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**State Demonstrations Group**

June 25, 2025

John Connolly  
Deputy Commissioner and Medicaid Director  
Minnesota Department of Human Services  
540 Cedar Street  
St. Paul, Minnesota 55164-0983  
Dear Director Connolly:

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

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

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

**Updates to Demonstration Monitoring**

Below are the updated aspects of demonstration monitoring for the Minnesota Prepaid Medical Assistance Project Plus (PMAP+) (Project Number 11-W-00039/5) demonstration.

*Reporting Cadence and Due Date*

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, and in alignment with the Minnesota Prepaid Medical Assistance Project Plus (PMAP+) demonstration's STCs, CMS is retaining the cadence for this demonstration (see also section 1115(d)(2)(D)-(E) of the

Act). However, CMS is extending the due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state's work to draft, review, and submit the report timely.

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

The next annual monitoring report for the Minnesota Prepaid Medical Assistance Project Plus (PMAP+) will be due on December 29, 2025, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting due date.

#### *Structured Monitoring Report Template*

As noted in STC 7.4, "Annual Monitoring Reports," monitoring reports "must follow the framework provided by CMS, which is subject to change as monitoring systems are developed / evolve and be provided in a structured manner that supports federal tracking and analysis." Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report's content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

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

#### *Demonstration Monitoring Calls*

As STC 7.7 "Monitoring Calls" describes, CMS may "convene periodic conference calls with the state," and the calls are intended "to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration." Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely

assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

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

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent Minnesota Prepaid Medical Assistance Project Plus (PMAP+) section 1115 demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

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

Sincerely,



Karen LLanos  
Acting Director

Enclosure

cc: Sandra Porter, State Monitoring Lead, Medicaid and CHIP Operations Group

## **CENTERS FOR MEDICARE & MEDICAID SERVICES**

### **WAIVER AUTHORITY**

**NUMBER:** 11-W-00039/5

**TITLE:** Minnesota Prepaid Medical Assistance Project Plus (PMAP+) Section 1115(a) Demonstration

**AWARDEE:** Minnesota Department of Human Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project from January 1, 2024 through December 31, 2028.

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 in effect to enable Minnesota to carry out the PMAP+ demonstration.

#### **Title XIX Waivers**

##### **1. Redeterminations for Caretaker Adults**

##### **Section 1902(a)(17)**

To the extent necessary to enable the state to not perform a redetermination of the basis of eligibility for caretaker adults with income at or below 133 percent of FPL because they assume responsibility for and live with a child age 18 who is not a full-time student in secondary school.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES**

### **EXPENDITURE AUTHORITY**

**NUMBER:** 11-W-00039/5

**TITLE:** Minnesota Prepaid Medical Assistance Project Plus (PMAP+) Section 1115(a) Demonstration

**AWARDEE:** Minnesota Department of Human Services

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under Section 1903, shall, for the period from January 1, 2024, through December 31, 2028, unless otherwise specified, be regarded as expenditures under the state's Medicaid Title XIX state plan.

#### **Expenditure Authorities**

Under the authority of Section 1115(a)(2) of the Act, expenditures made by the state for the items identified below (which are not otherwise included as expenditures under Section 1903) will be regarded as expenditures under the state's Title XIX plan for the period of this extension.

The expenditure authorities listed below promote the objectives of Title XIX by increasing overall coverage of low-income individuals in the state and improving health outcomes for Medicaid and other low-income populations in the state.

The following expenditure authorities shall enable Minnesota to operate its Section 1115 demonstration:

1. Population 1: Expenditures for Medicaid coverage for children from ages 12 months through 23 months, who would not otherwise be eligible for Medicaid, with income above 275 percent and at or below 283 percent of the federal poverty level (FPL).
2. Expenditures for Medicaid coverage for pregnant women described in Section 1902(a)(47) of the Act, to the extent that services are provided during a hospital presumptive eligibility period, that are in addition to ambulatory prenatal care services.

## CENTERS FOR MEDICARE & MEDICAID SERVICES

### SPECIAL TERMS AND CONDITIONS

**NUMBER:** 11-W-00039/5

**TITLE:** Minnesota Prepaid Medical Assistance Project Plus (PMAP+) Section 1115(a) Demonstration

**AWARDEE:** Minnesota Department of Human Services

#### 1. PREFACE

The following are the Special Terms and Conditions (STCs) for Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115(a) Medicaid demonstration extension (herein after "demonstration"). These STCs govern the operation of the PMAP+ demonstration by the Minnesota Department of Human Services (DHS), which has been approved by the Centers for Medicare & Medicaid Services (CMS) to facilitate the STCs set forth that detail the nature, character, extent of federal involvement in the demonstration, and the state's obligations to CMS during the life of the demonstration. The STCs are effective on the date of the approval letter unless otherwise specified. All previously approved STCs, Waivers, Expenditure Authorities and Not Applicables are superseded as of the date of approval. This demonstration extension is approved through December 31, 2028.

The STCs have been arranged into the following subject areas:

1	Preface
2	Program Description and Objectives
3	General Program Requirements
4	Eligibility and Demonstration Scope
5	Benefits
6	Cost Sharing
7	Monitoring and Reporting Requirements
8	General Financial Requirements
9	Monitoring Budget Neutrality for the Demonstration
10	Evaluation of the Demonstration
11	Schedule of State Deliverables for the Demonstration Extension Period

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

Attachment A	Developing the Evaluation Design
Attachment B	Preparing the Interim and Summative Evaluation Reports
Attachment C	Evaluation Design (Reserved)
Attachment D	Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment

## 2. PROGRAM DESCRIPTION AND OBJECTIVES

Minnesota's Section 1115 PMAP+ demonstration was initially approved and implemented in July 1995. Its original purpose was to enable the state to establish a prepaid, capitated managed care delivery model that operates statewide and to provide federal support for the extension of health care coverage to additional populations through the MinnesotaCare program. The demonstration has also been used to test waivers and expenditure authorities that allow the state to simplify and streamline Medicaid program administration, and for alternative funding and payment approaches to support graduate medical education (GME) through the Medical Education and Research Costs (MERC) fund.

