DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

April 6, 2021

Kate Massey
Director
State of Michigan, Medical Services Administration
400 South Pine Street
Lansing, MI 48913

Dear Ms. Massey:

On February 18, 2021, the Centers for Medicare & Medicaid Services (CMS) sent you a letter regarding the December 21, 2018 extension of the section 1115 demonstration project entitled "Healthy Michigan Plan" (Project Number 11-W-00245/5). The letter advised that CMS would commence a process of determining whether or not to withdraw the authorities previously approved in the Healthy Michigan Plan demonstration that permit the state to require work and other community engagement activities as a condition of Medicaid eligibility. It explained that in light of the ongoing disruptions caused by the COVID-19 pandemic, Michigan's community engagement requirement risks significant coverage losses and harm to beneficiaries. For the reasons discussed below, CMS is now withdrawing approval of the community engagement requirement in the December 21, 2018 extension of the Healthy Michigan Plan, which is not currently in effect and which would have expired by its terms on December 31, 2023.

Section 1115 of the Social Security Act (the Act) provides that the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act. In so doing, the Secretary may waive Medicaid program requirements of section 1902 of the Act, and approve federal matching funds per section 1115(a)(2) for state spending on costs not otherwise matchable under section 1903 of the Act, which permits federal matching payments only for "medical assistance" and specified administrative expenses.[1] Under section 1115 authority, the Secretary can allow states to undertake projects to test changes in Medicaid eligibility, benefits, delivery systems, and other areas across their Medicaid programs that the Secretary determines are likely to promote the statutory objectives of Medicaid.

As stated in the above referenced letter sent on February 18, 2021, under section 1115 and its implementing regulations, CMS has the authority and responsibility to maintain continued oversight of demonstration projects in order to ensure that they are currently likely to assist in promoting the objectives of Medicaid. CMS may withdraw waivers or expenditure authorities if it "find[s] that [a] demonstration project is not likely to achieve the statutory purposes." 42 C.F.R. § 431.420(d); see 42 U.S.C. § 1315(d)(2)(D).

As the February 18, 2021 letter explained, the Healthy Michigan Plan community engagement requirement is not in effect. Although implementation began in January 2020, it was halted by court order in March 2020. The early evidence for Michigan, especially considered in light of

[1] 42 U.S.C. § 1315.

the COVID-19 pandemic and its expected aftermath, makes clear that the Healthy Michigan Plan community engagement requirement is infeasible. In addition, implementation of the community engagement requirement is currently prohibited by the Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, Div. F, § 6008(a) and (b), 134 Stat. 208 (2020), which conditioned a state's receipt of an increase in federal Medicaid funding during the pandemic on the state's maintenance of certain existing Medicaid parameters. Michigan has chosen to claim the 6.2 percentage point FFCRA Federal Medical Assistance Percentage (FMAP) increase, and therefore, while it does so, must maintain the enrollment of beneficiaries who were enrolled as of, or after, March 18, 2020.

The February 18, 2021 letter noted that, although the FFCRA's bar on disenrolling such beneficiaries will expire after the COVID-19 public health emergency ends, CMS still has serious concerns about testing policies that create a risk of substantial loss of health care coverage and harm to beneficiaries even after the expiration of the bar on disenrolling beneficiaries. The COVID-19 pandemic has had a significant impact on the health of Medicaid beneficiaries. Uncertainty regarding the current crisis and the pandemic's aftermath, and the potential impact on economic opportunities (including job skills training, work and other activities used to satisfy the community engagement requirement, i.e., work and other similar activities), and access to transportation and affordable child care, have greatly increased the risk that implementation of the community engagement requirement approved in this demonstration will result in substantial coverage loss In addition, the uncertainty regarding the lingering health consequences of COVID-19 infections further exacerbates the harms of coverage loss for Medicaid beneficiaries.

Accordingly, the February 18, 2021 letter indicated that, taking into account the totality of circumstances, CMS had preliminarily determined that allowing the community engagement requirement to take effect in Michigan would not promote the objectives of the Medicaid program. Therefore, CMS provided the state notice that we were commencing a process of determining whether to withdraw the authorities approved in the Healthy Michigan Plan demonstration that permit the state to require work or other community engagement activities as a condition of Medicaid eligibility. See Special Terms and Conditions ¶ 11. The letter explained that if CMS ultimately determined to withdraw those authorities, it would "promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date." *Id*. The February 18, 2021 letter indicated that, if the state wished to submit to CMS any additional information that in the state's view may warrant not withdrawing those authorities, such information should be submitted to CMS within 30 days. We have not received any additional information from Michigan in response to the February 18, 2021 letter.

In light of these concerns, for the reasons set forth below, CMS has determined that, on balance, the authorities that permit Michigan to require community engagement as a condition of eligibility are not likely to promote the objectives of the Medicaid statute. Therefore, we are withdrawing those authorities that were added in the December 21, 2018 extension approval of the Healthy Michigan Plan demonstration.

Background of Michigan's Demonstration

Michigan's demonstration was originally approved by CMS in January 2004 as the "Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver)," and provided a limited ambulatory benefit package to previously uninsured, low-income non-pregnant childless adults ages 19 to 64 years with incomes at or below 35 percent of the federal poverty level (FPL) who were not eligible for Medicaid.

In December 2009, the Adult Benefits Waiver was reauthorized as a new Medicaid section 1115 demonstration. On December 30, 2013 CMS approved an amendment that transitioned the Adults Benefits Waiver demonstration to the Healthy Michigan Plan demonstration, beginning April 1, 2014. As of that date, the state expanded Medicaid to cover the new adult group (beneficiaries authorized under 1902(a)(10)(a)(i)(VIII) of the Act) through Medicaid state plan authority. Concurrent with the implementation of Medicaid expansion, the amendment to the demonstration allowed the state to charge premiums to beneficiaries in the new adult group with income above 100 percent of the FPL, not to exceed two percent of their household income. In addition, a "MI Health Account" was established for each beneficiary enrolled in a Medicaid managed care plan to track beneficiaries' contributions and how they were expended. Beneficiaries were allowed opportunities to reduce their regular monthly premiums or copayments by demonstrating achievement of specified healthy behaviors.

On December 21, 2018, CMS approved an amendment as part of the demonstration's extension, requiring most new adult group beneficiaries, ages 19 to 62, with certain exemptions, to complete and timely report 80 hours per month of community engagement activities, such as employment, education directly related to employment, job training, job search activities, participation in substance use disorder treatment (SUD), and community service, as a condition of continued Medicaid eligibility. Beneficiaries who were non-compliant with the community engagement requirement for three months in a 12-month period would be disenrolled at the end of the fourth month and subject to a one month lock-out, unless the beneficiary could demonstrate good cause for the failure or that he or she qualifies for an exemption, or satisfy the community engagement requirement by reporting completion of 80 hours in the fourth month. An individual disenrolled for noncompliance could regain coverage within the same 12-month period if he or she completed 80 hours of qualifying activities in a calendar month prior to re-applying for coverage. The demonstration's Special Terms and Conditions specified that the community engagement requirement was not authorized to be implemented sooner than January 1, 2020.

Early Experience from the Community Engagement Requirement in Michigan

Early experience with the community engagement requirement in Michigan and other states with similar demonstrations indicates that such a requirement risks rapid coverage loss.

Under the Healthy Michigan Plan demonstration, beneficiaries were required to comply with the community engagement requirement beginning January 1, 2020. On March 4, 2020, the U.S. District Court for the District of Columbia vacated the approval of the requirement that was

authorized in the demonstration extension, prior to the disenrollment and lock-out penalties taking effect.

Within the short span of the policy's implementation, 80,000 beneficiaries, or about 1 in 3 of those subject to the community engagement requirement, were at risk of loss of coverage for failing to report compliance with the community engagement requirement.[2,3,4] Further underscoring these figures, Michigan projected that 100,000 beneficiaries subject to the community engagement requirement would have been disenrolled within the first year of implementation.[5] The magnitude and proportion of such coverage losses based on this count of 100,000 represent the high end of the 6 to 17 percent coverage loss that Kaiser Family Foundation researchers forecasted could result from implementing community engagement requirements nationwide.[6]

Despite the high rate of noncompliance during the first month of the demonstration, one study estimates that all but a small minority of Medicaid expansion beneficiaries in Michigan were either working or were ill or disabled (and therefore should have qualified for an exemption from the community engagement requirement).[7] According to research from the Kaiser Family Foundation using the Current Population Survey (CPS) data,[8] in Michigan, 62 percent (63 percent nationally) of Medicaid beneficiaries aged 19 to 64 without Supplemental Security Income (SSI) in 2019 were working, and of those who were not working in Michigan, 34 percent (27 percent nationally) indicated that their reason for not working was due to illness or disability. While data for Michigan were too limited to be conclusive, over half of Medicaid beneficiaries not working nationally indicated they were caretaking or attending school. Under Michigan's community engagement requirement, illness, disability, and caregiving were qualifying exemptions, and educational activities were qualifying community engagement activities. Accordingly, these data suggest that the vast majority of beneficiaries subject to Michigan's

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[2] Wagner, J., & Schubel, J. (2020). States' experiences confirming harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[3] Norris L. (2020). Michigan and the ACA's Medicaid expansion. Retrieved from: https://www.healthinsurance.org/michigan-medicaid/#enrollmen

[4] Eggert, D. (2020). Federal judge invalidates Medicaid work requirements in Michigan. Detroit Free Press. Retrieve from https://www.freep.com/story/news/local/michigan/2020/03/04/federal-judge-invalidates-michigan-medicaid-work-requirements/4952261002/

[5] Michigan Department of Human and Health Services (DHS). (2020). Michigan Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-healthy-michigan-qtrly-rpt-jan-mar-2020.pdf

[6] Garfield, R., Rudowitz, R. & Musumeci, M. (2018). Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses. Kaiser Family Foundation. Retrieved from https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/

[7] Garfield, R., Rudowitz, R., Guth, M., Orgera, K., & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/

[8] Garfield, R., Rudowitz, R., Guth, M., Orgera, K., & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-appendix-2/

community engagement requirement who were not working were otherwise meeting or exempt from the community engagement requirement.

