calculations for this COVID-19 PHE amendment to the Illinois Continuity of Care and Administrative Simplification demonstration. In general, CMS has determined that the costs to the federal government are likely to have been otherwise incurred and allowable. Illinois will still be required to track demonstration amendment expenditures and will be expected to evaluate the connection between those expenditures and the state's response to the PHE and unwinding period, as well as the cost-effectiveness of those expenditures. Due to the highly limited scope of the changes under the amendment, CMS is incorporating this amendment as Attachment D to the Illinois Continuity of Care and Administrative Simplification special terms and conditions (STC).

[3] Pursuant to 42 CFR 431.416(g), CMS has determined that the existence of unforeseen circumstances resulting from the COVID-19 PHE warrants an exception to the normal state and federal public notice procedures to expedite a decision on a proposed COVID-19 section 1115 demonstration or amendment. States applying for a COVID-19 section 1115 demonstration or amendment are not required to conduct a public notice and input process. CMS is also exercising its discretionary authority to expedite its normal review and approval processes to render timely decisions on state applications for COVID-19 section 1115 demonstrations or amendments. CMS will post all section 1115 demonstrations approved under this COVID-19 demonstration opportunity on the Medicaid.gov website.

Request CMS is Approving at this Time

CMS is approving the Medicaid expenditure authority excerpted below, from March 1, 2020 through the end of the COVID-19 PHE unwinding period, or until all redeterminations are conducted during the unwinding period as discussed in SHO #22-001.

> **Continuous Coverage for Individuals Aging Out of CHIP**. Expenditures to provide continued eligibility for CHIP enrollees who turned 19 during the public health emergency (and therefore lost eligibility for CHIP due to age).

Monitoring and Evaluation Requirements

The state must submit an Evaluation Design to CMS within 60 days of the demonstration amendment approval. CMS will provide guidance on an Evaluation Design specifically for the Medicaid expenditure authority approved for the COVID-19 emergency, including any amendments. The state is required to post its Evaluation Design to the state's website within 30 days of CMS approval of the Evaluation Design, per 42 CFR 431.424(e).

Given the unique circumstances and time-limited nature of this demonstration amendment, CMS expects Illinois to undertake data collection and analyses that are meaningful, but not unduly burdensome for the state. Specifically, the state can focus on qualitative methods and descriptive data to address evaluation questions that will support understanding the successes, challenges, and lessons learned in implementing the demonstration amendment.

The state is required to submit a Final Report. The Final Report will consolidate monitoring and evaluation reporting requirements for this demonstration authority. The state must submit this Final Report no later than one year after the end of the COVID-19 section 1115 demonstration authority. The Final Report will capture data on the demonstration amendment implementation, lessons learned, and best practices for similar situations. Per 42 CFR 431.428(a), for each year of the PHE demonstration authority, the state is required to complete an annual report for this component, and the state should submit all applicable requirements stipulated for an annual report (e.g., administrative difficulties in the operation of the demonstration, issues and/or complaints identified by beneficiaries about the health care delivery system under the demonstration, any state legislative developments that may impact the demonstration) in the Final Report. CMS will provide additional guidance on the structure and content of the Final Report.

Approval of this demonstration amendment is subject to the limitations specified in the approved expenditure authority and the enclosed Attachment D to the STCs. The state may deviate from its Medicaid state plan requirements only to the extent specified in the approved expenditure authority and the STCs for the demonstration. This approval is conditioned upon continued compliance with the previously approved STCs, which set forth in detail the nature, character, and extent of anticipated federal involvement in the project.

The award is subject to CMS receiving written acceptance of this award within 15 days of the date of this approval letter. Your project officer is Jonathan Morancy. Mr. Morancy is available to answer any questions concerning implementation of the state's section 1115(a) demonstration amendment and his contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: Jonathan.Morancy@cms.hhs.gov

We appreciate your state's commitment to addressing the significant challenges posed by the COVID-19 pandemic, and we look forward to our continued partnership on the Illinois Continuity of Care and Administrative Simplification section 1115(a) demonstration. If you have any questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

Enclosure

cc: Courtney Savage, State Monitoring Lead, Medicaid and CHIP Operations Group

Attachment D

Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment

Expenditure Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall be regarded as expenditures under section 1903 of the Act, for the period from March 1, 2020, through the end of the COVID-19 PHE unwinding period, or until all redeterminations are conducted during the unwinding period.

1. **Continuous Coverage for Individuals Aging Out of CHIP**. Expenditures to provide continued eligibility for CHIP enrollees who turn 19 during the public health emergency (and therefore lost eligibility for CHIP due to age).