In December 2013, Minnesota was granted a one-year temporary extension for PMAP+, with amendments to reflect new health care coverage options introduced in 2014 under the Affordable Care Act. The extended demonstration continued MinnesotaCare coverage only for 19 and 20-year olds, caretaker adults, and adults without children with incomes above 133 percent and at or below 200 percent of the federal poverty level (FPL), with the expectation that MinnesotaCare would eventually be transitioned to a Basic Health Plan (BHP) option for these groups in 2015. Other populations that participated in MinnesotaCare — pregnant women, children, foster care age outs, juvenile residential correctional facility post-release, and adults with incomes at or below 133 percent of the FPL — began receiving Medicaid coverage in 2014 under Minnesota's state plan, and MinnesotaCare adults with incomes above 200 percent of FPL were transitioned to subsidized qualified health plan coverage through Minnesota's new state-based Marketplace. Waiver and expenditure authorities allowing streamlining benefit sets for pregnant women, GME funding through MERC, medical assistance for children ages 12 through 23 months with incomes at or below 283 percent of FPL, and mandatory managed care for population groups were continued in the extended demonstration. New authority was granted to provide medical assistance for caretaker adults who live with and are responsible for children age 18 who are not full-time secondary school students.

In December 2014, CMS approved a one-year temporary extension of the PMAP+ demonstration, through December 31, 2015 to continue authorities for:

- Coverage of children ages 12 through 23 months with incomes above 275 percent FPL and at or below 283 percent of the FPL;
- Coverage of parents and caretaker adults with incomes at or below 133 percent of the FPL who assume responsibility for and live with an 18-year-old who is not a full-time secondary school student;
- Pregnant women in need of full medical assistance benefits during their hospital presumptive eligibility period;
- Mandatory enrollment into prepaid managed care of certain groups that are excluded from such under Section 1932 of the Act; and
- GME payments through the MERC fund.

On January 1, 2016, CMS approved a five-year extension of the demonstration through December 31, 2020. This extension continues all the features of the previous demonstration except the authority related to mandatory enrollment into managed care was removed from the demonstration and the authority related to parents and caretaker relatives was changed from an expenditure to a waiver authority, since it became clear that there is no extension of eligibility, merely a change in eligibility redetermination practices.

On June 29, 2020, Minnesota submitted a request for a five-year extension of the demonstration. In December 2020, CMS approved a one-year temporary extension of the PMAP+ demonstration through December 31, 2021 to continue authorities for the same populations while the state and CMS continued working on the extension. In December 2021, CMS approved a second one-year temporary extension, through December 31, 2022 to allow for continued negotiations. During this period, the state was expected to transition authority for GME payments through the MERC fund to the Medicaid state plan, to align with CMS policy. In this temporary extension, Minnesota and CMS agreed that expenditure authority for GME payments would expire on December 31, 2022. In December 2022, CMS approved a temporary extension for six months, through June 30, 2023, followed by a temporary extension period ending on September 30, 2023, and another temporary extension through December 31, 2023.

On November 15, 2023, CMS approved a five-year extension of the PMAP+ demonstration, beginning January 1, 2024 through December 31, 2028. This extension continued authorities for the following three programs:

- Coverage of children ages 12 through 23 months with incomes above 275 percent FPL and at or below 283 percent of the FPL;
- Coverage of parents and caretaker adults with incomes at or below 133 percent of the FPL who assume responsibility for and live with an 18-year-old who is not a full-time secondary school student; and
- Pregnant women in need of full medical assistance benefits during their hospital presumptive eligibility period.

### **3. GENERAL PROGRAM REQUIREMENTS**

- 3.1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
- 3.2. Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP Programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part) apply to the demonstration.



- 3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
- 3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.
  - b. If mandated changes in the federal law requires state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.
- 3.5. **State Plan Amendments.** The state will not be required to submit Title XIX or XXI state plan amendments (SPAs) for changes any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such instances, the Medicaid and CHIP state plans governs.
- 3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Social Security Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7, below, except as provided in STC 3.3.

- 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 the 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 required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to the following:
- a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
  - b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
  - c. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
  - d. An up-to-date CHIP allotment neutrality worksheet, if necessary; and
  - e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.
- 3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR §431.412I. States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 3.9.
- 3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:
- a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In

addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

- b. Transition and Phase-Out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redetermination of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
- c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.
- d. Transition and Phase-Out Procedures: The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.
- e. Exemption from the Public Notice Procedures of 42 CFR §431.416(g): CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR §431.416(g).
- f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall 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 participants.

- 3.10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's 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.
- 3.11. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
- 3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, 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.
- 3.13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.
- 3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
- 3.15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

## 4. ELIGIBILITY AND DEMONSTRATION SCOPE

4.1. **Eligibility.** Demonstration eligibles are described in the chart below:

a. Expansion Groups Eligible Through the Demonstration

Population Number	Population Description	Funding Stream	CMS-64 Eligibility Group
Population 1	Infants age 12 months through 23 months (MA One Year Olds) with incomes above 275 percent FPL and at or below 283 percent FPL.	Title XIX	MA Children Age 1

b. Other Groups Affected by the Demonstration

- i. **Medicaid Caretaker Adult.** Medicaid Caretaker Adults with income at or below 133 percent of the FP living with child(ren) age 18 will not have the basis for their eligibility redetermined on the basis that the child(ren) are not full-time secondary school students. The term “caretaker adult” includes parents and other caretaker relatives. Caretaker adults have incomes at or below 133 percent of the FPL the demonstration provides expenditure authority for Medicaid Caretaker adults who meet the income standards for Medical Assistance and live with and assume primary responsibility for child(ren) age 18 who are not enrolled full time in secondary school.
- ii. **Pregnant Women in a Hospital Presumptive Eligibility Period.** The demonstration provides Medicaid coverage for pregnant women described in Section 1902(a)(47) of the Act, to the extent that services are provided during a hospital presumptive eligibility period, that are in addition to ambulatory prenatal care services.