Notwithstanding state assurances in the demonstration's Special Terms and Conditions that Michigan would provide the necessary outreach to Medicaid beneficiaries, experience from the state shows significant challenges with outreach efforts to educate beneficiaries about the community engagement requirement, which could have resulted in significant coverage losses.[9, 10,11] It has been reported that Michigan made a substantial investment of $28 million in beneficiary outreach efforts and other implementation activities to help beneficiaries comply with the community engagement requirement before the requirement took effect in January 2020. While even more costly investments were slated to be made before the court decision halting the requirement, based on the initial data on reporting non-compliance from the state, it does not appear that the state's outreach initiatives were effective.

As previously noted, based on the study from the Kaiser Family Foundation, nearly everyone who was targeted by the community engagement requirement in Michigan already met the requirement or was exempt from it, so there was little margin for the program to increase work or community engagement among beneficiaries.[12] This is consistent with research indicating more generally that most Medicaid beneficiaries are already working or are likely to be exempt from a potential community engagement requirement.[13,14,15,16] For example, the study from the Kaiser Family Foundation cited above found that 81 percent of adults with Medicaid coverage live in families with a working adult, and 6 in 10 are working themselves.[17] Similarly, a study

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[9] Wagner, J., & Schubel, J. (2020). States' experiences confirming harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[10] Bagley, N. (2019). "Opinion: Enforcing Work Requirements is a Waste," The Detroit News. Retrieved from https://www.detroitnews.com/story/opinion/2019/12/05/opinion-enforcing-work-requirements-waste/2608089001/

[11] Eggert, D. (2020). Federal judge invalidates Medicaid work requirements in Michigan. Detroit Free Press. Retrieve from https://www.freep.com/story/news/local/michigan/2020/03/04/federal-judge-invalidates-michigan-medicaid-work-requirements/4952261002/

[12] Garfield, R., Rudowitz, R., Guth, M., Orgera, K., & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-appendix-2/

[13] Garfield, R., Rudowitz, R., Guth, M., Orgera, K., & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/

[14] Huberfeld, N. (2018). Can work be required in the Medicaid program? N Engl J Med;378:788-791. DOI: 10.1056/NEJMp1800549

[15] Goldman, A.L., Woolhandler, S, Himmelstein, D.U., Bor, D.H. & McCormick, D. (2018). Analysis of work requirement exemptions and Medicaid spending. JAMA Intern Med, 178:1549-1552. DOI:10.1001/jamainternmed.2018.4194

[16] Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center of Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed

[17] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from

published in 2017 found that, out of the 22 million adults covered by Medicaid nationwide (representing 58 percent of all adults on Medicaid) who could be subject to a community requirement designed like that in the Healthy Michigan Plan demonstration, 50 percent were already working, 14 percent were looking for work, and 36 percent were neither working nor looking for work.[18] For those beneficiaries not working or looking for work, 29 percent indicated that they were caring for a family member, 17 percent were in school, and 33 percent noted that they could not work because of a disability (despite excluding from analysis those qualifying for Medicaid on the basis of disability, highlighting the difficulty with disability determination), with the remainder citing layoff, retirement, or a temporary health problem.

Thus, overall, prior to the pandemic, the available data indicated that the substantial majority of the population that would be targeted by a community engagement requirement like in Michigan's demonstration were already meeting the terms of such a requirement or would qualify for an exemption from it. This makes it challenging for community engagement requirements to produce any meaningful impact on employment outcomes by incentivizing behavioral changes in a small fraction of beneficiaries, all the while risking substantial coverage losses among those subject to the requirements.

In addition to Michigan, some early data on potential enrollment impacts of a community engagement requirement as a condition of Medicaid eligibility are available for Arkansas and New Hampshire.[19] And the initial data from these two states are in accord with the Michigan experience.[20] Experience from these states indicate that large portions of the beneficiaries who were subject to these states' community engagement requirements failed to comply with the community engagement reporting requirements or became disenrolled once the requirements were implemented. In Arkansas, for instance, before the court halted the community engagement requirement, the state reported that from August 2018 through December 2018, a total of 18,164 individuals were disenrolled from coverage for "noncompliance with the work requirement."[21] During these five months, the monthly rate of coverage loss as a percentage of those who were required to report work and community engagement activities fluctuated between 20 and 47 percent.[22] Moreover, according to Sommers et al. (2020), in Arkansas, those

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https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[18] Leighton Ku, L & Brantley, E. (2017). Medicaid Work Requirements: Who's At Risk? Health Affairs Blog. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20170412.059575/full/

[19] Utah and Indiana also briefly implemented the community engagement requirement that was part of these states' section 1115 demonstrations, but the program designs in these states did not require beneficiaries subject to the community engagement requirement to comply with reporting minimum-hours requirement within the period the requirement was in effect in each state.

[20] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from https://aspe.hhs.gov/system/files/pdf/265161/medicaid-waiver-evidence-review.pdf

[21] Arkansas Department of Human Services (DHS). (2018 & 2019). Arkansas Works Section 1115 Demonstration Annual Reports. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf; https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-annl-rpt-jan-dec-2019.pdf

[22] Arkansas Department of Human Services (DHS). (2018). Arkansas Works Section 1115 Demonstration Annual Report: January 1, 2018 – December 31, 2018. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-

ages 30–49 who had lost Medicaid or Marketplace coverage in the prior year experienced significantly higher medical debt and financial barriers to care, compared to similar Arkansans who maintained coverage.[23] Specifically, 50 percent of Arkansans affected by disenrollment in that age group reported serious problems paying off medical bills; 56 percent delayed seeking health care and 64 percent delayed taking medications because of cost considerations.[24] These rates were all significantly higher than among individuals who retained coverage in Medicaid or Marketplace all year. Evidence also indicates that those with chronic conditions were more likely to lose coverage,[25] which could lead to worse health outcomes in the future. And in New Hampshire, almost 17,000 beneficiaries (about 40 percent of those subject to the community engagement requirement, and representing one-third of the demonstration's total enrollment) were set to be suspended for non-compliance and lose Medicaid coverage within the span of just over a month when that state's community engagement requirement was in effect.[26,27,28] Based on that early data, another study projected that between 30 and 45 percent of New Hampshire's beneficiaries subject to the community engagement requirement would have been disenrolled within the first year of implementation.[29]

Parallel to the difficulties in Michigan with beneficiary outreach efforts, there was evidence of widespread confusion and lack of awareness among demonstration beneficiaries in Arkansas and New Hampshire, as well.[30] Moreover, in all three states, evidence suggests that even individuals who were working or those who had serious health needs, and therefore should have been

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Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf

[23] Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. Health Affairs, 39(9), 1522-1530. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538

[24] Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. Health Affairs, 39(9), 1522-1530. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538

[25] Chen, L. & Sommers, B.D. (2020). Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018. American Journal of Public Health, 110, 1208-1210. DOI https://doi.org/10.2105/AJPH.2020.305697

[26] Wagner, J., & Schubel, J. (2020). States' experiences confirming harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[27] New Hampshire Department of Health and Human Services. (2019). DHHS Community Engagement Report: June 2019. Retrieved from https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf

[28] Hill, I., Burroughs, E., & Adams, G. (2020). New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results. Urban Institute. Retrieved from https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results

[29] The Commonwealth Fund Blog. (2019). New Hampshire's Medicaid Work Requirements Could Cause More Than 15,000 to Lose Coverage. Retrieved from https://www.commonwealthfund.org/blog/2019/new-hampshires-medicaid-work-requirements-could-cause-coverage-loss

[30] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from https://aspe.hhs.gov/system/files/pdf/265161/medicaid-waiver-evidence-review.pdf

eligible for an exemption, lost coverage or were at risk of losing coverage because of complicated administrative and paperwork requirements.[31]

In all states, consistent and stable employment is often out of reach for beneficiaries who might be subject to a community engagement requirement. Many low-income beneficiaries face a challenging job market, which often offers only unstable or low-paying jobs with unpredictable or irregular hours, sometimes resulting in spells of unemployment, particularly in seasonal work.[32,33,34,35] The Healthy Michigan Plan demonstration's rigid requirement for reporting 80 or more hours every month is a concern even for low-income adults who are working. For example, 46 percent of this group nationally, as well as 25 percent of those working as many as 1,000 hours during a year (which would be sufficient for meeting the 80-hour monthly requirement), could be at risk of losing coverage for one or more months because they would not meet the 80-hour minimum requirement in every month.[36,37]

Furthermore, research examining the outcomes of statutorily authorized work requirements in other public assistance programs, such as Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP), indicates that such requirements generally have only modest and temporary effects on employment, failing to increase long-term employment or reduce poverty.[38,39,40] Additionally, studies have found that imposing work requirements in the SNAP program led to substantial reductions in enrollment, even after

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[31] Wagner, J., & Schubel, J. (2020). States' Experiences Confirm Harmful Effects of Medicaid Work Requirements. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements

[32] Butcher, K. & Schanzenbach, D. (2018). Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in

[33] Center on Budget and Policy Priorities. (2020). Taking Away Medicaid for Not Meeting Work Requirements Harms Low-Wage Workers. Retrieved from https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-low-wage-workers

[34] Gangopadhyaya, A., Johnston, E., Kenney, G. & Zuckerman, S. (2018). Kentucky Medicaid Work Requirements: What Are the Coverage Risks for Working Enrollees? Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/98893/2001948_kentucky-medicaid-work-requirements-what-are-the-coverage-risks-for-working-enrollees.pdf

[35] New Hampshire Fiscal Policy Institute. (2019). Medicaid Work Requirements and Coverage Losses. Retrieved from https://nhfpi.org/resource/medicaid-work-requirements-and-coverage-losses/

[36] Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center of Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed

[37] Aron-Dine, A., Chaudhry, R. & Broaddus, M. (2018). Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements. Retrieved from https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements

[38] Katch, H., Wagner, J. & Aron-Dine, A. (2018). Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce

[39] Danziger, S.K., Danziger, S., Seefeldt, K.S. & Shaefer, H.L. (2016). From Welfare to a Work-Based Safety Net: An Incomplete Transition. Journal of Policy Analysis & Management, 35(1), 231-238. DOI: https://doi.org/10.1002/pam.21880

[40] Pavetti, L. (2016). Work Requirements Don't Cut Poverty, Evidence Shows. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows

controlling for changes in unemployment and poverty levels.[41] In fact, evidence suggests that there were large and rapid caseload losses in selected areas after SNAP work requirements went into effect, similar to what early data from Arkansas show, and what appeared would likely to happen in New Hampshire and Michigan after these states began implementing community engagement requirements, if those states' community engagement requirements had been implemented long enough to reach the scheduled suspensions or disenrollments.