Monitoring and Evaluation Requirements

1. **Evaluation Design.** The state must submit an Evaluation Design to CMS within 60 days of the demonstration amendment approval. The state is required to post its Evaluation Design to the state's website within 30 days of CMS approval of the Evaluation Design, per 42 CFR 431.424(e). CMS will provide technical assistance to help the state fulfill the monitoring and evaluation requirements, including in developing the Evaluation Design. Given the unique circumstances and time-limited nature of this demonstration amendment, CMS expects Illinois to undertake data collection and analyses that are meaningful, but not unduly burdensome for the state. Specifically, the state can focus on qualitative methods and descriptive data to address evaluation questions that will support understanding the successes, challenges, and lessons learned in implementing the demonstration amendment

2. **Final Report.** The state is required to submit a Final Report. The Final Report will consolidate monitoring and evaluation reporting requirements for this demonstration amendment authority. The state must submit this final report no later than one year after the end of the COVID-19 section 1115 demonstration authority. The Final Report will capture data on the demonstration amendment implementation, lessons learned, and best practices for similar situations. For each year that the state is required to complete an annual report per 42 CFR 431.428(a), the state may submit all applicable information in the Final Report.

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

May 4, 2023

Theresa Eagleson
Director
Department of Healthcare and Family Services
201 South Grand Ave. East
Springfield, IL 62763-0002

Dear Theresa Eagleson:

Illinois submitted the Reasonable Opportunity Period (ROP) Extension COVID-19 Public Health Emergency (PHE) section 1115 demonstration application on March 17, 2023. This letter serves as a time-limited approval of the request included in the state's ROP Extension COVID-19 PHE section 1115 demonstration application, which will be approved as an amendment under the Illinois Continuity of Care and Administrative Simplification section 1115(a) demonstration (Project Number 11-W-00341/5). This authority is effective from the date the state begins its unwinding period and lasts for up to 15 months.

In response to the section 1115(a) demonstration opportunity announced to states on March 22, 2020 in State Medicaid Director Letter (SMDL) #20-002[1], as well as the 2022 State Health Official Letter (SHO) #22-001, offering the ROP 1115 opportunity[2], Illinois submitted on March 17, 2023, a section 1115 COVID-19 demonstration application to address the COVID-19 PHE currently expected to end on May 11, 2023.[3] CMS has determined that the state's application is complete and, consistent with the exemptions and flexibilities outlined in 42 C.F.R. 431.416(e)(2) and 431.416(g).[4] CMS expects that states will offer, in good faith and in a prudent manner, a post-submission public notice process, including tribal consultation as applicable, to the extent circumstances permit.

[1] See SMDL #20-002, "COVID-19 Public Health Emergency Section 1115(a) Opportunity for States," available at https://www medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx.
[2] SHO #22-001, "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency," available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.
[3] https://aspr hhs.gov/legal/PHE/Pages/COVID19-9Feb2023.aspx
https://www.hhs.gov/about/news/2023/02/09/letter-us-governors-hhs-secretary-xavier-becerra-renewing-covid-19-public-health-emergency html
[4] Pursuant to 42 C.F.R. §.431.416(g), CMS has determined that the unforeseen circumstances resulting from the COVID-19 PHE warrant an exception to the normal state and federal public notice procedures to expedite a decision on a proposed COVID-19 section 1115 demonstration. States applying for a COVID-19 section 1115 demonstration are not required to conduct a public notice and input process. CMS is also exercising its discretionary authority to expedite its normal review and approval processes to render timely decisions on state applications for COVID-19 section 1115 demonstrations. CMS will post all section 1115 demonstrations approved under this COVID-19 demonstration opportunity on the Medicaid.gov website.

This amendment will test, in the context of the COVID-19 PHE unwinding period, how the expenditure authority to provide coverage beyond the statutorily limited 90-day ROP for individuals who have declared to U.S. citizenship, but for whom that status has not been verified, will support state's management of workload during the unwinding period in a manner that promotes continuity of coverage and reduces barriers to care, in line with the objectives of the Medicaid program. The amendment requires that the state develop an Evaluation Design, expected for submission to CMS within 180 calendar days after the approval of the demonstration amendment. The design will support an evaluation that will advance the state and CMS's understanding of the successes and challenges in implementing the expenditure authority in the wake of the COVID-19 PHE and help inform best practices for similar situations in the future.