## 5. BENEFITS

- 5.1. **Benefits Package: MA One Year Olds.** The benefit offered to MA One Year Olds is the Medicaid full benefit set for infants, including all services that meet the definition of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) found in Section 1905(a)(16)(B) and 1905(r) of the Act whether funded by Medicaid or CHIP.
- 5.2. **Benefits Package: Pregnant Women.** The benefit for pregnant women during a hospital presumptive eligibility period (as defined in Section 1902(a)(47)(B)) will be the full medical assistance benefit that is available to qualified pregnant women (in accordance with Section 1902(a)(10)(A)(i)(III) of the Act

## 6. COST SHARING

## 6.1. Cost Sharing in Medicaid

- a. The cost sharing requirements for Medicaid eligibles under the Medicaid state plan must conform to the requirements set forth in the state plan.
- b. The cost sharing requirements for MA One Year Olds must be identical to the requirements specified for Medicaid eligible infants, as specified in the Medicaid state plan.
- c. The cost sharing requirements for pregnant women described in Section 1902(a)(47) and MA Caretaker Adults with an 18-year-old conform to the requirements set forth under the state plan for those populations, respectively.
- d. Co-Payments and Indians. Items or services furnished to an Indian directly by Indian Health Services, an Indian Tribe or Tribal Organization or an Indian Urban Organization (I/T/U), or through referral under contract health services are exempt from copayments, coinsurance, deductibles, or similar charge.

## 7. MONITORING AND REPORTING REQUIREMENTS

- 7.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the 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.

In the event that either (1) the state has not submitted a written request to CMS for approval of an extension, as described below, within 30 calendar days after the deliverable was due, or (2) the state has not submitted a revised resubmission or a plan for corrective action to CMS within 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement including the information needed to bring the deliverable into alignment with CMS requirements; the following process is triggered:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state’s anticipated date of submission. Should CMS agree in writing to the state’s request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state’s written extension request.

- c. If CMS agrees to an interim corrective process in accordance with subsection (b) above, and the state fails to comply with the corrective action plan or still fails to submit the overdue deliverable(s) that meet 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.

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

**7.3. 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 section 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and
- c. Submit deliverables to the appropriate system as directed by CMS.

**7.4. Annual Monitoring Reports.** The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 90 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. 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 Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

- a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other

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. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports 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 toward meeting the demonstration's goals. Additionally, 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 on beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.
- c. The state and CMS will work collaboratively to finalize the list of metrics to reported in Annual Monitoring Reports. The demonstration's monitoring metrics must cover categories including, but not limited to: enrollment, access to providers, utilization of services, and quality of care and health outcomes. The state should also report provider-level metrics, if applicable. The state must undertake robust reporting of select set of established quality of care and health outcomes metrics aligned with the demonstration's policies and objectives for all demonstration populations. Metrics may include well-child visits in the first 30 months of life for the children ages 12 through 23 months population; asthma medication ratio and diabetes short-term complications admission rate for the Medicaid caretaker adults living with a 18-year-old population; and prenatal and postpartum care or birth weight of newborns for the pregnant women population. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, disability status, and geography) and by demonstration component, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.
- d. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
- e. **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 Form CMS-64.

- f. **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.

7.5. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing preventive services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

7.6. **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 Close-Out Report must comply with the most current guidance from CMS.
- b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 10.7 and 10.8, respectively.
- c. The state will present to and participate in a discussion with CMS on the Close-Out Report.
- d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.
- e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.
- f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 7.1.

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

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

**7.8. Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar 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 Monitoring Report on its Medicaid website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

## **8. GENERAL FINANCIAL REQUIREMENTS**

- 8.1. Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.
- 8.2. Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid Section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in Section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

- 8.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this Section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with Section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.
- a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
  - b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.
  - c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.
- 8.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:
- a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with Section 1903(w) of the Act and applicable implementing regulations.
  - b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

- c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.
- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in Section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.
- e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

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

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

**8.6. Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).
- b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).
- c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

- d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).
  - e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.
- 8.7. **State Monitoring of Non-Federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 7.1. This report must include:
- a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;
  - b. Number of providers in each locality of the taxing entities for each locality tax;
  - c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
  - d. The assessment rate that the providers will be paying for each locality tax;
  - e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
  - f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
  - g. The monitoring plan for the taxing arrangement to ensure that the tax complies with Section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
  - h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under Section 1903(w) of the Act.
- 8.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in Section 9
- a. Administrative costs, including those associated with the administration of the demonstration;
  - b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

- c. Medical assistance expenditures and prior period adjustments made under Section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.
- 8.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.
- 8.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

**Table 1. Master MEG Chart**

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
MA Children Aged One	Hypo 1	X		X	Infants age 12 months through 23 months (MA One Year Olds) with incomes above 275 percent FPL and at or below 283 percent FPL.
Medicaid Caretakers adults living with 18 year old	Hypo 2	X		X	Adults with income at or below 133 percent of FPL living with child(ren) age 18 will not have their basis for their eligibility redetermined on the basis that the child(ren) are not full-time secondary school students.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

- 8.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of Title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00039/5). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.
- a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
  - b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.
  - c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.
  - d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in Section 9 administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

- e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in STC 7, the state must report the number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
- f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.
- g. **Expenditure and Member Month Reporting.** Notwithstanding section 8.11, paragraphs (e) and (f), the state may estimate member month and expenditure data for the Medicaid Caretakers adults living with 18 year-old MEG. The state will use the following formula to estimate allocated costs for this group: 1.75% multiplied by expenditures for MA Caretaker Adults. This allocation percentage is based on the percentage of MA Caretaker Adults with the youngest or only child age 18 as compared to all MA Caretaker Adults. The estimated amount will be used for reporting, including on Schedule C, of the CMS-64. This allocation percentage will also be used to estimate member months for this MEG.