Therefore, existing evidence from states that have implemented community engagement requirements through Medicaid demonstrations, evidence from other public programs with work requirements, and the overall work patterns and job market opportunities for the low-income adults who would be subject to such requirements all highlight the potential ineffectiveness of community engagement requirements at impacting employment outcomes for the target population. And while there are variations in the design and implementation of community engagement requirements in each state that has implemented such a requirement, as well as differences in employment and economic opportunities, findings from the states that implemented community engagement requirements point in the general direction of coverage losses among individuals subject to such requirements.

Thus, CMS is not aware of any reason to expect that the community engagement requirement as a condition of eligibility in Michigan's Medicaid demonstration project would have a different outcome in the future than what was observed during the initial implementation of such a requirement in other states, or suggested by Michigan's own early experience with implementing the community engagement requirement, when 80,000 beneficiaries, or about 33 percent of those subject to the requirement, were at risk of disenrollment for non-compliance within just the first few weeks. Accordingly, there is risk that Michigan's demonstration project, as extended and amended in December 2018, will lead to substantial coverage losses, a risk that is exacerbated by the ongoing COVID-19 public health emergency and its likely aftermath.

Impact of COVID-19 and its Aftermath

The COVID-19 pandemic and the uncertainty surrounding the long-term effects on economic activity and opportunities across the nation exacerbate the risks associated with tying a community engagement requirement to eligibility, making Michigan's community engagement requirement infeasible under the current circumstances. There is a substantial risk that the COVID-19 pandemic and its aftermath will have a negative impact on economic opportunities

[41] Ku, L., Brantley, E. & Pillai, D. (2019). The Effects of SNAP Work Requirements in Reducing Participation and Benefits From 2013 to 2017. American Journal of Public Health 109(10), 1446-1451. DOI: https://doi.org/10.2105/AJPH.2019.305232. Retrieved from https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305232

for Medicaid beneficiaries. If employment opportunities are limited, Medicaid beneficiaries may find it difficult to obtain paid work in the aftermath of the COVID-19 pandemic.[42,43]

As discussed above, prior to the pandemic, most adult Medicaid beneficiaries who did not face a barrier to work were working full or part-time.[44] However, one in three working adult Medicaid beneficiaries was doing only part-time work prior to the COVID-19 public health emergency, often due to fewer opportunities for full-time employment. The pandemic is expected to only have aggravated the challenges of finding full-time employment, along with causing greater obstacles from lack of childcare options or increased caregiving responsibilities.[45]

Moreover, during the pandemic, the different sectors of the economy have seen disparate levels of disruption, which has affected labor market outcomes for certain populations more than the others. While the national employment rate[46] declined by 10.2 percent from January 2020 to January 2021, employment rates for workers in the bottom wage quartile decreased by a larger percentage than for workers in the highest wage quartile across that time period (28.7 percent vs. 1.7 percent).[47] In Michigan, employment rates for low-wage earners (i.e., annual wages under $27,000) declined by 30 percent, compared to virtually no change in employment rates for high-wage earners (i.e., wages above $60,000 per year) from January 2020 to January 2021.[48]

Further, declines in employment have been much higher for Black and Hispanic women and for workers in several low-wage service sectors, such as hospitality and leisure, while workers in other sectors, such as financial services, have seen virtually no change.[49] In April 2020, the estimated unemployment rates (including individuals who were employed but absent from work and those not in the workforce but who wanted employment) for the Black and Hispanic populations were as high as 32 and 31 percent, respectively, compared to 24 percent for the

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[42] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[43] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

[44] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[45] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[46] Not seasonally adjusted.

[47] Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from www.tracktherecovery.org

[48] Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from www.tracktherecovery.org

[49] Rouse, C. (2021). The Employment Situation in February. The White House Briefing Room. Retrieved from https://www.whitehouse.gov/briefing-room/blog/2021/03/05/the-employment-situation-in-february/

White population.[50] Hispanic populations specifically are more likely to be affected due to their disproportionate representation in industries such as hospitality and construction, which have been most affected by the pandemic-related layoffs.[51,52,53]

Moreover, pandemic-related job and income losses have also been more acute among the low-income population—those with the least wherewithal to withstand economic shocks, and who are disproportionately enrolled in Medicaid.[54] In fact, 52 percent of lower income adults (annual income below $37,500) live in households where someone has lost a job or taken a pay cut due to the pandemic.[55] Understandably, households with a job or income loss were two-to-three times more likely to experience economic hardship than those who did not experience such a loss.[56,57] Fifty-nine percent of lower-income adults said they worry every day or almost every day about paying their bills.[58] There are also racial and ethnic disparities in the likelihood of reporting hardships; for example, compared to White households, Black households reported significantly higher chances of putting off filling prescriptions and difficulties making housing and other bill payments. Also, Hispanic households were more likely to experience food insecurity compared to White households.[59,60]

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[50] Fairlie, R., Couch, K. & Xu, H. (2020). The Impacts of COVID-19 on Minority Unemployment: First Evidence from April 2020 CPS Microdata. National Bureau of Economic Research. Retrieved from https://www.nber.org/system/files/working_papers/w27246/w27246.pdf

[51] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[52] Industries like health care and transportation have been less affected by the pandemic, and that has provided some cushion for black workers. See Despard et al. (2020).

[53] Krogstad, J.M., Gonzalez-Barrera, A. & Noe-Bustamante, L. (2020). U.S. Latinos among hardest hit by pay cuts, job losses due to coronavirus. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2020/04/03/u-s-latinos-among-hardest-hit-by-pay-cuts-job-losses-due-to-coronavirus/

[54] Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/

[55] Parker, K., Horowitz, J.M., & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/

[56] Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/

[57] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

[58] Parker, K., Horowitz, J.M., & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/

[59] Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/

[60] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

Existing disparities in access to computers and reliable internet may also exacerbate issues in finding and maintaining employment during the pandemic. For example, 29 percent of adults in households with annual incomes below $30,000 did not own a smartphone, and 44 percent did not have home broadband services in 2019.[61] Moreover, fewer than 8 percent of Americans with earnings below the 25th percentile have the capabilities to work remotely.[62] These disparities will result in fewer opportunities for beneficiaries to satisfy a community engagement requirement, particularly as more jobs have shifted to telework or "work from home" during the public health emergency. Therefore, implementation of the community engagement requirement approved in this demonstration increases the risk of coverage loss for these low-income individuals.[63,64]

The pandemic also has disproportionately impacted the physical and mental health of racial and ethnic minority groups, who already experience disparities in health outcomes. Racial minorities and people living in low-income households are more likely to work in industries that are considered "essential services," which have remained open during the pandemic.[65] Additionally, occupations with more frequent exposure to COVID-19 infections, and that require close proximity to others (such as personal care aides and bus drivers) employ Black individuals at higher rates than White individuals.[66] As a result, Black people may be at higher risk of contracting COVID-19 through their employment. The pandemic's mental health impact also has been pronounced among populations experiencing disproportionately high rates of COVID-19 cases and deaths. Specifically, Black and Hispanic adults have been more likely than White adults to report symptoms of anxiety and/or depressive disorder during the pandemic.[67]

Since the start of the pandemic, individuals have delayed or postponed seeking care, either due to concerns with out-of-pocket expenses or to avoid risk of contact with infected individuals in health care settings. For example, one study showed that screenings for breast, colon, prostate, and lung cancers were between 56 and 85 percent lower in April 2020 than in the previous

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[61] Anderson, M. & Kumar, M. (2019). Digital Divide Persists Even as Lower-Income Americans Make Gains in Tech Adoption. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/

[62] Maani, N., Galea, S. (2020). COVID-19 and Underinvestment in the Health of the US Population. The Milbank Quarterly. Retrieved from https://www.milbank.org/quarterly/articles/covid-19-and-underinvestment-in-the-health-of-the-us-population/

[63] Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/

[64] Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

[65] Raifman, M.A., & Raifman, J.R. (2020). Disparities in the Population at Risk of Severe Illness From COVID-19 by Race/Ethnicity and Income. American Journal of Preventive Medicine, 59(1), 137–139. https://doi.org/10.1016/j.amepre.2020.04.003

[66] Hawkins, D. (2020). Differential Occupational Risk for COVID-19 and Other Infection Exposure According to Race and Ethnicity. American Journal of Industrial Medicine, 63(9):817-820. DOI: 10.1002/ajim.23145

[67] Panchal, N., Kamal, R., Cox, C. & Garfield, R. (2021). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

year.[68] Results of another survey-based study show that 40 percent of respondents canceled upcoming health care appointments due to the pandemic, and another 12 percent reported they needed care but did not schedule or receive services.[69] These unmet health care needs may lead to substantial increases in subsequent mortality and morbidity.[70] In addition to the health consequences associated with delaying care, pandemic-related delays in seeking care are estimated to increase annual health care costs nationwide by a range of $30 to $65 billion.[71] The impact of the COVID-19 public health emergency on the economy has been significant, and, importantly, experience with previous recessions suggests the impact is likely to persist for an extended period of time. The unemployment rate went up from 3.5 percent in February 2020, prior to when the pandemic hit, to 14.8 percent in April 2020, and has subsequently fallen to 6.2 percent in February 2021.[72] The labor force participation rate (i.e., the percentage of the civilian non-institutional population age 16 or older who are working or actively seeking work during the prior month) likewise dipped from 63.3 percent in February 2020 to 60.2 percent in April 2020 only to recover somewhat to 61.4 percent in February 2021.[73] Compared to pre-pandemic conditions, these data suggest that the labor force is still down by approximately 4.24 million individuals.[74]