CMS has determined that this demonstration amendment – including the expenditure authority detailed below – addresses the state's needs in managing workload during the unwinding period to conduct renewals and other eligibility and enrollment actions (including outstanding verifications). As such, the authority would help support the objectives of the Medicaid program related to ensuring access to care and coverage while the state is returning to normal operations.

Consistent with the expectations outlined in the State Health Official (SHO) Letter #22-001, this demonstration amendment supports states in their efforts to restore routine eligibility and enrollment operations when the PHE ends, including conducting renewals of eligibility for all beneficiaries, in a manner that promotes continuity of coverage and establishes a sustainable workload in future years.[5] The ROP Extension demonstration assists states in processing eligibility and enrollment actions during the unwinding period by providing additional time to complete outstanding verifications to prevent inappropriate terminations of coverage, which may not be possible for those whose declared U.S. citizenship status has not been verified or whose status is inconsistent with available data sources absent this demonstration. Furthermore, this demonstration supports parity with existing policy that allows states to, through a state plan amendment, implement a good faith extension of the ROP for individuals who have attested to a satisfactory immigration status.[6]

This extension allows the state to maintain coverage for individuals declaring to be U.S. citizens if the agency has not been able to verify the individual's status through available electronic data sources, if the agency determines that the individual is making a good faith effort to obtain any necessary documentation, or to assist the individual in obtaining documents needed to verify their status. This extension also supports the need to ensure individuals in an ROP understand what is being required of them to establish their eligibility; and ensures parity with the option available to states in order to provide a good faith extension during an ROP provided to verify immigration status.

The expenditure authority would allow the state to extend the ROP during the unwinding period which is likely to facilitate an equitable application of the verification policies and processes for

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[5] SHO #22-001, "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency," available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[6] 42 C.F.R. 435.956(b)(2)(ii)(B).

individuals who have declared to U.S. citizenship and individuals who have declared to satisfactory immigration status. States can utilize the good faith extension permitted under existing regulatory authority at 42 C.F.R. 435.956(b)(2)(ii)(B) and implemented under the state plan to extend the ROP for individuals who have declared to satisfactory immigration status to align with and manage their eligibility and enrollment workload, including outstanding verifications, during the unwinding period.

To achieve the same goal of assisting states in aligning and managing their eligibility and enrollment workload when the PHE ends, states will need expenditure authority to continue processing verifications of individuals who have declared to U.S. citizenship for 15 months beginning with the first month of a state's unwinding period. These 15 months include a state's 12-month unwinding period as described in SHO 22-001, plus three additional months for the state to complete its verification of U.S. citizenship for an individual whose case comes up for processing in month 12 of the unwinding period. For any given individual, the authority to extend the ROP will terminate 3 months after the state initiates the verification for the individual. At the end of the verification process for a specific individual, if the state is either unable to verify an individual's status or determines the individual is not a U.S. citizen, the state must take action to terminate eligibility within 30 days in accordance with section 1902(ee)(1)(B)(ii)(III) of the Act and 42 C.F.R. 435.956(b)(3), and provide notice and fair hearing rights in accordance with 42 C.F.R. 431 subpart E.

To that end, the expenditure authority during the unwinding period is expected to help maintain access to care for individuals in an ROP, and state alignment and management of the workload to conduct redeterminations and other eligibility actions. This authority allows the state to maintain coverage for individuals declaring to be U.S. citizens if the agency has not been able to verify the individual's status through available electronic data sources, if the agency determines that the individual is making a good faith effort to obtain any necessary documentation, or to assist the individual in obtaining documents needed to verify his/her status.

Expenditure Authority

CMS is approving expenditure authority for the state, for up to 15 months beginning with the first day of the first month of the state's unwinding period, to provide coverage beyond the 90-day ROP provided under section 1902(ee)(1)(B)(ii), for individuals who have declared to U.S. citizenship, but for whom that status has not been verified, and are otherwise eligible for Medicaid. This expenditure authority allows for coverage of individuals who have been in an ROP beginning on March 18, 2020 or at any time thereafter during the PHE, and who have had their coverage maintained in order to comply with the continuous enrollment condition under section 6008(b)(3) of the Families First Coronavirus Response Act.

This expenditure authority exempts the state from compliance with the requirements under section 1902(ee)(1)(B)(ii)(II) of the Act and allows Illinois to maintain coverage for individuals declaring to be U.S. citizens if the agency needs more time to verify the individual's status through available electronic data sources, if the agency determines that the individual is making a good faith effort to obtain any necessary documentation, or to assist the individual in obtaining documents needed to verify their status. At the end of the verification process, if the individual's U.S. citizenship is either unable to be verified or is determined to not be a U.S. citizen, the state

must take action to terminate eligibility within 30 days in accordance with 1902(ee)(1)(B)(ii)(III) of the Act and 42 C.F.R. 435.956(b)(3), and in accordance with part 42 C.F.R. 431 subpart E (relating to notice and fair hearing rights).