**Table 2. MEG Detail for Expenditure and Member Month Reporting**

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
MA Children Aged One	Report all medical assistance expenditures for eligible 12 – 23-month olds enrolled in Medical Assistance		Follow standard CMS-64.9 Category of Service Definitions		MAP	Y	7/1/1995	12/31/2028
Medicaid Caretakers adults living with 18 year old	Report all medical assistance expenditures for Medicaid caretaker adults, as defined in STC 8.11.g		Follow standard CMS-64.9 Category of Service Definitions		MAP	Y	7/1/2013	12/31/2028
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	7/1/2009	12/31/2028

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group

- 8.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

**Table 3. Demonstration Years**

Demonstration Year 30	January 1, 2024 to June 30, 2024	6 months
Demonstration Year 31	July 1, 2024 to June 30, 2025	12 months
Demonstration Year 32	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 33	July 1, 2026 to June 30, 2027	12 months
Demonstration Year 34	July 1, 2027 to June 30, 2028	12 months
Demonstration Year 35	July 1, 2028 to December 31, 2028	6 months

- 8.13. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing the demonstration’s expenditures to the budget neutrality expenditure limits described in Section 9 CMS will provide technical assistance, upon request.<sup>1</sup>
- 8.14. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- 8.15. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:
- To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care

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<sup>1</sup> Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS’s current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the expenditures which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of Section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

- b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
- c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

8.16. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

- a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 8.16.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a

new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

- b. **Types of Allowable Changes.** Adjustments will be made only for costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
  - i. Provider rate increases that are anticipated to further strengthen access to care;
  - ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;
  - iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
  - iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
  - v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
  - vi. High cost innovative medical treatments that states are required to cover; or,
  - vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.
- c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
  - i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,
  - ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

## 9. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 9.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Hypothetical Budget Neutrality Test, as described below. CMS’s assessment of the state’s compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.
- 9.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart and Table 2, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.
- 9.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
- 9.4. **Main Budget Neutrality Test.** This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests, including “capped hypotheticals.” Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.



9.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other Title XIX authority (such as a waiver under Section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

9.6. **Hypothetical Budget Neutrality Test 1: MA One Year Olds and Medicaid Caretaker Adults.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

**Table 4. Hypothetical Budget Neutrality Test 1**

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 30	DY 31	DY 32	DY 33	DY 34	DY 35
MA One Year Olds	PC	Both	5.2%	\$336.47	\$349.54	\$367.76	\$386.93	\$407.10	\$422.91
Medicaid Caretaker Adults	PC	Both	5.5%	\$637.97	\$664.11	\$700.64	\$739.18	\$779.83	\$811.78



- 9.7. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.
- 9.8. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 1/1/2024 to 12/31/2028. If at the end of the demonstration approval period the Budget Neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.
- 9.9. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

**Table 5. Budget Neutrality Test Corrective Action Plan Calculation**

Demonstration Year	Cumulative Target Definition	Percentage
DY 30	Cumulative budget neutrality limit plus:	2.0 percent
DY 30 through DY 31	Cumulative budget neutrality limit plus:	1.5 percent
DY 31 through DY 32	Cumulative budget neutrality limit plus:	1.0 percent
DY 32 through DY 33	Cumulative budget neutrality limit plus:	0.5 percent
DY 33 through DY 35	Cumulative budget neutrality limit plus:	0.0 percent

## 10. EVALUATION OF THE DEMONSTRATION

- 10.1. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to,

commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 7.1.

**10.2. Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance 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.

**10.3. Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs, and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 10.7 and 10.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

In the event of demonstration extensions, for components that are continuing from the prior demonstration approval period, the state's Evaluation Design must reframe and refocus as needed the evaluation hypotheses and research questions to appropriately factor in where it can reasonably expect continued improvements, and where the demonstration's role might be



more to help stabilize outcomes. Likewise, for continuing policies, the state must revisit its analytic approaches compared to those used in the prior approval period evaluation activities, to ensure that the evaluation of those policies taps into the longer implementation time span.

**10.4. Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the 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.

**10.5. Evaluation Design Approval and Updates.** The state must submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. 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 to the state's Medicaid website within 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 Annual 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.

**10.6. Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of preventive services. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by National Quality Forum (NQF).

Specifically, evaluation hypotheses must focus on the effectiveness of the demonstration in helping eligible beneficiaries access preventive services. Hypotheses must include, but not limited to, outcomes such as: beneficiary enrollment and enrollment continuity, health status, beneficiary access to and utilization of preventive services (e.g., utilization rates of well-child visit among beneficiaries who are 12 to 23 months old) and maternal health and birth outcomes (e.g., the rate of preterm and low birthweight births), with a focus on addressing any demographic disparities. The state must also collect necessary data to accommodate CMS's evaluation expectations to rigorously assess the effects of the state's expenditure authorities on beneficiaries and providers, for example, by examining outcomes such as likelihood of enrollment and enrollment continuity and health status.

The state should ideally undertake a well-designed beneficiary survey, which would significantly strengthen the demonstration's evaluation. Finally, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race and ethnicity, primary language, disability status, and geography). Such stratified analyses will provide a fuller understanding of existing shortcomings or disparities in access to and quality of care and health outcomes and help inform how the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

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

- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
- b. For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.
- c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

- e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.
- f. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

**10.8. Summative Evaluation Report.** The state must submit to CMS a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.
- b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

**10.9. 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 an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

**10.10 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.

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

**10.12 Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration, over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given

30 calendar 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.