Evidence shows that losing a job can have significant long term effects on an individual's future earnings. Studies have found that workers who lose their jobs in mass layoffs still earn 20 percent less than similar workers who kept their jobs, 15 to 20 years after the layoff, and the impacts are greater for individuals who lose their jobs during a recession. On average, men lost 2.8 years of pre-layoff earnings when the mass layoff occurred in a time when the unemployment rate was above eight percent.[75] Further, workers who enter the labor market during a recession also face long-term consequences for their earnings.[76] Additionally, non-White individuals and

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[68] Patt, D., Gordan, L., Diaz, M., Okon, T., Grady, L., Harmison, M., Markward, N., Sullivan, M., Peng, J., Zhau, A. (2020). Impact of COVID-19 on Cancer Care: How the Pandemic Is Delaying Cancer Diagnosis and Treatment for American Seniors. JCO Clinical Cancer Informatics, 4, 1059-1071. DOI: 10.1200/CCI.20.00134. Retrieved from https://ascopubs.org/doi/full/10.1200/CCI.20.00134

[69] McKinsey & Company (2020). Understanding the Hidden Costs of COVID-19's Potential on U.S. Healthcare. Retrieved from https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-hidden-costs-of-covid-19s-potential-impact-on-us-healthcare#

[70] Chen, J. & McGeorge, R. (2020). Spillover Effects Of The COVID-19 Pandemic Could Drive Long-Term Health Consequences For Non-COVID-19 Patients. Health Affairs Blog, DOI: 10.1377/hblog20201020.566558. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20201020.566558/full/

[71] McKinsey & Company (2020). Understanding the Hidden Costs of COVID-19's Potential on U.S. Healthcare. Retrieved from https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-hidden-costs-of-covid-19s-potential-impact-on-us-healthcare#

[72] U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/cps/

[73] U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/cps/

[74] U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/web/empsit/cpseea08b.pdf

[75] Davis, S.J. & von Wachter, T. (2011). Recessions and the Costs of Job Loss. Brookings Papers on Economic Activity. Retrieved from https://www.brookings.edu/wp-content/uploads/2011/09/2011b_bpea_davis.pdf

[76] Schwandt, H. & von Wachter, T.M. (2018). Unlucky Cohorts: Estimating the Long-term Effects of Entering the Labor Market in a Recession in Large Cross-sectional Data Sets. NBER Working Paper 25141. Retrieved from https://www.nber.org/papers/w25141

individuals with lower educational attainment have experienced larger and more persistent earning losses than other groups who enter the labor market during recessions.[77]

Layoffs can also impact an individual's mortality and morbidity risks.[78] For example, workers experienced mortality rates that were 50-100 percent higher than expected in the year after a layoff occurred, and 20 years later, mortality rates remained 10-15 percent higher for these individuals.[79] Furthermore, workers experiencing layoff have reductions in health care utilization, especially among those who lose coverage, which suggests that access to coverage, and continuity of care, could be important in alleviating the long-term ill effects of layoffs on mortality.[80]

In summary, the short-to-long-term adverse implications of the COVID-19 pandemic on the economic opportunities for Medicaid beneficiaries, which have been aggravated further by challenges around shifting childcare and caregiving responsibilities as well as constraints on public transportation during the pandemic, heightens the risks of attaching a community engagement requirement to eligibility for coverage. In addition, the uncertainty regarding the lingering health complications of COVID-19 infections exacerbates the risk of potential coverage losses for Medicaid beneficiaries. The likely ramifications of losing timely access to necessary health care also can be long lasting. As such, CMS believes that the potential for coverage loss among Medicaid beneficiaries—especially from a requirement that is difficult for beneficiaries to understand and administratively complex for states to implement—would be particularly harmful in the aftermath of the pandemic, and makes the community engagement requirement impracticable.

Withdrawal of Community Engagement Requirement in the December 21, 2018 Extension of the Healthy Michigan Plan Demonstration

Based on the foregoing, and pursuant to our obligation under section 1115 of the Act to review demonstration projects and ensure they remain likely to promote the objectives of Medicaid, CMS has determined that, on balance, the extension approval authorizing Michigan to implement a community engagement requirement as a condition of eligibility is not likely to promote the objectives of the Medicaid program. At a minimum, in light of the significant risks and uncertainties described above about the adverse effects of the pandemic and its aftermath, the information available to CMS does not provide an adequate basis to support an affirmative judgment that the community engagement requirement is likely to assist in promoting the

[77] Schwandt, H. & von Wachter, T.M. (2018). Unlucky Cohorts: Estimating the Long-term Effects of Entering the Labor Market in a Recession in Large Cross-sectional Data Sets. NBER Working Paper 25141. Retrieved from https://www.nber.org/papers/w25141

[78] Banks, J., Karjalainen, H. & Propper, C. (2020). Recessions and Health: The Long-Term Health Consequences of Responses to the Coronavirus. Journal of Applied Public Economics. DOI: 10.1111/1475-5890.12230. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1111/1475-5890.12230

[79] Sullivan, D. & von Wachter, T. (2009). Job Displacement and Mortality: An Analysis Using Administrative Data. Quarterly Journal of Economics. Retrieved from http://www.econ.ucla.edu/tvwachter/papers/sullivan_vonwachter_qje.pdf

[80] Schaller, J., Stevens, A. (2015). Short-Run Effects of Job Loss on Health Conditions, Health Insurance, and Health Care Utilization. Journal of Health Economics, 43, 190-203. DOI: 0.1016/j.jhealeco.2015.07.003. Retrieved from https://www.sciencedirect.com/science/article/pii/S0167629615000788

objectives of Medicaid. Accordingly, pursuant to its authority and responsibility under applicable statutes and regulations to maintain ongoing oversight of whether demonstration projects are currently likely to promote those objectives, CMS is hereby withdrawing its approval of that portion of the December 21, 2018 extension that permits the state to require work and community engagement as a condition of eligibility under the Healthy Michigan Plan demonstration. The provisions of CMS's letter approving the December 21, 2018 extension and the corresponding provisions of the waivers and Special Terms and Conditions that authorize the community engagement requirement are withdrawn.

The withdrawal of these authorities is effective on the date that is thirty days after the date of this letter, unless the state timely appeals, as discussed below. The waivers, expenditure authorities, and Special Terms and Conditions reflecting this change are attached to this letter and will govern the Healthy Michigan Plan demonstration from the effective date of the withdrawal of the community engagement authorities until the demonstration expires on December 31, 2023.

As indicated in CMS's February 18, 2021 letter, CMS is also reviewing the other authorities that CMS previously approved in the Healthy Michigan Plan demonstration. That review remains ongoing. The state and CMS will work together to update the evaluation design, as needed, to reflect all the key policies that are implemented during the approval period. The current established timeline for the interim and summative evaluation reports will remain in effect. CMS looks forward to continuing to work with the state on the evaluation design, interim and summative evaluation reports.

Procedure to Appeal This Decision

In accordance with Special Terms and Conditions ¶ 11 and 42 C.F.R. § 430.3, the state may request a hearing to challenge CMS's determination prior to the above-referenced effective date by appealing this decision to the Departmental Appeals Board (DAB or Board), following the procedures set forth at 45 C.F.R. part 16. This decision shall be the final decision of the Department unless, within 30 calendar days after the state receives this decision, the state delivers or mails (the state should use registered or certified mail to establish the date) a written notice of appeal to the DAB.

A notice of appeal may be submitted to the DAB by mail, by facsimile (fax) if under 10 pages, or electronically using the DAB's electronic filing system (DAB E-File). Submissions are considered made on the date they are postmarked, sent by certified or registered mail, deposited with a commercial mail delivery service, faxed (where permitted), or successfully submitted via DAB E-File. The Board will notify the state of further procedures. If the state faxes its notice of appeal (permitted only if the notice of appeal is under 10 pages), the state should use the Appellate Division's fax number, (202) 565-0238.

To use DAB E-File to submit your notice of appeal, the state's Medicaid Director or its representative must first become a registered user by clicking "Register" at the bottom of the DAB E-File homepage, https://dab/efile.hhs.gov/; entering the information requested on the "Register New Account" form; and clicking the "Register Account" button. Once registered, the state's Medicaid Director or its representative should login to DAB E-File using the e-mail

address and password provided during registration; click "File New Appeal" on the menu; click the "Appellate" button; and provide and upload the requested information and documents on the "File New Appeal-Appellate Division" form. Detailed instructions can be found on the DAB E-File homepage.

Due to the COVID-19 public health emergency, the DAB is experiencing delays in processing documents received by mail. To avoid delay, the DAB strongly encourages the filing of materials through the DAB E-File system. However, should the state so choose, written requests for appeal should be delivered or mailed to U.S. Department of Health and Human Services, Departmental Appeals Board MS 6127, Appellate Division, 330 Independence Ave., S.W., Cohen Building Room G-644, Washington, DC 20201. Refer to 45 C.F.R. Part 16 for procedures of the Departmental Appeals Board.

The state must attach to the appeal request, a copy of this decision, note its intention to appeal the decision, a statement that there is no dollar amount in dispute but that the state disputes CMS's withdrawal of certain section 1115 demonstration authorities, and a brief statement of why the decision is wrong. The Board will notify the state of further procedures. If the state chooses to appeal this decision, a copy of the notice of appeal should be mailed or delivered (the state should use registered or certified mail to establish the date) to Judith Cash, Acting Deputy Director, Center for Medicaid and CHIP Services at 7500 Security Blvd, Baltimore, MD 21244.

If you have any questions, please contact Judith Cash at (410) 786-9686.

Sincerely,

[redacted]

Elizabeth Richter
Acting Administrator

CENTERS FOR MEDICARE & MEDICAID SERVICES
SERVICES WAIVER LIST

NUMBER: **11-W-00245/5**

TITLE: **Healthy Michigan Plan Section 1115 Demonstration**

AWARDEE: **Michigan Department of Health and Human Services**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived, shall apply to the demonstration project effective January 1, 2019 through December 31, 2023. In addition, these waivers 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 waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the Healthy Michigan Plan section 1115 demonstration.

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

To the extent necessary to enable the state to require monthly premiums for individuals eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act, who have incomes between 100 and 133 percent of the federal poverty level (FPL).