The authority ends no more than 15 months from the beginning with the first day of the first month of the state's unwinding period. This authority is available to the state from April 1, 2023 (the beginning of the state's unwinding period) and ends 15 months thereafter on June 30, 2024. These 15 months include the state's 12-month unwinding period, plus three months for the state to complete the verification of U.S. citizenship for an individual whose case comes up for renewal in month 12 of the unwinding period. For any given individual, the authority to extend the ROP will terminate 3 months after the state initiates a renewal (or other eligibility action) for the individual.

Monitoring and Evaluation

Given the scope and time-limited nature of this demonstration amendment, and recognizing the challenges associated with the COVID-19 PHE, including the substantial work the state would be undertaking during the unwinding period, CMS has streamlined the monitoring and evaluation expectations for this demonstration amendment. As it is still important to gather evidence regarding the operation and effectiveness of this amendment, the approval of this expenditure authority requires that Illinois undertake data collection and analyses that are meaningful but not unduly burdensome for the state during and after this unprecedented public health emergency, while also being consistent with the applicable provisions of 42 CFR 431.424 and 431.428. In effect, CMS expects the state to accommodate a qualitative assessment of the expenditure authority with applicable descriptive and contextual data. The state is required to prepare an Evaluation Design and a Final Report. The Final Report will consolidate the amendment's monitoring and evaluation requirements. The draft Evaluation Design will be due to CMS within 180 calendar days after approval of the amendment. The draft Final Report will be due to CMS 18 months after the expiration of the amendment approval period.

CMS will provide technical assistance to help the state fulfill the monitoring and evaluation requirements, including developing the Evaluation Design. CMS expects that the Evaluation Design will be a brief outline of the state's plans to evaluate the demonstration amendment. The evaluation will support understanding the successes, challenges, and lessons learned in implementing the demonstration amendment, to help inform best practices for similar situations in the future. The state may use evaluation questions that would provide information and understanding about: the populations affected by the expenditure authority under this amendment; the relevant policies and procedures that would support reducing barriers to care; challenges associated with implementing the amendment and engaging with individuals in an ROP as well as mechanisms and experiences overcoming these challenges, as applicable; and principal lessons learned for any future PHEs. The Final Report should also outline any challenges and limitations that might be encountered in the planning and conduct of the monitoring and evaluation activities. Since the expenditure authority would last more than one year (i.e., 15 months), the state is also required to satisfy 42 CFR 431.428 by ensuring that the Final Report captures all applicable requirements stipulated for an annual report (e.g., incidence and results of any audits, investigations or lawsuits, or any state legislative developments that may impact the demonstration). Per 42 C.F.R. 431.420(f), the state must comply with any requests for data from CMS or its federal evaluation contractors. Once approved, per 42 C.F.R.

431.424(e), the state is required to post the Evaluation Design to its Medicaid agency website within 30 calendar days of CMS approval. Likewise, per the standard Public Access requirement associated with section 1115 demonstration deliverables, the state will post the CMS-approved Final Report to its website within 30 calendar days of CMS approval.

Other Information

Approval of this demonstration amendment is subject to the limitations specified in the approved expenditure authority. The state may deviate from its Medicaid state plan requirements only to the extent specific in the approved expenditure authority and the enclosed STCs for the demonstration. Approval of this expenditure authority is conditioned upon compliance with the previously approved special terms and conditions, which set forth in detail the nature, character and extent of anticipated federal involvement in the project.

In addition, the approval is subject to CMS receiving written acceptance of this award within 15 days of the date of this approval letter. Your project officer is Jonathan Morancy. Mr. Morancy is available to answer any questions concerning implementation of the state's section 1115(a) demonstration and his contact information is as follows:

Centers for Medicare & Medicaid Services
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Mail Stop S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: Jonathan.Morancy@cms.hhs.gov

We appreciate your state's commitment to addressing the significant challenges posed by the COVID-19 pandemic, and we look forward to our continued partnership on the Continuity of Care and Administrative Simplification demonstration. If you have any questions regarding this approval, please contact Ms. Mehreen Rashid, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

Enclosure

cc: Courtenay Savage, State Monitoring Lead, Medicaid and CHIP Operations Group