## 11. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date - Specific	Deliverable	STC Reference
Within six months of demonstration implementation and annually thereafter	Post Award Forum	STC 7.8
90 calendar days after the end of each DY	Annual Monitoring Report	STC 7.4
No later than 60 calendar days after receiving CMS comments	Revised Annual Monitoring Report	STC 7.4
60 days following the end of the quarter	CMS-64 Reports	STC 8.2
60 days following the end of the quarter	Eligible Member Months	STC 8.11.e
30 days following the end of the quarter	Quarterly Financial Reports	STC 8.2
No later than 180 calendar days after the approval date	Draft Evaluation Design	STC 10.3
No later than 60 calendar days after receipt of CMS comments	Revised Evaluation Design	STC 10.5
One year prior to demonstration expiration	Draft Interim Evaluation Report	STC 10.7.c

(December 31, 2027), or with extension application		
No later than 60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 10.7.d
No later than 18 months after expiration of this demonstration period (June 30, 2030)	Draft Summative Evaluation Report	STC 10.8
No later than 60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 10.8.a



## **Attachment A**

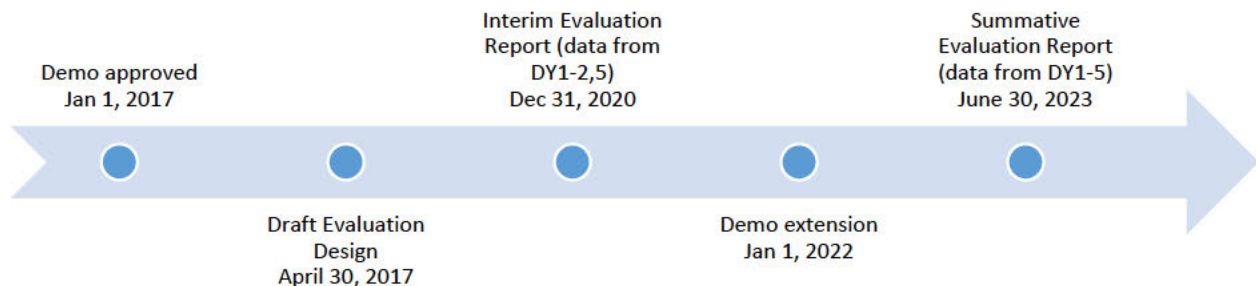
### **Developing the Evaluation Design**

#### **Introduction**

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. 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. Evaluations should include findings about 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).

#### **Submission Timelines**

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



#### **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 section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. 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.

**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 description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. 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.

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

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. 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 can be measured. 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, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver

diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>.

**C. 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, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

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.) 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. 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.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will 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).
  - b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
  - c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
  - d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for 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
<b>Hypothesis 1</b>				
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
<b>Hypothesis 2</b>				
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 more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these 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.

CMS also 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. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
  - a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
  - b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

- a. Operating smoothly without administrative changes;
- b. No or minimal appeals and grievances;
- c. No state issues with CMS-64 reporting or budget neutrality; and
- d. No Corrective Action Plans for the demonstration.

#### **E. 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 and prepare objective Evaluation Reports. 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 costs, 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, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
- 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 milestones for the development and submission of the Interim and Summative Evaluation Reports. 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**

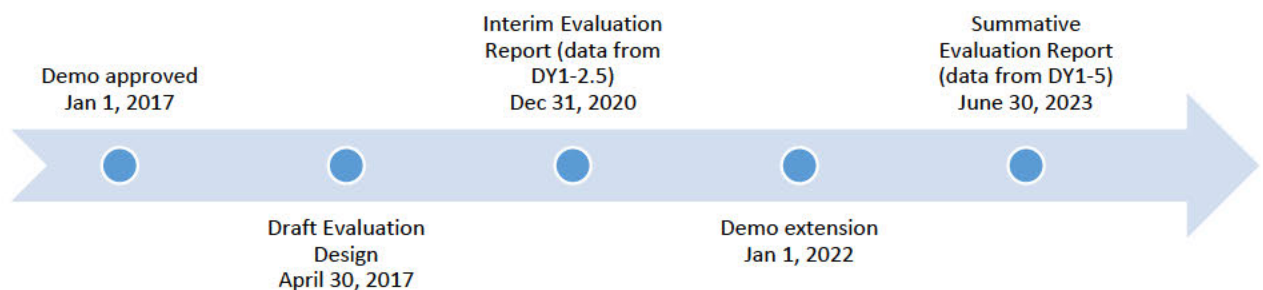
### **Preparing the Interim and Summative Evaluation Reports**

#### **Introduction**

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. 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. Evaluations should include findings about 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).

#### **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 a deliverables 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 Interim and Summative Evaluation 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.



#### **Expectations for Evaluation Reports**

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are 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). 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. When

conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for extension, 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.

CMS expects Interim and Summative Evaluation Reports 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 reports, the state should contact its demonstration team.

### **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 evaluation report submissions must provide comprehensive written presentations 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.

### **Required Core Components of Interim and Summative Evaluation Reports**

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports 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. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

- A. The format for the Interim and Summative Evaluation reports is as follows: 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).

**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 issue/s 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 description of the population groups impacted by the demonstration.
4. 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.
5. 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. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

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

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
3. 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.
4. 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.

**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, (using references), meets the prevailing standards of scientific and academic

rigor, and the results are statistically valid and reliable.

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

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make 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, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

- 1) *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
- 2) *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
- 3) *Evaluation Period* – Describe the time periods for which data will be collected.
- 4) *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
- 5) *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
- 6) *Analytic Methods* – Identify specific statistical testing which was 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.