2. Statewideness **Section 1902(a)(1)**

To the extent necessary to enable the state to require enrollment in managed care plans only in certain geographical areas for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to restrict freedom of choice of provider for those eligible in the adult population described in section 1902(a)(10)(A)(i)(VIII) of the Act. No waiver of freedom of choice is authorized for family planning providers.

4. Proper and Efficient Administration **Section 1902(a)(4)**

To the extent necessary to enable the state to limit beneficiaries to enrollment in a single prepaid inpatient health plan or prepaid ambulatory health plan in a region or region(s) and restrict disenrollment from them.

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

To the extent necessary to enable the state to vary the premiums, cost-sharing and healthy behavior reduction options as described in these terms and conditions.

6. Provision of Medical Assistance **Section 1902(a)(8) and 1902(a)(10)**

To the extent necessary to enable Michigan to disenroll, and not make medical assistance available to, HMP beneficiaries with incomes above 100 percent of the FPL who have had 48 months of cumulative HMP eligibility and who do not complete a health risk assessment (HRA) or have not completed a healthy behavior, as described in these STCs, within the past twelve months.

7. Eligibility **Section 1902(a)(10)**

To the extent necessary to enable Michigan to disenroll, prohibit re-enrollment, and deny eligibility to HMP beneficiaries with income above 100 percent of the FPL who have had 48 months of cumulative HMP eligibility and who do not complete a HRA or have not completed a healthy behavior, as described in these STCs, within the past twelve months.

To the extent necessary to enable Michigan to disenroll, prohibit re-enrollment, and deny eligibility to HMP beneficiaries with income above 100 percent of the FPL who have had 48 months of cumulative HMP eligibility and who do not pay the monthly five percent premium, as described in these STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00245/5

TITLE: Healthy Michigan Plan Section 1115 Demonstration

AWARDEE: Michigan Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Healthy Michigan Plan" section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Michigan Department of Health and Human Services (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 (Act), which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. The Healthy Michigan Plan (HMP) demonstration will be statewide and is approved for a 5-year period, from January 1, 2019 through December 31, 2023. The demonstration provides approval for the state to require, beginning no sooner than January 1, 2020, (1) beneficiaries who have been enrolled in the demonstration more than 48 months to pay a monthly premium of five percent of income for continued eligibility, and (2) beneficiaries who have been enrolled in the demonstration more than 48 months to complete a health risk assessment (HRA) at redetermination or complete a healthy behavior in the previous 12 months, as a condition of eligibility.

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: Implementation Plan
Attachment D: Monitoring Protocol
Attachment E: Healthy Behaviors List

II. PROGRAM DESCRIPTION AND OBJECTIVES

In January 2004, the "Adult Benefits Waiver" (ABW) (21-W-00017/5) was initially approved and implemented as a Title XXI funded Section 1115 demonstration. The ABW provided a limited ambulatory benefit package to previously uninsured, low-income non-pregnant childless adults ages 19 through 64 years with incomes at or below 35 percent of the federal poverty level (FPL) who were not eligible for Medicaid. The ABW services were provided to beneficiaries through a managed healthcare delivery system utilizing a network of county administered health plans (CHPs) and Public Mental Health and Substance Abuse provider network.

In December 2009, Michigan was granted approval by CMS for a new Medicaid Section 1115 demonstration, entitled "Michigan Medicaid Non-pregnant Childless Adults Waiver (Adult Benefits Waiver)" (11-W-00245/5), to allow the continuation of the ABW health coverage program after December 31, 2009. Section 112 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) prohibited the use of Title XXI funds for childless adults' coverage after December 31, 2009, but allowed the states that were affected to request a new Medicaid demonstration to continue their childless adult coverage programs in 2010 and beyond using Title XIX funds. The new "Adult Benefits Waiver" demonstration allowed Michigan to continue offering the ABW coverage program through September 30, 2014, under terms and conditions similar to those provided in the original Title XXI demonstration.

On April 1, 2014, Michigan expanded its Medicaid program to include adults with income up to 133 percent of the FPL. To accompany this expansion, the Michigan "Adult Benefits Waiver" was amended and transformed to establish the HMP, through which the state intended to test innovative approaches to beneficiary cost sharing and financial responsibility for care for the new adult eligibility group, which was authorized under section 1902(a)(10)(A)(i)(VIII) of the Act (the "adult group"). Beneficiaries receiving coverage under the sunsetting ABW program transitioned to the state plan and the Healthy Michigan Plan on April 1, 2014. Individuals in the new adult population with incomes above 100 percent of the FPL are required to make contributions equal to two percent of their family income toward the cost of their health care. In addition, all newly eligible adults with income from 0 to 133 percent of the FPL are required to pay copayments through an account operated in coordination with the Medicaid Health Plan (MHP). A MI Health Account was established for each enrolled individual to track beneficiaries' contributions and how they were expended. Beneficiaries receive quarterly statements that summarized the MI Health Account funds balance and flows of funds into and

out of the account, and the use of funds for health care service copayments. Beneficiaries have opportunities to reduce their regular monthly contributions or average utilization based contributions by demonstrating achievement of recommended Healthy Behaviors. HMP beneficiaries receive a full health care benefit package as required under the Affordable Care Act, which includes all of the Essential Health Benefits and the requirements for an alternative benefit plan, as required by federal law and regulation, and there are no limits on the number of individuals who can enroll.

In September 2015, the state sought CMS approval of an amendment to HMP to implement additional directives contained in the state law (Public Act 107 of 2013). CMS approved the amendment on December 17, 2015, which effectuated the Marketplace Option, a premium assistance program for a subset of HMP eligible beneficiaries. However, the Marketplace Option was never implemented.

In December 2017, the state submitted an application to extend the HMP demonstration. In September 2018, the state submitted an additional application to amend certain elements of the HMP to comply with new state law provisions, and changes to eligibility for health care coverage and cost-sharing requirements for certain beneficiaries. The state also requested to end the Marketplace Option program. As approved, beneficiaries in the demonstration between 100 percent and 133 percent of the FPL who have had 48 months of cumulative eligibility for health care coverage through HMP will be required to pay premiums of five percent of income and have completed a health risk assessment (HRA) at their next redetermination or have engaged in specified healthy behaviors within the twelve- month period prior to the annual redetermination deadline as conditions of eligibility.

III. GENERAL PROGRAM REQUIREMENTS

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

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in federal law, regulation, and written policy, not expressly

waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

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

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

    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. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.

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

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

    a. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

    b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c. An explanation of the public process used by the state consistent with the requirements of STC 13; and,

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

8. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than twelve (12) months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

    a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a

notification letter and a draft transition and phase-out plan to CMS no less than six (6) 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 13, 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 transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility 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 comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. 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, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

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). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six (6) months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. Expiration Requirements. The state must include, at a minimum, in its demonstration authority expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities.

b. Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. 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, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider

comments received during the 30-day period during its review of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) calendar days after CMS approval of the demonstration authority expiration plan.

d. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

11. **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 waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the 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.

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

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

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

14. **Federal Financial Participation (FFP).** No federal matching for state expenditures under 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.

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

IV. ELIGIBILITY FOR THE DEMONSTRATION

16. **Eligibility Groups Affected By the Demonstration.** Only beneficiaries eligible for Medicaid under an eligibility group listed in Table 1 are subject to the provisions within this demonstration; these beneficiaries will be referred to as "HMP beneficiaries." State plan groups derive their eligibility through the Medicaid state plan, and coverage for this group is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs.

Table 1. Medicaid Eligibility Groups Affected by the Demonstration

Eligibility Group	Citations
New Adult Group	1902(a)(10)(A)(i)(VIII) 42 CFR 435.119

17. **Beneficiaries with income above 100 percent through 133 percent of the FPL and 48 Months of Eligibility.** In order to maintain eligibility for HMP, HMP beneficiaries enrolled in MHPs with income between 100 percent and 133 percent of the FPL, who have had 48 months of cumulative HMP eligibility since April 1, 2014, must**:**

    a. Complete all required questions on a HRA or have completed a healthy behavior in the prior 12 months, as described in STC 24; and

b. Pay a premium of five percent of income (in lieu of copayments, coinsurance, and similar payments), not to exceed limits defined in 42 CFR 447.56(f), as described in STC 23(a).

18. **Beneficiaries with income at or below 100 percent of the FPL and 48 months of Eligibility.** HMP beneficiaries with income at or below 100 percent of the FPL who have had 48 months of cumulative HMP eligibility from April 1, 2014 will continue to be subject to the cost-sharing responsibilities as described in STC 22(d).

V. BENEFITS

19. **Healthy Michigan Plan Benefits.** HMP beneficiaries will receive benefits as provided in the state's approved Alternative Benefit Plan for HMP.

VI. COST SHARING, CONTRIBUTIONS, AND HEALTHY BEHAVIORS

20. **Cost Sharing: General Requirements.** All cost sharing must be in compliance with Medicaid requirements that are set forth in federal statute, regulation, the state plan, and policies, except as modified by the waivers and STCs granted for this demonstration.

21. **MI Health Account**. The state may require each HMP beneficiary to have a MI Health Account that tracks and records beneficiary payments and liabilities.

22. **Cost Sharing for Beneficiaries with Fewer than 48 Cumulative Months in the HMP.** All HMP beneficiaries with fewer than 48 months of cumulative HMP eligibility from April 1, 2014, are subject to the following cost-sharing requirements:

    a. Copayments. All HMP beneficiaries with fewer than 48 months of cumulative eligibility in HMP are required to pay nominal copayment requirements as specified in the Medicaid state plan.

        i. Copayments during the initial six months of enrollment. During a beneficiary's first six months of enrollment in a MHP, there will be no copayments collected at the point of service for health plan covered services.

        ii. Quarterly copayments. At the end of the initial six-month enrollment period, the state will calculate an average monthly co-payment for the beneficiary, based on the beneficiary's first six months of enrollment. The beneficiary will be billed for his or her average monthly copayments only at the end of each quarter. Beneficiaries can be billed for copayment liability in any six month period after the first six months of enrollment. Maximum billed amounts must be equal to or less than the average of the beneficiary's incurred copayments for the previous six month period

(except for any reductions to copayments due to Healthy Behaviors, described in STC 22(b)). Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56.

b. Healthy Behaviors: Cost sharing reductions. Beneficiaries in this category are eligible to receive incentive payments to offset cost sharing liability via reductions in their copayment liability and a 50 percent reduction in their monthly contribution if certain healthy behaviors are maintained or attained (described in STC 24).

c. Cost-sharing: beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL. Beneficiaries in this category will be responsible for copayment liability based upon the prior six months of utilization for the beneficiary (see STC 22(b)) and a monthly contribution that shall not exceed two percent of income. In addition, reductions for healthy behavior incentives will be applied to the copayment liability (after the beneficiary has reached two percent of income in copayments), monthly contribution, or both, through the MI Health Account. Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter. No interest will be due on accrued copayment liability. Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56. No beneficiary with income from 100 percent of the FPL through 133 percent of the FPL and fewer than 48 cumulative months in the HMP may lose eligibility for Medicaid or be denied eligibility for Medicaid, be denied enrollment in a MHP or be denied access to services for failure to pay premiums or copayment liabilities.

d. Cost-sharing: beneficiaries with income at or below 100 percent of the FPL. Beneficiaries in this category will be responsible for copayment liability based upon the prior six months of copayment experience for the beneficiary (see STC 22(b)). Beneficiaries will be notified of the copayment liability by the provider, but will be billed for such copayments only at the end of quarter. No interest will be due on accrued copayment liability. In addition, reductions for healthy behavior incentives will be applied to the copayment liability due after the beneficiary has reached two percent of income in copayments. No premiums will be paid by this population. Beneficiary cost-sharing must be compliant with the rules established in 42 CFR 447.56. No beneficiary with income at or below 100 percent of the FPL will lose eligibility for Medicaid or be denied eligibility for Medicaid, be denied enrollment in a MHP or be denied access to services for failure to pay copayment liabilities.

23. Cost sharing for Beneficiaries with 48 or More Cumulative Months in the HMP. Effective on or after January 1, 2020 all HMP beneficiaries with 48 or more months of cumulative eligibility are subject to the following cost-sharing requirements:

a. Cost-sharing: beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL. Beneficiaries in this category are not subject to the copayment requirements specified in the Medicaid state plan and are not eligible for any cost-sharing reductions related to healthy behavior completion incentives. Instead, beneficiaries in this category are subject to a monthly premium requirement that shall not exceed five percent of income beginning the first day of the calendar month following the beneficiary's 48th month of cumulative HMP eligibility, but no earlier than January 1, 2020. Sixty days before a beneficiary reaches 48 months of cumulative enrollment, (or, for beneficiaries who have already reached 48 months of cumulative enrollment by January 1, 2020, 60 days prior to January 1, 2020), the beneficiary will be noticed of the five percent premium requirement. No sooner than 60 days after the invoice date of the missed premium, beneficiaries who fail to pay the monthly contribution will be terminated from coverage after proper notice. Disenrolled beneficiaries must pay the missed premium payment(s) accumulated by the beneficiary while enrolled prior to being re-enrolled, at which point the individual will be eligible to re-apply and begin receiving coverage, so long as the individual is otherwise eligible. Beneficiaries who are disenrolled as a result of non-payment of premiums but who, during that disenrollment, would become exempt from premiums or otherwise become eligible for Medicaid under an eligibility group not subject to the premium requirement, may re-enroll with an effective date consistent with the beneficiary's eligibility category without paying owed premiums.

b. Cost-sharing: beneficiaries with income at or below 100 percent of the FPL. Beneficiaries in this category will continue to be subject to the cost-sharing requirements described in STC 22(a) and 22(d).

24. Healthy Behaviors Incentives Program. The Healthy Behaviors Incentives Program incentivizes beneficiaries to engage in certain healthy behaviors. Beneficiaries who complete a HRA and agree to address or maintain healthy behaviors will receive an incentive described below. Incentives are reflected in a beneficiary's MI Health Account statement (as described in STC 21).

a. Beneficiaries with incomes at or below 100 percent of the FPL. Beneficiaries in this category who have paid two percent of their income in copayments are eligible for a 50 percent reduction in their copayment liability if certain healthy behaviors are maintained or attained.

b. Beneficiaries with incomes above 100 percent of the FPL through 133 percent of the FPL with less than 48 cumulative months in HMP. Beneficiaries in this category who have paid two percent of their income in copayments are eligible for a 50 percent reduction in their copayment liability. In addition,

beneficiaries are eligible for a 50 percent reduction in their monthly contribution if certain healthy behaviors are maintained or attained.

c. Beneficiaries with income above 100 percent of the FPL through 133 percent of the FPL with 48 or more cumulative months in HMP. Beneficiaries with 48 months of eligibility in this category must complete the required questions on a HRA or complete a healthy behavior prior to beneficiary's next redetermination as a condition of continued eligibility. Responses to questions on the HRA will not impact an individual's Medicaid eligibility. Beneficiaries will be sent individual written notices about the requirement 60 days before the beneficiary reaches 48 months cumulative enrollment. If a beneficiary does not complete an HRA or if the state cannot confirm completion of a healthy behavior (see Attachment E for the complete list of qualifying healthy behaviors) in the 12 months preceding the beneficiary's annual redetermination, then the beneficiary will be disenrolled from HMP and must complete an HRA prior to being re-enrolled, at which point the beneficiary will be eligible to re-enroll and begin receiving coverage the first day of the month in which the beneficiary applied. If a beneficiary fails to answer all required questions on the HRA, eligibility for the demonstration will be denied. Beneficiaries who are disenrolled as a result of non-completion of an HRA or a healthy behavior, but who, during that disenrollment, would become exempt from the healthy behavior requirement or otherwise become eligible for Medicaid under an eligibility group not subject to the healthy behavior requirement, may re-enroll with an effective date consistent with the beneficiary's eligibility category without completing a HRA or healthy behavior. Beneficiaries in this category will not receive any reductions in copayment liability or monthly contributions for completion of healthy behaviors.

25. Beneficiaries Exempt from the 48 Month Cost-Sharing and Healthy Behaviors Requirements.

a. American Indian/Alaska Natives and children under 21 years of age are exempt from paying premiums pursuant to 42 CFR 447.56(a), but will still be required to complete an HRA or complete an annual healthy behavior in order to remain on HMP.
b. Pregnant women are exempt from paying premiums pursuant to 42 CFR 447.56(a), and while they are encouraged to participate in the Healthy Behavior Incentives Program, they will not be subject to loss of eligibility for failure to comply with the HRA or annual healthy behavior requirement.
c. Beneficiaries who are identified or self-report as medically frail, as described in 42 CFR 440.315, will be exempt from paying premiums and from the requirement to complete an HRA or complete an annual healthy behavior.
d. Beneficiaries who are not enrolled in a MHP are exempt from the premiums and from the requirement to complete an HRA or complete an annual healthy behavior.

e. Beneficiaries who are enrolled in the Flint Michigan section 1115 demonstration are exempt from the premiums and from the requirement to complete an HRA or complete an annual healthy behavior.

26. Premiums: State Assurances. The state shall:

a. Permit the state's premium vendor to attempt to collect the unpaid premiums from the beneficiary, but the state's premium vendor may not report the premium amount owed to credit reporting agencies, place a lien on a beneficiary's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the beneficiary's earnings for enrollees at any income level. The state will not "sell" the obligation for collection by a third-party. Further, while the amount is collectible by the state, re-enrollment is not conditioned upon repayment, except for beneficiaries described in STC 23(a);
b. Monitor that beneficiaries do not incur household cost sharing and premiums that, combined, exceed five percent of the aggregate household income, in accordance with 42 CFR 447.56(f);
c. Ensure that the state, or its designee, does not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing are considered an administrative expense by the state;
d. Ensure that all payments from the beneficiary, or on behalf of the beneficiary, are accurately credited toward unpaid premiums in a timely manner, and provide the beneficiary an opportunity to review and seek correction of the payment history;
e. Ensure that the state has a process to refund any premiums paid for a month in which the beneficiary is ineligible for Medicaid services for that month;
f. Ensure that a beneficiary will not be charged a higher premium the following month due to nonpayment or underpayment of a premium in the previous month/s, except that amounts outstanding and due from the previous month/s may be reflected separately on subsequent invoices;
g. Ensure the state ends monthly billing of premiums to beneficiaries who have been disenrolled for failure to meet the HRA/healthy behaviors requirements, and provide written notice to prevent overpayment of premiums;
h. Conduct outreach and education to beneficiaries to ensure that they understand the program policies regarding premiums and associated consequences for nonpayment. Beneficiaries must be provided individual written notice of how premium payments should be made; the potential impact of a change in income on premium payments owed; the consequences of failure to report a change in income or circumstances that affect eligibility; the time period over which income is calculated (e.g., monthly income); the deadline for reporting changes in circumstances; and how to re-enroll if disenrolled for non-payment of premiums;
i. Provide opportunities to demonstrate good cause for failure to pay premiums that would allow beneficiaries to avoid the consequences for non-payment described

in STC 23(a). Good cause circumstances must include, at a minimum, the following:

i. The beneficiary was hospitalized, otherwise incapacitated, or has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and as a result is unable to pay premiums, or is a person with a disability who was not provided with reasonable modifications needed to pay the premium, or is a person with a disability and there were no reasonable modifications that would have enabled the individual to pay premiums;
ii. A member of the beneficiary's immediate family who was living in the home with the beneficiary was institutionalized or died or the immediate family member has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and caretaking or other disability-related responsibilities resulted in an inability to pay the premiums;
iii. The birth of a family member living with the beneficiary;
iv. The beneficiary experienced a family emergency;
v. The beneficiary experienced a life changing event (e.g., divorce, domestic violence);
vi. The beneficiary experienced a temporary illness or injury.
vii. The beneficiary was evicted from their home or experienced homelessness, or
viii. The beneficiary was the victim of a natural disaster, such as a flood, storm, earthquake, or serious fire.

j. Provide all applicants and beneficiaries with timely and adequate written notices of any decision affecting their eligibility, including an approval, denial, termination, or suspension of eligibility or a denial or change in benefits and services pursuant to 42 CFR 435.917. The state will also make program information available and accessible in accordance with 42 CFR 435.901 and 435.905. The state will provide beneficiaries with 10 days advance notice for any adverse action prior to the date of action pursuant to 42 CFR 431.211;
k. Provide notice to beneficiaries, prior to adverse action, about the disenrollment, and explaining what this status means, including but not limited to: their right to appeal, their opportunity to cure, their right to apply for Medicaid on a basis not affected by this status, what this status means with respect to their ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange), what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category, as well as any implications with respect to whether they have minimum essential coverage;
l. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications related to premium payment; and

m. Maintain a system that identifies, validates, and provides reasonable modifications related to the obligation to pay premiums to beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Patient Protection and Affordable Care Act.