**D. 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 demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

**G. Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

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?
  - a. If the state did not fully achieve its intended goals, why not?
  - b. 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 interpretations 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, it should include potential “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

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

**J. Attachment(s)**

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



**Attachment C**  
**PMAP+ Evaluation Design**  
(Reserved)

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

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



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November 14, 2024

John Connolly  
Assistant Commissioner and Minnesota Medicaid Director  
Minnesota Department of Human Services  
540 Cedar Street  
St. Paul, Minnesota 55164-0983

Dear Assistant Commissioner Connolly,

The Centers for Medicare & Medicaid Services (CMS) is approving Minnesota's request for an amendment to the "Prepaid Medical Assistance Project Plus" (PMAP+) section 1115 demonstration (Project Number 11-W-00039/5) in accordance with section 1115(a) of the Social Security Act (the "Act"). Approval of this request will provide expenditure authority to allow the state to provide continuous eligibility to children up to age six, from birth through the end of the month of their sixth birthday, and children ages 19 up to age 21 for 12 months. The authority is effective from the date of this approval and will remain in effect through the rest of the demonstration approval period, which is set to expire December 31, 2028.

CMS's approval of this section 1115(a) demonstration amendment is subject to the limitations specified in the attached expenditure authority, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The STCs in Attachment E of this letter should be considered as part of the broader set of STCs that were approved on January 2, 2024 for the "Prepaid Medical Assistance Project Plus" (PMAP+) demonstration and will be incorporated into the full STCs at the next approval action for this demonstration. All continuous eligibility requirements in statute and regulations, as well as CMS guidance explaining continuous eligibility apply to this demonstration, unless the governing expenditure authorities and STCs state that a particular rule or policy does not apply.

**Extent and Scope of Demonstration Amendment**

Minnesota will provide continuous eligibility to these populations for the specified length of time:

- Continuous eligibility for children up to age six through the end of the month of their sixth birthday, regardless of changes in circumstances that would otherwise cause a loss of eligibility.
- 12 months of continuous eligibility for Medicaid children, age 19 up to age 21, through the end of the month of their 21<sup>st</sup> birthday, regardless of changes in circumstances that would otherwise cause a loss of eligibility.

Continuous eligibility is intended to support consistent coverage and continuity of care by keeping children enrolled, regardless of changes in circumstances that would otherwise cause a

loss of eligibility or other changes that would affect eligibility, such as a change in income. Expanding continuous eligibility beyond what is allowable in the Medicaid state plan is likely to assist in promoting the objectives of Medicaid by minimizing coverage gaps and helping to maintain continuity of access to program benefits for these populations, thereby improving health outcomes, and reducing churn. In 2018, one in ten Medicaid/CHIP enrollees disenrolled and reenrolled in Medicaid/CHIP in under one year.<sup>1</sup> Continuous eligibility also supports reducing administrative costs resulting from churn; estimates from 2015 show that the administrative cost of one instance of churn (disenrolling and reenrolling) for one individual ranges from \$400-\$600.<sup>2</sup> Continuous coverage is also likely to be an important driver of reducing the rate of uninsured and underinsured individuals.<sup>3</sup> To facilitate access to and continuity of care, and recognizing that beneficiaries may not be aware of their continued coverage<sup>4</sup>, the amendment requires that the state have procedures and processes in place to provide individuals who qualify for a continuous eligibility period that exceeds 12 months an annual reminder of continued eligibility.

### **Budget Neutrality<sup>5</sup>**

CMS has long required, as a condition of demonstration approval, that demonstrations be “budget neutral,” meaning the federal costs of the state’s Medicaid program with the demonstration cannot exceed what the federal government’s Medicaid costs in that state likely would have been without the demonstration. The demonstration amendment is projected to be budget neutral to the federal government. The state will be held to the budget neutrality monitoring and reporting requirements as outlined in the attachment and current STCs. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 demonstration approvals.

Under this approval, projected demonstration expenditures associated with the new continuous eligibility population will be treated as hypothetical for the purposes of budget neutrality, and the WOW baselines have been trended forward to determine the maximum expenditure authority for the approval period.

### **Monitoring and Evaluation Requirements**

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<sup>1</sup> Corallo B, Garfield R, Tolbert J, Rudowitz R. Medicaid enrollment churn and implications for continuous Coverage Policies | KFF. KFF. Published December 15, 2021. <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>

<sup>2</sup> Swartz K, Short PF, Graefe DR, Uheroi N. Reducing Medicaid churning: Extending eligibility for twelve months or to end of calendar year is most effective. *Health Affairs*. 2015;34(7):1180-1187. doi:10.1377/hlthaff.2014.1204

<sup>3</sup> A [September 2023 State Health Official letter](#) provides background on the importance of continuous eligibility in preventing interruptions that impede access to health coverage to support better short- and long-term health outcomes, and describes policies related to implementing continuous eligibility under the Consolidated Appropriations Act, 2023 (CAA, 2023) amendments.

<sup>4</sup> McIntyre A, Smith RB, Sommers BD. Survey-Reported Coverage in 2019-2022 and Implications for Unwinding Medicaid Continuous Eligibility. *JAMA Health Forum*. 2024;5(4):e240430. doi:10.1001/jamahealthforum.2024.0430; <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2817285>.

<sup>5</sup> For more information on CMS’s current approach to budget neutrality, see <https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html>

States are required to conduct systematic monitoring and robust evaluation of section 1115 demonstrations in accordance with the STCs. For the continuous eligibility policy, monitoring reporting must provide metrics data for enrollment and ex parte renewals, and narrative updates on the successes and challenges of collecting and providing applicable information as outlined in the STCs. States must also evaluate the impact of the policy on all relevant populations, appropriately tailored for the specific time span of eligibility. Evaluation hypotheses must focus on, but may not be limited to, enrollment continuity, utilization of age-appropriate preventive care, inpatient admissions and avoidable emergency care, and health disparities.

### **Consideration of Public Comments**

The federal comment period was open from February 5, 2024 through March 6, 2024 for the demonstration amendment request submitted January 25, 2024, during which CMS received eight comments, five of which were relevant to continuous eligibility. These comments were submitted by various community and advocacy organizations. All commenters were strongly supportive of both the proposal to provide continuous eligibility for children and to extend 12-month continuous eligibility to 19- and 20-year-olds. One commenter asked about the implications for children between five and 19 years old.

After carefully reviewing the proposal and all other relevant materials provided by the state, CMS has concluded that the approval of this amendment is likely to assist in promoting the objectives of Medicaid.

### **Other Information**

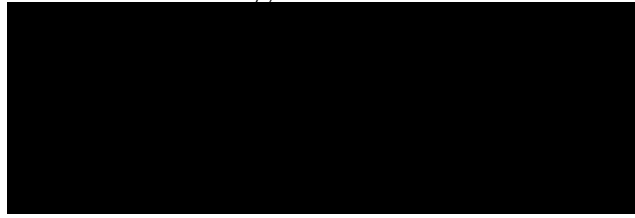
CMS's approval of this demonstration project is conditioned upon compliance with the previously approved expenditure authorities and special terms and conditions, which set forth in detail the nature, character and extent of anticipated federal involvement in the project.

In addition, the approval is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer is Amy Schlom. She is available to answer any questions concerning this amendment. Ms. Schlom's contact information is as follows:

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

We appreciate your state's commitment to addressing continuous eligibility, and we look forward to our continued partnership on the "PMAP+" demonstration. If you have any questions regarding this approval, please contact Ms. Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786 – 9686.

Sincerely,



Daniel Tsai  
Deputy Administrator and Director

Enclosure

cc: Sandra Porter, Monitoring Lead, Medicaid and CHIP Operations Group

**Attachment E**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**Expenditure Authority**

**NUMBER:** 11-W-00039/5

**TITLE:** Prepaid Medical Assistance Project Plus (PMAP+)

**AWARDEE:** Minnesota Department of Human Services

**Title XIX Expenditure Authority**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Minnesota for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX plan. The following expenditure authority must only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Minnesota to implement the section 1115 demonstration amendment. All other requirements of the Medicaid program, including current and future CMS guidance for continuous eligibility, as expressed in law, regulation, and policy statements must apply to these expenditures, unless identified as not applicable below.

**Continuous Eligibility.** Expenditures for continued state plan benefits for individuals who have been determined eligible as specified in Table 1 of STC 1.2, who are not otherwise excluded under STC 1.3 for the applicable continuous eligibility period, and who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 1.4.

**SPECIAL TERMS AND CONDITIONS**

**1. Eligibility and Enrollment**

- 1.1 Continuous Eligibility:** Eligible populations, identified in STC 1.2, will receive continuous eligibility through the demonstration. The state is authorized to provide continuous eligibility for the populations for the durations specified in Table 1 below, regardless of the delivery system through which these populations receive Medicaid benefits.
- a. For individuals who qualify for continuous eligibility, the continuous eligibility period begins on the effective date of the individual's eligibility under 42 CFR 435.915, or the effective date of the most recent redetermination.

- b. Because individuals are continuously eligible regardless of changes in circumstances, the state does not need to conduct renewals or redeterminations of eligibility consistent with 42 CFR 435.916 and 435.919 for individuals who qualify for continuous eligibility until the end of the individual's continuous eligibility period, except in the limited circumstances of a beneficiary meeting one of the exceptions outlined in STC 1.4.
- c. At the end of the continuous eligibility periods, Minnesota must conduct a renewal of Medicaid eligibility and consider eligibility on all bases consistent with 42 CFR 435.916(d)(1) prior to terminating coverage. Individuals determined eligible on another basis at the end of the CE period will be moved to the appropriate group at that time. Individuals determined eligible on another basis resulting in a reduction of Medicaid eligibility or services or increase in cost sharing or premiums will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(d)(2).

**1.2 Populations and Duration:** The state is authorized to provide continuous eligibility for the following populations for the associated durations.

- a. Children up to age six. Except as provided in STC 1.4, individuals age zero through the end of the month of their sixth birthday, who enroll in Medicaid shall qualify for continuous eligibility until the end of the month in which their sixth birthday falls.
- b. Children aged 19 through 21. Except as provided in STC 1.4, the state is authorized to provide 12 months of continuous eligibility for children who enroll in Medicaid from age 19 until the end of the month in which their 21<sup>st</sup> birthday falls.

<b>Table 1: Eligible Populations and Associated Duration for Continuous Eligibility (CE)</b>	
<b>Population</b>	<b>Duration of CE</b>
Children up to age 6	Until the end of the month of their 6th birthday
Children aged 19 up to age 21	12 months

**1.3 Eligibility Exclusions:** The following children are excluded from receiving continuous eligibility:

- a. Have only established Medicaid eligibility as medically needy (as set forth in section 1902(a)(10)(C) of the Act),
- b. Have been determined presumptively eligible for Medicaid but have not yet received an eligibility determination based on a regular application, or
- c. Upon the adult and child's renewal are determined to only be eligible for Medicaid based on transitional medical assistance (as set forth in section 1925 of the Act).



**1.4 Exceptions to Continuous Eligibility:** Notwithstanding STC 1.2, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be redetermined or terminated:

- a. The beneficiary attains the age limit of the continuous eligibility period or eligibility group (if applicable);
- b. The beneficiary is no longer a Minnesota resident;
- c. The beneficiary or their representative requests termination of eligibility;
- d. The beneficiary dies;
- e. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual

**1.5 Beneficiary-Reported Information and Periodic Data Checks:**

- a. The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their continuous eligibility as outlined STC 1.4 (such as a change in state residency) and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).
- b. For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals.
- c. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d). The state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.919 and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j).
- d. Because individuals are receiving continuous eligibility beyond their eligibility period, the state does not need to complete the individual's annual renewal or act on changes in circumstances that would otherwise affect eligibility, except as detailed in STC 1.4, until the end of the individual's continuous eligibility period. Additionally, if the state obtains information about changes that may affect eligibility (e.g., change in income), they are not permitted to use the information related to the change to end the continuous eligibility period early and terminate coverage, unless the change relates to one or more of the exceptions detailed in STC 1.4.