27. Healthy Behaviors: State Assurances. The state shall:

a. Develop uniform standards for healthy behavior incentives including, but not limited to, a health risk assessment to identify behavior that the initiative is targeting. Such targeted behaviors could include: routine ER use for non-emergency treatment, multiple co-morbidities, alcohol abuse, substance use disorders, tobacco use, obesity, and deficiencies in immunization status.
b. Include a selection of targeted healthy behaviors that is sufficiently diverse and a strategy to measure access to necessary providers to ensure that all beneficiaries have a meaningful opportunity to receive healthy behavior incentives, taking into account individual physical and mental health status.
c. Implement a comprehensive pre-implementation education and outreach strategy regarding the Healthy Behaviors Incentive Program including strategies related to the ongoing engagement of stakeholders and the public in the state;
d. Provide written notice to beneficiaries regarding:
    i. The rights of people with disabilities to receive reasonable modifications related to engaging in healthy behaviors;
    ii. What specific healthy behaviors will qualify to meet the requirement;
    iii. How beneficiaries can report engagement in healthy behaviors, in accordance with 42 CFR 435.907(a); and
    iv. Prior to adverse action, information about disenrollment from HMP and an explanation of what this status means, including but not limited to: their right to appeal, their right to cure, their right to apply for Medicaid on a basis not affected by this status, what this status means with respect to their ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange), what they should do if their circumstances change such that they may be eligible for coverage in another Medicaid category, as well as any implications with respect to whether they have minimum essential coverage.
e. Develop a data driven strategy of how healthy behaviors will be tracked and monitored at the beneficiary and provider level, including standards of accountability for providers. This must include the timeline for development and/or implementation of a systems based approach which shall occur prior to implementing the Healthy Behaviors initiative.
f. Develop a beneficiary and provider education strategy and timeline for completion prior to program implementation.
g. For beneficiaries who complete the HRA, provide those beneficiaries with information about ongoing structured interventions that will assist beneficiaries in improving health outcomes.

h. Maintain ongoing education and outreach post implementation regarding the Healthy Behaviors Incentive Program including strategies related to the ongoing engagement of stakeholders and the public in the state;
i. Determine how the MHP will coordinate with the beneficiaries and the state in ensuring the beneficiaries understand the impact of failing to engage in healthy behaviors, including the impact on cost-sharing and the potential for disenrollment;
j. Develop a description of other incentives in addition to reductions in cost sharing or premiums that the state will implement;
k. Develop a process to inform beneficiaries how to remedy not answering all the required questions on the HRA and the consequences if they do not;
l. Provide opportunities to demonstrate good cause for failure to pay complete the HRA or healthy behavior that would allow beneficiaries to avoid the consequences for that failure described in STC 24(c). Good cause circumstances must include, at a minimum, the following; and:

    i. The beneficiary was hospitalized, otherwise incapacitated, or has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and as a result is unable to pay premiums, or is a person with a disability who was not provided with reasonable modifications needed to pay the premium, or is a person with a disability and there were no reasonable modifications that would have enabled the individual to pay premiums;
    ii. A member of the beneficiary's immediate family who was living in the home with the beneficiary was institutionalized or died, or the immediate family member has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and caretaking or other disability-related responsibilities resulted in an inability to pay the premiums;
    iii. The birth of a family member living with the beneficiary;
    iv. The beneficiary experienced a family emergency;
    v. The beneficiary experienced a life changing event (e.g., divorce, domestic violence);
    vi. The beneficiary experienced a temporary illness or injury.
    vii. The beneficiary was evicted from their home or experienced homelessness, or
    viii. The beneficiary was the victim of a natural disaster, such as a flood, storm, earthquake, or serious fire that occurred.

m. Ensure that this healthy behaviors feature of the demonstration is implemented in a way that does not discriminate against people with disabilities on the basis of disability in violation of the ADA, Section 504, Section 1557 or any other federal civil rights laws

VII. DELIVERY SYSTEM

28. Healthy Michigan Plan. Services for Healthy Michigan Plan adults will be provided through a managed care delivery system.

a. **Types of Health Plans.** The state will use two different types of managed care plans to provide the full Alternative Benefit Plan for the demonstration population:
   i. Comprehensive Health Plans: MHPs that provide acute care, physical health services and most pharmacy benefits on a statewide basis. These MHPs will be the same MHPs that provide acute care and physical health coverage for other Medicaid populations.
   ii. Behavioral Health Plans: These will be Pre-paid Inpatient Health Plans (PIHPs) that provide inpatient and outpatient mental health, substance use disorder, and developmental disability services statewide to all enrollees in the demonstration. The PIHPs will be the same entities that serve other Medicaid populations.

29. Healthy Michigan Plan Enrollment Requirements. The state may require HMP beneficiaries to enroll in MHPs and PIHPs (with the exception of those beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria).

a. Mandatory enrollment may occur only when the MHPs or PIHPs have been determined by the state to meet readiness and network requirements to ensure sufficient access, quality of care, and care coordination for beneficiaries as established by the state, consistent with 42 CFR 438 and as approved by CMS.
b. Newly eligible beneficiaries will initially be placed in fee-for-service (FFS), during which the individual will be responsible for paying all copayments, in amounts that are in accord with the state plan, at the time of service.
c. The state will use an enrollment broker to assist individuals with selection of a MHP before relying on auto-assignments.
d. Any individual that does not make an active selection will be assigned, by default, to a participating MHP.
e. Individuals will have choice of MHPs in all areas except the rural counties that are not defined as urban by the Executive Office of Management and Budget. In rural counties, the state will only contract with one MHP to serve those

beneficiaries, consistent with the standards in section 1932(a)(3)(B) of the Act. In those rural areas that qualify for only one plan, the state will ensure the choice of providers as detailed in 42 CFR. 438.52(b)(1). In all areas of the state, individuals will only be permitted to enroll in the one PIHP that serves their area of residence.

f. Upon completion of the 90-day disenrollment period, during which time individuals may choose a different MHP, individuals that are mandatorily enrolled into a MHP will be locked into that MHP for a period of no longer than 12 months, unless they have a for-cause reason for disenrollment, as defined by the state. Individuals that are voluntarily enrolled into a MHP will be permitted to disenroll at any time.
g. All individuals will be automatically assigned to the single PIHP that serves beneficiaries in their area of residence in order to access services in the behavioral health system, provided the PIHP has been determined to meet readiness and network requirements, as described above.
h. Mandatory enrollment cannot include individuals specifically exempted from mandatory enrollment in managed care under section 1932 of the Act. These individuals may elect to receive benefits through a FFS delivery system.
i. Notice Information. The state must provide transition notice to any beneficiaries impacted by a change in delivery system at least 30 days in advance of the change. Notices will be written in simple and understandable terms and in a manner that is accessible to persons who are limited English proficient and individuals living with disabilities.
j. Transition Period. When beneficiaries transition delivery systems, beneficiaries in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the nonparticipating/non-contracted provider through the duration of their prescribed treatment.

30. Healthy Michigan Plan Managed Care Benefit Package. Individuals enrolled in Healthy Michigan Plan will receive from the managed care program the benefits in the approved Alternative Benefit Plan (ABP) SPA that aligns with the benefit package in the state plan. Covered benefits should be delivered and coordinated in an integrated fashion, using an interdisciplinary care team, to coordinate all physical and behavioral health services. Care coordination and management is a core expectation for these services. MHPs/PIHPs will refer and/or coordinate enrollees' access to needed services that are excluded from the managed care delivery system but available through a FFS delivery system (e.g. Home Help services or certain psychotropic medications).

31. Managed Care Requirements. The state must comply with the managed care regulations published at 42 CFR 438, except as waived herein. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.5. The certification shall identify historical utilization of services that are the same as outlined in the corresponding Alternative Benefit Plan and used in the rate development process.

32. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of this demonstration authority as well as CMS approval of such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

33. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

34. **AI/AN Access to Behavioral Health Services.** American Indian/Alaska Native beneficiaries may elect to obtain Medicaid mental health and substance abuse services directly from Medicaid enrolled Indian Health Service (IHS) facilities and Tribal Health Centers (THCs). For mental health and substance abuse services provided to Native American beneficiaries, the IHS facilities and THCs will be reimbursed directly for those services by the state in accordance with the applicable rates in the approved state plan and the Michigan Medicaid Provider Manual. Any Native American Indian beneficiary who needs specialty mental health, developmental disability or substance abuse services may also elect to receive such care under this demonstration through the PIHP. The PIHPs have been specifically instructed by the state to assure that Indian health programs are included in the PIHP provider panel, to ensure culturally competent specialty care for the beneficiaries in those areas.

VIII. GENERAL REPORTING REQUIREMENTS

35. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the 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 (30) days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements.

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s) and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

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.

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

37. 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.

38. Implementation Plan. The state must submit an Implementation Plan to CMS no later than ninety (90) calendar days after approval of the demonstration. The Implementation Plan must cover at least the key policies being tested under this demonstration, including but not limited to~~,~~ cost-sharing and healthy behaviors. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment C. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the Implementation Plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

39. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than one hundred fifty (150) calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment D.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 40(b) below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to, cost-sharing and healthy behaviors. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g, operational updates as described in STC 40(a) below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

40. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the

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

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

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS's framework which includes the following key policies under this demonstration, including but not limited to --, cost-sharing and healthy behaviors. The performance metrics will also reflect all other components of the state's demonstration. For example, these metrics will cover enrollment, disenrollment or suspension by specific demographics and reason, , access to care, and health outcomes.

   Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals.

   The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the CMS framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for

monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

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

41. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

42. Close Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.

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

c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.

d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 39.

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

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

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

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

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

IX. GENERAL FINANCIAL REQUIREMENTS

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

45. General Financial Requirements. The state must comply with all general financial requirement under Title XIX, as well as any applicable reporting requirement related to monitoring budget neutrality, set forth in Section XI of these STCs.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

46. Budget Neutrality. Consistent with the August 22, 2018, State Health Official Letter #18-009, CMS has determined that this demonstration is budget neutral based on CMS's assessment that the waiver authorities granted for the demonstration are unlikely to result in any increase in federal Medicaid expenditures for medical assistance, and that no expenditure authorities are associated with the demonstration. The state will not be allowed to obtain budget neutrality "savings" from this demonstration. The demonstration will not include a budget neutrality expenditure limit, and no further test of budget neutrality will be required. CMS reserves the right to request budget neutrality worksheets and analyses from the state whenever the state seeks a change to the demonstration, per STC 7.

XI. EVALUATION OF THE DEMONSTRATION

47. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and

analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirements that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 39.

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

49. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than one hundred eighty (180) calendar days after approval of the demonstration.

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

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

    d. All applicable Evaluation Design guidance, including but not limited to guidance about, cost-sharing and healthy behaviors. Hypotheses for cost-sharing and healthy behaviors will include (but not be limited to): effects on access to care; and health outcomes. Hypotheses applicable to the demonstration as a whole, and to all key policies referenced above, will include (but will not be limited to): the effects of the demonstration on health outcomes; the financial impact of the demonstration (for example, such as an assessment of medical debt and uncompensated care costs); and the effect of the demonstration on Medicaid program sustainability.

    e. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as

provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a draft Evaluation Design.

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

51. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Reports) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS's measure sets for eligibility and coverage, 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).

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

53. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

    f. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design. 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.

g. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted, should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

h. 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.

i. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

54. 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 a 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.

j. Unless otherwise agreed upon in writing by CMS, the state shall submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.

k. 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.

55. 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. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

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.

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

57. **Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

Attachment A: Developing the Evaluation Design

Introduction

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

Expectations for Evaluation Designs

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-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

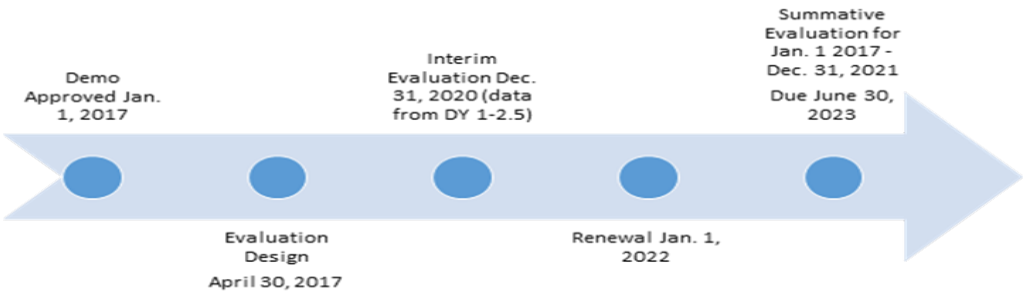
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses,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



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

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

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

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

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

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

5) Describe the population groups impacted by the demonstration.

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

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

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

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

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

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

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

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

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

a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
d. The application of sensitivity analyses, as appropriate, should be considered.

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

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

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

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

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

When the demonstration is considered successful without issues or concerns that would require more regular reporting, such as:

a. Operating smoothly without administrative changes; and
b. No or minimal appeals and grievances; and
c. No state issues with CMS 64 reporting or budget neutrality; and

d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

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

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

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

Attachment B: Preparing the 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

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

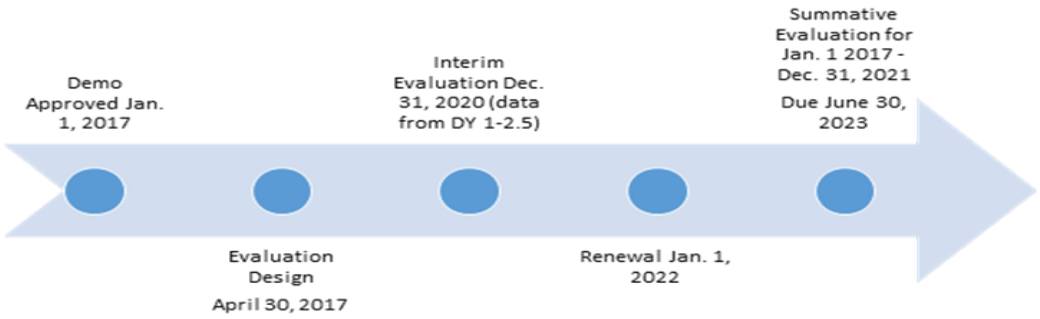
The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;

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

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline 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 thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

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

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

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

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

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

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

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

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate

data development and collection in a timely manner to support developing an interim evaluation.

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

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

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

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

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

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

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

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

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

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

J. Attachment

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

Attachment C: Implementation Plan
[To be incorporated after CMS approval.]

Attachment D: Monitoring Protocol
[To be incorporated after CMS approval.]

Attachment E: Healthy Behaviors List

PREVENTIVE DENTAL SERVICES	
PROCEDURE	**DIAGNOSIS CODE**
D0120	Z0120, Z0121, Z1384
D0191	Z0120, Z0121, Z1384
D1110	Z0120, Z0121, Z1384
D1354	Z0120, Z0121

ACIP VACCINES	
PROCEDURE	**DIAGNOSIS CODE**
90620	NA
90621	NA
90630	NA
90632	NA
90636	NA
90649	NA
90650	NA
90651	NA
90654	NA
90656	NA
90658	NA
90661	NA
90670	NA
90673	NA
90674	NA
90686	NA
90688	NA
90707	NA
90714	NA
90715	NA
90716	NA
90732	NA
90733	NA
90734	NA
90736	NA
90740	NA
90744	NA
90746	NA
90747	NA
G0008	NA
G0009	NA
G0010	NA
Q2034	NA
Q2035	NA
Q2036	NA
Q2037	NA
Q2038	NA

Q2039	NA

ANNUAL PREVENTIVE VISIT	
PROCEDURE	**DIAGNOSIS CODE**
99385	NA
99386	NA
99395	NA
99396	NA
99401	NA
99402	NA

CANCER SCREENING: BREAST	
PROCEDURE	**DIAGNOSIS CODE**
77063	NA
77067	NA
G0202	NA

CANCER SCREENING: CERVICAL/VAGINAL	
PROCEDURE	**DIAGNOSIS CODE**
87623	NA
87624	NA
87625	NA
88141	NA
88142	NA
88143	NA
88147	NA
88148	NA
88155	NA
88164	NA
88165	NA
88166	NA
88167	NA
88174	NA
88175	NA
G0101	NA
G0476	NA
Q0091	NA

CANCER SCREENING: COLORECTAL	
PROCEDURE	**DIAGNOSIS CODE**
45330	Z1211, Z1212, Z1213, Z800, Z8371,
45331	Z1211, Z1212, Z1213, Z800, Z8371,
45333	Z1211, Z1212, Z1213, Z800, Z8371,
45338	Z1211, Z1212, Z1213, Z800, Z8371,
45346	Z1211, Z1212, Z1213, Z800, Z8371,
45378	Z1211, Z1212, Z1213, Z800, Z8371,
45380	Z1211, Z1212, Z1213, Z800, Z8371,
45384	Z1211, Z1212, Z1213, Z800, Z8371,

45385	Z1211, Z1212, Z1213, Z800, Z8371,
45388	Z1211, Z1212, Z1213, Z800, Z8371,
81528	NA
82270	NA
82274	Z1211, Z1212, Z1213, Z800, Z8371,
G0104	NA
G0105	NA
G0121	NA
G0328	NA

CANCER SCREENING: LUNG	
PROCEDURE	**DIAGNOSIS CODE**
71250	F172, Z122, Z720, Z87891
G0297	NA

CANCER SCREENING: PROSTATE	
PROCEDURE	**DIAGNOSIS CODE**
84152	Z125, Z8042
84153	Z125, Z8042
84154	Z125, Z8042
G0102	NA
G0103	NA

HEP C VIRUS INFECTION SCREENING	
PROCEDURE	**DIAGNOSIS CODE**
86803	NA
G0472	NA

HIV SCREENING	
PROCEDURE	**DIAGNOSIS CODE**
86689	Z114
86701	Z114
86702	Z114
86703	Z114
87389	Z114
87390	Z114
87391	Z114
87534	Z114
87535	Z114
87536	Z114
87537	Z114
87538	Z114
87539	Z114
87806	Z114
G0432	NA
G0433	NA
G0435	NA

OSTEOPOROSIS SCREENING	
PROCEDURE	**DIAGNOSIS CODE**
76977	Z13820, Z8262
77078	Z13820, Z8262
77080	Z13820, Z8262
77081	Z13820, Z8262

STI SCREENING: CHLAMYDIA	
PROCEDURE	**DIAGNOSIS CODE**
87110	NA
87270	NA
87320	NA
87490	NA
87491	NA
87492	NA
87810	NA

STI SCREENING: GONORRHEA	
PROCEDURE	**DIAGNOSIS CODE**
87590	NA
87591	NA
87592	NA
87850	NA

STI SCREENING: HEP B (NONPREGNANT)	
PROCEDURE	**DIAGNOSIS CODE**
86704	NA
86705	NA
86706	NA
87340	NA
G0499	NA

STI SCREENING: SYPHILIS (NONPREGNANT)	
PROCEDURE	**DIAGNOSIS CODE**
86592	NA
86593	NA

TUBERCULOSIS SCREENING	
PROCEDURE	**DIAGNOSIS CODE**
86480	Z111, Z201
86481	Z111, Z201
86580	Z111, Z201
87116	Z111, Z201