**1.6 Annual Updates to Beneficiary Contact Information:** For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to accept and update beneficiary contact information and must attempt to update beneficiary contact information on an annual basis, which may include examining data sources annually and partnering with managed care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting continuous eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d), the receipt of this third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

**1.7 Annual Reminders of Continued Eligibility:** The state must have procedures and processes in place to provide individuals who qualify for a continuous eligibility period that exceeds 12 months an annual reminder of continued eligibility. The annual reminder of continued eligibility must:

- a. Be written in plain language;
- b. Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with 42 CFR 435.905(b); and
- c. If provided in electronic format, comply with requirements for electronic notices in 42 CFR 435.918.

The annual reminder of continued eligibility must, at a minimum, include:

- d. An explanation of the individual's continued eligibility, including the end date of the continuous eligibility period;
- e. The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's continuous eligibility;
- f. Basic information on the level of benefits and services available as described at 42 CFR 435.917(b)(1)(iv); and
- g. If the beneficiary's eligibility is based on having household income at or below the applicable MAGI standard, the content regarding non-MAGI eligibility described at 42 CFR 435.917(c).

**1.8 Cost Sharing within Continuous Eligibility:** Individuals receiving continuous eligibility enrolled in this demonstration may be subject to cost sharing responsibilities, such as monthly premiums and co-payments, to the extent allowable under title XIX requirements or as approved under current section 1115 demonstration authority. However, beneficiaries may not be disenrolled from this demonstration for failure to pay a premium during the individual's continuous eligibility period approved in the demonstration.

## 2. Monitoring and Reporting Requirements

- 2.1 Performance Metrics:** For the continuous eligibility policy, monitoring metrics must support tracking enrollment and ex parte renewals. The state must describe successes and challenges related to activities to annually update beneficiary contact information, provide beneficiaries reminders of continued eligibility, verify beneficiary residency, and confirm that the beneficiary is not deceased, for all beneficiaries who qualify for a continuous eligibility period that exceeds 12 months.

## 3. Evaluation of the Demonstration

### 3.1 Evaluation Questions and Hypotheses:

- a. For the continuous eligibility policy, the state must evaluate the impact of the policy on all relevant populations, appropriately tailored for the specific time span of eligibility. Evaluation hypotheses must focus on, but may not be limited to, enrollment continuity, utilization of age-appropriate preventive care, inpatient admissions and avoidable emergency care, and health disparities.

## 4. General Financial Requirements

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

Table 2: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
CE MA Children Age 1 to 6	Hypo 2	X		X	All expenditures for continued benefits for children age one to six who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination.
CE MA 19, 20 Year-Olds	Hypo 2	X		X	All expenditures for continued benefits for children age 19 through 20 who have been determined eligible for the continuous eligibility period and who would otherwise lose coverage during an eligibility determination.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

**4.2 Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00039/5). For the CE MEG, 2.6 percent for adults or 0.11 percent for children of expenditures are allocated to the CE MEG. Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by Demonstration Year (DY) according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- a. Member Months. As part of the Quarterly and Annual Monitoring Reports, the state must report the actual number of “eligible member months” and expenditures for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below, with the exception of the Continuous Eligibility (CE) MEGs. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

For CE MEGs, states will report a calculated number, or percentage, of the actual member months and expenditures of the corresponding non-CE MEG. As applicable, the corresponding non-CE MEG member months and expenditures will then be reduced by the same percentage. For the Children CE MEGs, this percentage will be 0.11 percent. For example, the actual member months and expenditures for Children Age 1 to 6 in the Children’s MEG will be reduced by 0.11 percent and the equivalent member months and expenditures will be reported on the CE Children Age 1 to 6 MEG so that the total calculated member months and expenditures between the two MEGs are equal to the actual member months and expenditures for the Children Age 1 to 6 group.

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

<b>Table 3: MEG Detail for Expenditure and Member Month Reporting</b>							
MEG (Waiver Name)	Detailed Description	CMS-64.9 or 64.10 Line(s) to Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
CE MA Children Age 1 to 6	MA children age 1 to 6 who are eligible via CE, equaling 0.11% of total Medicaid expenditure for the Children Age 1 to 6	Follow 64.9 Base Category of Service Definition	Date of service	MAP	Y 0.11% of total member months for the MA Children Age 1 to 6	11/14/2024	12/31/2028
CE MA 19, 20 Year-Olds	MA children age 19 and 20 who are eligible via CE, equaling 0.11% of total Medicaid expenditure for the MA 19, 20 Year-Olds	Follow 64.9 Base Category of Service Definition	Date of service	MAP	Y 0.11% of total member months for the MA 19, 20 Year-Olds	11/14/2024	12/31/2028

**4.3 Budget Neutrality Monitoring Tool:** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing the demonstration’s actual expenditures to the budget neutrality expenditure limits described in Section 5. CMS will provide technical assistance, upon request.<sup>1</sup>

## 5. Monitoring BN for the Demonstration

**5.1 Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual or calculated number of member months, and aggregate components, which project fixed total

<sup>1</sup> Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS’s current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual or calculated costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of Federal Financial Participation (FFP) that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

**5.2 Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

**5.3 Hypothetical Budget Neutrality Test 2: Continuous Eligibility:** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditure in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

<b>Table 4: Hypothetical Budget Neutrality Test 2</b>									
MEG	PC or AGG	WOW Only, WW Only, or Both	Base Year DY 28	Trend Rate	DY31	DY32	DY33	DY34	DY35

CE MA Children Age 1 to 6	<b>PC</b>	<b>Both</b>	\$377.04	4.8%	\$395.14	\$414.11	\$433.99	\$454.82	\$476.65
CE MA 19, 20 Year-Olds	<b>PC</b>	<b>Both</b>	\$690.96	4.8%	\$724.13	\$758.89	\$795.32	\$833.50	\$873.51

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver