DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

August 10, 2021

T. Clark Phillip
Interim Director
State of South Carolina, Department of Health & Human Services
1801 Main Street PO Box 8206
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Dear Mr. Phillip:

On February 12, 2021, the Centers for Medicare & Medicaid Services (CMS) sent you a letter regarding the section 1115 demonstration project entitled "Palmetto Pathways to Independence" (Project Number 11-W-00335/4). The letter advised that CMS would commence a process of determining whether to withdraw the authorities previously approved in the Palmetto Pathways to Independence demonstration that would permit the state to require work and other community engagement activities as a condition of initial and continued Medicaid eligibility. It explained that in light of the ongoing disruptions caused by the COVID-19 pandemic, South Carolina's community engagement requirement compromises the demonstration's intended purpose and effectiveness in promoting coverage for its intended beneficiaries. For the reasons discussed below, CMS is now withdrawing approval of the community engagement requirement in the December 12, 2019 approval of the Palmetto Pathways to Independence demonstration, which is not currently in effect, and which would have expired by the terms of the demonstration on November 30, 2024.

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

As stated in the above referenced letter sent on February 12, 2021, under section 1115 and its implementing regulations, CMS has the authority and responsibility to maintain continued oversight of demonstration projects in order to ensure that they are currently likely to assist in promoting the objectives of Medicaid. CMS may withdraw waivers or expenditure authorities if

[1] 42 U.S.C. § 1315.

it "find[s] that [a] demonstration project is not likely to achieve the statutory purposes." 42 C.F.R. § 431.420(d); see 42 U.S.C. § 1315(d)(2)(D).

As the February 12, 2021, letter explained, the Palmetto Pathways to Independence community engagement requirement is not in effect. Although the demonstration was approved in December 2019, the Special Terms and Conditions stipulated that the state may not require compliance with the community engagement requirement and may not implement subsequent consequences for failure to meet the requirement sooner than one year after demonstration approval. In the state's draft Implementation Plan submitted to CMS in March 2020, the state indicated a demonstration implementation date of January 1, 2022.[2] Upon this projected implementation of the community engagement requirement, the compliance requirement would have taken effect. Since the time of submission of the state's draft Implementation Plan, the COVID-19 pandemic and its expected aftermath have made the demonstration community engagement requirement infeasible. In addition, implementation of the community engagement requirement is currently prohibited by the Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, Div. F, § 6008(a) and (b), 134 Stat. 208 (2020), which conditioned a state's receipt of an increase in federal Medicaid funding during the pandemic on the state's maintenance of certain existing Medicaid parameters. South Carolina has chosen to claim the 6.2 percentage point FFCRA Federal Medical Assistance Percentage (FMAP) increase, and therefore, while it does so, must maintain the enrollment of beneficiaries who were enrolled as of, or after, March 18, 2020. Moreover, as further discussed below, CMS is concerned about the effect of the community engagement requirement on potential beneficiaries and their ability to enroll in and access health care coverage if they do not satisfy the community engagement requirement as a condition of initial and continued eligibility.

CMS has serious concerns about testing policies that create enrollment and access barriers to health care coverage and harm to beneficiaries. The COVID-19 pandemic has had a significant impact on the health of low-income people, the effects of which are likely to continue after the pandemic has ended, while also demonstrating the need for health care coverage. Uncertainty regarding the current crisis and the pandemic's aftermath, and the potential impact on economic opportunities (including job skills training, work and other activities used to satisfy the community engagement requirement), and access to transportation and affordable child care, have greatly increased the risk that implementation of the community engagement requirement approved in this demonstration will create barriers to enrolling and accessing coverage in a time of great health care needs among low-income people. In addition, the uncertainty regarding the lingering health consequences of COVID-19 infections further exacerbates the harms of these barriers to coverage for low-income people.

CMS also has concerns about the demonstration's ability to fulfill its intended purpose of expanding coverage to a state-estimated total 45,100 beneficiaries, given the evidence discussed further below regarding other states' experience implementing community engagement requirements and the impact of the COVID-19 pandemic. Specifically, CMS is concerned that the factors resulting in observed coverage losses, including as a result of confusion about reporting requirements, that were associated with the implementation of the community

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[2] South Carolina Department of Health and Human Services. (2020). Healthy Connections Works Draft Implementation Plan. Submitted March 11, 2020. Under CMS Review.

engagement requirements in other states would prevent a substantial number of potential demonstration beneficiaries from enrolling in and maintaining access to coverage in South Carolina.

Accordingly, the February 12, 2021 letter indicated that, taking into account the totality of circumstances, CMS had preliminarily determined that allowing the community engagement requirement to take effect in South Carolina would not promote the objectives of the Medicaid program. Therefore, CMS provided the state notice that we were commencing a process of determining whether to withdraw the authorities approved in the Palmetto Pathways to Independence demonstration that permit the state to require work or other community engagement activities as a condition of initial and continued Medicaid eligibility. See Special Terms and Conditions ¶ 10. The letter explained that if CMS ultimately determined to withdraw those authorities, it would "promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date." *Id.* The February 12, 2021 letter indicated that, if the state wished to submit to CMS any additional information that in the state's view may warrant not withdrawing those authorities, such information should be submitted to CMS within 30 days.

On March 11, 2021, South Carolina submitted additional information in response to CMS's February 12, 2021 letter. As further described later in this letter, the additional information that South Carolina submitted did not address the concerns we raised in the February 12, 2021 letter. Specifically, the state did not dispute that the COVID-19 pandemic has had a significant impact on the health of Medicaid beneficiaries, including a discernible uptick in substance use disorder and mental health crises in the state, or that there is uncertainty about the lingering health effects of COVID-19. These COVID-19-related impacts highlight the importance of the demonstration's intended purpose of expanding coverage to more low-income adults. The state did not provide any information to illustrate how it would assure that potentially eligible beneficiaries would succeed in gaining coverage. Furthermore, the state did not provide information to demonstrate how it would minimize deterred enrollment or loss of coverage, which likely would be further aggravated as a result of the pandemic.

Additionally, the state did not address how pandemic-related child care shortages in South Carolina could affect individuals' ability to meet the community engagement requirement. Considering the physical, mental, social, and economic toll the public health emergency has taken on individuals, CMS believes it is especially important that the low-income individuals who are the intended beneficiaries of the Palmetto Pathways to Independence demonstration be able to access coverage and care, without the initial and continued eligibility obstacle of the community engagement requirement that may be unreasonably difficult or impossible for individuals to meet under the circumstances of COVID-19 and its likely aftermath. Overall, as addressed in detail later, the information available to CMS, including that which was submitted in South Carolina's March 11, 2021 letter, does not provide an adequate basis to resolve the concerns stated in our February 12, 2021 letter.

In light of these concerns, for the reasons set forth below, CMS has determined that, on balance, permitting South Carolina to require community engagement as a condition of eligibility is not

likely to promote the objectives of the Medicaid statute. Therefore, we are withdrawing the community engagement authorities that were approved in the December 12, 2019 approval of the Palmetto Pathways to Independence demonstration. This action leaves in place South Carolina's coverage of the Targeted Adult Group and the demonstration eligible group identified as Population I, which the state remains authorized to implement.

Background of South Carolina's Demonstration

On December 12, 2019, the Palmetto Pathways to Independence demonstration was approved for an initial five-year demonstration period. The demonstration authorized newly-provided coverage for individuals ages 19 through 64 who meet the criteria for the Medicaid state plan parent/caretaker relative (P/CR) group but who have incomes above the Medicaid standard of 62 percent of the federal poverty level (FPL) up to and including 95 percent of the FPL (effectively 100 percent with the five percent income disregard) and who are not otherwise eligible for full Medicaid coverage, referred to as Population I in the Special Terms and Conditions. This approval also allows South Carolina to provide full Medicaid state plan benefits to individuals ages 19 through 64, without dependent children, who otherwise would not be eligible for Medicaid, and who meet specific defined criteria that include being chronically homeless, justice involved and in need of substance use or mental health treatment, or needing substance use disorder (SUD) treatment, known as the Targeted Adult Group.

The demonstration authorized the state to require community engagement as a condition of initial and continued eligibility for beneficiaries in Population I and the Targeted Adult Group, with some exemptions. Applicants who would not be exempt would be required to meet the community engagement requirement at application to gain coverage, and remain compliant thereafter to remain eligible for demonstration coverage. Non-exempt individuals would be required to complete on average a minimum of 80 hours per month of community engagement activities (averaged on a quarterly basis) and report compliance on an annual basis for those already employed at initial enrollment, and no more frequently than every 90 days for those who would complete other qualifying community engagement activities or who would newly meet the requirement through employment after initial enrollment.[3]

Under the Palmetto Pathways to Independence demonstration, the state would notify applicants who have met, or been determined exempt from, the community engagement requirement and have been determined eligible for coverage of their need to continue to participate in, or remain exempt from, community engagement activities in order to continue to receive coverage. If at some point during the benefit year, a beneficiary no longer participated in a sufficient number of hours of qualifying community engagement activities or qualified for an exemption from the requirements, the beneficiary would have 90 days to report that he or she either had resumed meeting the requirement, qualified for an exemption, or experienced a circumstance that would give rise to a good cause exception. If a beneficiary did not report this information within this 90-day period, he or she would be considered non-compliant and have coverage suspended until the beneficiary came into compliance. During an eligibility suspension, beneficiaries could

[3] South Carolina Department of Health and Human Services. (2019). Section 1115 Demonstration Application. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf

reactivate their eligibility in the month following notification to the state that they completed a calendar month of required community engagement hours or qualified for an exemption. If a suspended beneficiary did not complete the one month of community engagement hours to reactivate coverage by his or her redetermination date, and not qualify for an exemption or for another eligibility category not subject to the requirement, the individual would be disenrolled from Medicaid at that time.

Per the demonstration's Special Terms and Conditions, beneficiaries who would engage in extra hours of qualifying activities above what would be required in a month, could apply the extra hours to other months within a quarter, but could not apply those extra hours to another quarter. That is, beneficiaries could distribute the required 80 hours per month in any manner throughout the quarter, but no hours would be allowed to carry over from one quarter to the next. Individuals who would be exempt from satisfying the community engagement qualifying activities requirement included: individuals receiving Supplemental Security Income (SSI); primary caregivers of a child, up to age 18 and/or of a disabled adult; individuals identified as medically frail; members of federally recognized tribes; individuals diagnosed with an acute medical condition that would prevent them from complying with the requirements; individuals who are exempt from Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements; and individuals who are pregnant through 365 days postpartum.[4]

The state's demonstration application also requested to provide coverage beyond the postpartum period to women eligible for Medicaid based on pregnancy. South Carolina revised its request, and CMS approved authority under this demonstration to allow women up to twelve months postpartum to gain eligibility through their need for SUD treatment in the Targeted Adult Group, limited to a certain number of beneficiaries. Lastly, the state's demonstration application requested that beneficiaries in the P/CR group and beneficiaries in the Transitional Medical Assistance (TMA) period who are eligible under the Medicaid state plan be required to meet a community engagement requirement, which CMS approved separately under the "Healthy Connections Works" demonstration.

As stated above, the Palmetto Pathways to Independence demonstration was approved in December 2019, with implementation anticipated to occur beginning January 1, 2022. Therefore, the community engagement requirement under this demonstration has not been implemented and no penalties have yet taken effect.

Early Experience from the Implementation of Community Engagement Requirements through Medicaid Section 1115 Demonstrations in Other States

Since the Palmetto Pathways to Independence demonstration, including the community engagement requirement, has not been implemented, there is no direct evidence illustrating how the demonstration would affect the intended beneficiaries of this demonstration. The state estimated that after one year following implementation, an estimated 32,300 individuals would

[4] CMS. (2019). Palmetto Pathways to Independence Section 1115 Demonstration Approval. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-palmetto-pathways-ca.pdf

be eligible for coverage in the expanded P/CR group and an additional 14,250 individuals would be eligible for coverage through the Targeted Adult Group. Of these potentially eligible individuals, the state estimated that approximately 1,200 of the P/CR group and 250 of the Targeted Adult Group, i.e., a total of 1,450 individuals, would not meet or be exempt from the community engagement requirement to gain initial coverage, or would be disenrolled from the demonstration, in the first year due to non-compliance with the community engagement requirement.[5] However, research from the Kaiser Family Foundation on potential nationwide coverage losses resulting from community engagement requirements estimates that approximately 6–17 percent of individuals subject to a requirement like that in the Palmetto Pathways to Independence demonstration would lose access to coverage.[6] By those estimates, South Carolina could see as many as 7,914 potential beneficiaries fail to gain access to, or lose, demonstration coverage for which they are intended to be eligible just in the first year of the demonstration due to not satisfying the community engagement requirement. The estimates from the Kaiser Family Foundation were based on observed coverage losses in states that implemented community engagement requirements prior to the COVID-19 pandemic. In light of the evidence on the impact of the pandemic, as described below in this letter, the potential magnitude of eligible beneficiaries being unable to access, or losing access to, coverage due to the community engagement requirement would likely be even greater than the estimates above suggest.

An independent study from the Georgetown University Health Policy Institute—leveraging the Kaiser Family Foundation estimates of potential nationwide coverage losses resulting from community engagement requirements[7]—estimated that between 5,000 and 14,000 South Carolina parents would be denied or lose Medicaid coverage as a result of a community engagement requirement in the first year, and total coverage losses could reach up to 26,000 parents in the fifth year of implementation.[8] These estimates did not separately account for the target populations under the two South Carolina community engagement demonstrations, nor did they include populations beyond parents who would be subject to the community engagement requirement. Nonetheless, the study projected that the community engagement requirements in South Carolina would disproportionately affect very low-income mothers, Black populations, and those in small towns and rural communities, where families are more likely to have Medicaid coverage and employment is more difficult to find. Specifically, of the parents who

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[5] CMS. (2019). Palmetto Pathways to Independence Section 1115 Demonstration Approval. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-palmetto-pathways-ca.pdf

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

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

[8] Georgetown University Health Policy Institute. (2019). Low-Income Families with Children Will Be Harmed by South Carolina's Proposed Medicaid Work Reporting Requirement. Retrieved from https://ccf.georgetown.edu/wp-content/uploads/2019/01/SC-work-requirement-update_FINAL.pdf

would be subject to the state's community engagement requirements, 86 percent are mothers and 51 percent are Black (compared to 28 percent of the statewide population who is Black).[9]

Data also suggest that most Medicaid beneficiaries are already working or are likely to be exempt from a potential community engagement requirement.[10,11,12,13] For example, the study from the Kaiser Family Foundation cited above found that nationally, 81 percent of adults with Medicaid coverage live in families with a working adult, and 6 in 10 are working themselves.[14] Similarly, a study published in 2017 found that, out of the 22 million adults covered by Medicaid nationwide (representing 58 percent of all adults on Medicaid) who could be subject to a community engagement requirement designed like the one in the Palmetto Pathways to Independence demonstration, 50 percent were already working, 14 percent were looking for work, and 36 percent were neither working nor looking for work.[15] Of those beneficiaries not working or looking for work, 29 percent indicated that they were caring for a family member, 17 percent were in school, and 33 percent noted that they could not work because of a disability (despite excluding from analysis those qualifying for Medicaid on the basis of disability, highlighting the difficulty with disability determination), with the remainder citing layoff, retirement, or a temporary health problem.

According to research from the Kaiser Family Foundation using the Current Population Survey (CPS) data,[16] in South Carolina, 48 percent (63 percent nationally) of Medicaid beneficiaries aged 19 to 64 without SSI in 2019 were working. Of those in South Carolina who were not working, 27 percent (32 percent nationally) cited that they were caretaking. While these percentages are reflective of the currently-enrolled Medicaid beneficiaries up to 62 percent of the FPL (67 percent, with the five percent income disregard), the proportion employed would likely be even higher when accounting for the intended beneficiaries of the Palmetto Pathways to

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[9] Georgetown University Health Policy Institute. (2019). Low-Income Families with Children Will Be Harmed by South Carolina's Proposed Medicaid Work Reporting Requirement. Retrieved from https://ccf.georgetown.edu/wp-content/uploads/2019/01/SC-work-requirement-update_FINAL.pdf

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

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

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

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

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

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

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

Independence demonstration who would have incomes above the state's current income eligibility threshold up to and including 100 percent of the FPL. This is based on the employment rates among Medicaid-eligible populations nationally as well as in states where Medicaid covers beneficiaries up to a higher income threshold compared to South Carolina. Thus, overall, prior to the pandemic, the available data indicated that the substantial majority of the population that would be targeted by a community engagement requirement like in South Carolina's demonstration would be already meeting the terms of such a requirement or would qualify for an exemption from it. This makes it challenging for a community engagement requirement to produce any meaningful impact on employment outcomes by incentivizing behavioral changes in a small fraction of potential beneficiaries, all the while risking substantial coverage losses, or inability to access initial coverage, among those subject to the requirement.

While the Palmetto Pathways to Independence demonstration would not affect currently-enrolled Medicaid beneficiaries, there is evidence of the potential impact of community engagement requirements in other states that tied such a requirement to continued eligibility for Medicaid coverage that could be applicable to this demonstration and its ability to expand coverage, as its intended purpose. Arkansas, Indiana, Michigan, New Hampshire, and Utah all implemented a community engagement requirement approved under each state's section 1115 demonstration; however, not every state's requirement was in place long enough to trigger penalties associated with non-compliance with the requirement or to obtain meaningful data. Arkansas, Michigan and New Hampshire provide some early evidence on potential enrollment impacts from implementation of a community engagement requirement.[17,18] Experience from these states indicates that large portions of the beneficiaries subject to these states' community engagement requirements failed to comply with the community engagement reporting requirements or became disenrolled once the requirements were implemented.[19] In Arkansas, for instance, before the U.S. District Court for the District of Columbia halted the community engagement requirement, the state reported that from August 2018 through December 2018, more than 18,000 individuals were disenrolled from coverage for "noncompliance with the work requirement."[20] During these five months, the monthly rate of coverage loss, as a percentage of

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[17] Utah and Indiana each also briefly implemented a section 1115 community engagement requirement demonstration, but these states did not impose any non-compliance penalties because beneficiaries were not late in meeting their respective reporting requirements. In Indiana, while the state suspended the community engagement requirement in October 2019, a beneficiary could report compliance or exemption status any time until the last day of the calendar year 2019. In Utah, beneficiaries were required to report compliance, or eligibility for a qualifying exemption or a good cause exception, within three months after receiving the notice to comply. Since Utah suspended the requirement right after the third month of its implementation, no beneficiaries experienced a non-compliance penalty for the community engagement requirement.

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

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

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

those who were required to report work and community engagement activities, fluctuated between 20 and 47 percent.[21] In New Hampshire, almost 17,000 beneficiaries (about 40 percent of those subject to the requirement) were set to be suspended for non-compliance with the requirement and lose Medicaid coverage within the span of just over a month when that state's community engagement requirement was in effect.[22,23,24] Based on those early data, another study projected that between 30 and 45 percent of New Hampshire beneficiaries subject to the community engagement requirement would have been disenrolled within the first year of implementation.[25] And in Michigan, before the policy was vacated by the courts, 80,000 beneficiaries—representing nearly 33 percent of individuals subject to the community engagement requirement—were at risk of loss of coverage for failing to report compliance with the community engagement requirement.[26]

Notwithstanding state assurances in the demonstration's Special Terms and Conditions that South Carolina would provide the necessary outreach to the demonstration's intended beneficiaries, evidence shows that lack of awareness of and administrative barriers associated with a community engagement requirement can create serious challenges for current and potential beneficiaries, which could result in a significant number of individuals being denied, suspended or disenrolled from coverage.[27] Early experiences in other states implementing their community engagement requirements were characterized by evidence of widespread confusion and lack of awareness among demonstration beneficiaries regarding the requirements.[28] For example, many beneficiaries in New Hampshire reportedly did not know about the community engagement reporting requirement or received confusing and often contradictory notices about

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2018.pdf; https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-annl-rpt-jan-dec-2019.pdf

[21] Arkansas Department of Human Services (DHS). (2018). Arkansas Works Section 1115 Demonstration Annual Report: January 1, 2018 – December 31, 2018. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf

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

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

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

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

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

[27] Margo Sanger-Katz. (2018). Hate Paperwork? Medicaid Recipients Will Be Drowning in It. New York Times. Retrieved from https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html.

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

whether they were subject to the requirement.[29,30] Moreover, in Arkansas, Michigan, and New Hampshire, evidence suggests that even individuals who were working or those who had serious health needs, and therefore should have been eligible for exemptions, lost coverage or were at risk of losing coverage because of complicated administrative and paperwork requirements.[31] Beneficiaries also reported barriers to obtaining exemptions from the community engagement requirement. For example, beneficiaries with physical and behavioral health conditions reported that their providers were resistant to signing forms needed to establish that the beneficiary was unable to work so that the beneficiary could qualify for an exemption.[32]

There is overwhelming evidence that any impediment to coverage, including eligibility denials or coverage suspensions and disenrollments, could be detrimental to the health of beneficiaries. For example, one study found that low-income individuals without insurance coverage were more likely to avoid or delay needed care, which can lead to greater risk of avoidable illnesses or even death.[33] Further, disenrollment and coverage gaps have been associated with increased barriers to care, lower quality care, and greater medical debt among beneficiaries disenrolled from Medicaid, even after their coverage resumed.[34] Another study using data from Arkansas found that adults ages 30–49 who had lost Medicaid or Marketplace coverage in the prior year experienced significantly higher medical debt and financial barriers to care, compared to similar Arkansans who maintained coverage.[35] Specifically, 50 percent of Arkansans affected by disenrollment in that age group reported serious problems paying off medical bills; 56 percent delayed seeking health care and 64 percent delayed taking medications because of cost considerations.[36] These rates were all significantly higher than among individuals who retained

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[29] Solomon, D. (2019). Spreading the Word on Medicaid Work Requirement Proves Challenging. Union Leader. Retrieved from https://www.unionleader.com/news/health/spreading-the-word-on-medicaid-work-requirement-proves-challenging/article_740b99e7-9f48-52d4-b2d8-030167e66af8.html

[30] Moon, J. (2019). Confusing Letters, Frustrated Members: N.H.'s Medicaid Work Requirement Takes Effect. New Hampshire Public Radio. Retrieved from https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0

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

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

[33] Ku, L. & Ross, D.C. (2002). Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_dec_staying_covered__the_importance_of_retaining_health_insurance_for_low_income_families_ku_stayingcovered_586_pdf.pdf

[34] University of Wisconsin-Madison Institute for Research on Poverty. (2019). Evaluation of Wisconsin's BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2014 Waiver Provisions. Retrieved from https://www.irp.wisc.edu/wp/wp-content/uploads/2019/11/BC-2014-Waiver-Provisions-Final-Report-08302019.pdf

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

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

coverage in Medicaid or Marketplace all year. Evidence also indicates that those with chronic conditions were more likely to lose coverage,[37] which could lead to worse health outcomes in the future.

In all states, consistent and stable employment is often out of reach for populations who might be subject to a community engagement requirement. Many low-income workers face a challenging job market, which often offers only unstable or low-paying jobs with unpredictable or irregular hours, sometimes resulting in spells of unemployment, particularly in seasonal work.[38,39,40,41] For example, one study found that among Medicaid beneficiaries likely to be subject to a community engagement requirement who did not always work 20 hours per week, about half reported not working or not working more hours for reasons related to the labor market or the nature of their employment, such as difficulty finding work, employer restrictions on their work schedule, employment in temporary positions, or reduced hours because business was slow.[42] Given the range of labor market and employment barriers facing current and potential Medicaid beneficiaries who could be subject to the community engagement requirement, South Carolina's demonstration requirement for satisfying an average of 80 hours per month (averaged quarterly) is a concern even for low-income adults who are working.[43,44,45]

To compound the challenges in accessing coverage, the administrative aspect of the requirement can be onerous for the demonstration's potential beneficiaries.[46] In addition to the challenges

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

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

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

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

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

[42] Karpman, M. (2019). Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment. The Urban Institute. Retrieved from http://hrms.urban.org/briefs/hrms-medicaid-work-requirements-2019.pdf

[43] Per the demonstration's STCs, beneficiaries who engage in extra hours of qualifying activities than is required in a month can apply the extra hours to other months within the same quarter, but cannot apply the extra hours to another quarter. (STC 24.a).

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

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

[46] Herd P. & Moynihan, D. (2020). How Administrative Burdens Can Harm Health. Health Affairs: Health Policy Brief. Retrieved from https://www.healthaffairs.org/do/10.1377/hpb20200904.405159/full/

associated with learning about the community engagement participation requirement; the nuances of the exemptions, good cause exceptions, and qualifying activities; and the reporting obligations, the community engagement requirement could be difficult to comply with in terms of documenting employment or exemption status, filling out forms, and understanding and appropriately responding to notices. All of these can potentially limit access to health coverage and care.[47] Furthermore, such a requirement is likely to aggravate the psychological costs, including the stigma, stress, frustration, anxiety, and loss of autonomy, which can arise from interacting with administratively burdensome public programs, potentially adversely impacting beneficiary health.[48] Moreover, the mental stress and negative health implications of administratively burdensome programs may be more pronounced among beneficiary populations of racial minorities.[49]

Furthermore, research examining the outcomes of statutorily authorized work requirements in other public assistance programs, such as TANF and SNAP, indicates that such requirements generally have only modest and temporary effects on employment, failing to increase long-term employment or reduce poverty.[50,51,52,53] Additionally, studies have found that imposing work requirements in the SNAP program led to substantial reductions in enrollment, even after controlling for changes in unemployment and poverty levels.[54] In fact, evidence suggests that there were large and rapid caseload losses in selected areas after SNAP work requirements went into effect, similar to what early data from Arkansas show, and what appeared likely to happen in New Hampshire and Michigan, had those states' community engagement requirements been implemented long enough to begin suspending or disenrolling beneficiaries.

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[47] Herd P. & Moynihan, D. (2020). How Administrative Burdens Can Harm Health. Health Affairs: Health Policy Brief. Retrieved from https://www.healthaffairs.org/do/10.1377/hpb20200904.405159/full/

[48] Herd P. & Moynihan, D. (2020). How Administrative Burdens Can Harm Health. Health Affairs: Health Policy Brief. Retrieved from https://www.healthaffairs.org/do/10.1377/hpb20200904.405159/full/

[49] Schram, S., Soss, J., Fording, R., & Houser, L. (2009). Deciding to Discipline: Race, Choice, and Punishment at the Frontlines of Welfare Reform. American Sociological Review, 74(3): 398-422. Retrieved from https://journals.sagepub.com/doi/pdf/10.1177/000312240907400304

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

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

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

[53] Gray, C., Leive, A., Prager, E., Pukelis, K.B. & Zaki, M. (2021). Employed in a SNAP? The Impact of Work Requirements on Program Participation and Labor Supply. National Bureau of Economic Research, Working Paper 28877. Retrieved from https://www.nber.org/papers/w28877

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

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

In summary, the short-to-long-term adverse implications of the COVID-19 pandemic on the economic opportunities for existing and potential Medicaid beneficiaries and other low-income individuals amplifies the risks of attaching a community engagement requirement to eligibility for coverage. In addition, the uncertainty regarding the lingering health complications of COVID-19 infections may continue to affect South Carolinians, since as many as 30 percent of COVID-19 survivors experience symptoms at least six months after the infection,[55] and may be limited in their ability to perform community engagement activities due to lingering illness. The potential long-term adverse health effects resulting from the economic and non-economic consequences of the pandemic also exacerbate the risk of denial or loss of coverage for Medicaid beneficiaries or potential beneficiaries, including of Medicaid demonstration projects. The likely ramifications of denial or loss of timely access to necessary health care also can be long lasting. As such, CMS believes that the potential for denial or loss of coverage among beneficiaries and potential beneficiaries of Palmetto Pathways to Independence—especially from the community engagement requirement that is difficult for beneficiaries and potential beneficiaries to understand and administratively complex for the state to implement—would be particularly harmful in the aftermath of the pandemic, and makes the demonstration's community engagement provisions impracticable.

Impact of COVID-19 and its Aftermath

The COVID-19 pandemic and the uncertainty surrounding the long-term effects on economic activity and opportunities across the nation exacerbate the risks associated with tying a community engagement requirement to initial and continued Medicaid eligibility, making the Palmetto Pathways to Independence community engagement requirement infeasible under the current circumstances. These COVID-related complications may be exacerbated in South Carolina, where COVID-19 rates and deaths remain higher than the national average[56] and

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[55] Logue, J.K., Franko, N.M., McCulloch, D.J, McDonald, D., Magedson, A. Wolf, C.R. & Chu, H.Y. (2021). Sequalae in Adults at 6 Months After COVID-19 Infection. JAMA Network;4(2). doi:10.1001/jamanetworkopen.2021.0830. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776560

[56] Worldometer. (2021). United States Coronavirus Cases. Retrieved on June 16, 2021 from https://www.worldometers.info/coronavirus/country/us/

vaccination rates are slightly lower than the national average.[57] There is a substantial risk that the COVID-19 pandemic and its aftermath will have a negative impact on economic opportunities for Medicaid beneficiaries. If employment opportunities are limited, Medicaid beneficiaries may find it difficult to obtain paid work in the aftermath of the pandemic.[58,59]

As discussed above, prior to the pandemic, most adult Medicaid beneficiaries who did not face a barrier to work were already working full or part-time.[60] However, one in three working adult Medicaid beneficiaries was doing only part-time work prior to the COVID-19 public health emergency, often due to fewer opportunities for full-time employment. The pandemic is expected to exacerbate the challenges of finding not only full-time employment, but may create additional obstacles to securing even part-time work, due to shifting caregiving responsibilities and increased transportation barriers.[61]

During the pandemic, the different sectors of the economy have seen disparate levels of disruption, which has affected labor market outcomes for certain populations more than the others. While the national employment rate[62] declined by 2.1 percent from January 2020 to May 2021, employment rates for workers in the bottom wage quartile decreased by 21.4 percent while employment rates for workers in the highest wage quartile increased 7.4 percent across that time period.[63] In South Carolina, employment rates for low-wage earners (i.e., annual wages under $27,000) decreased by 11.9 percent, compared to a 19.8-percent increase in employment rates for high-wage earners (i.e., wages over $60,000 per year) from January 2020 to May 2021.[64]

Further, declines in employment have been much higher for Black and Hispanic women and for workers in several low-wage service sectors, such as hospitality and leisure, while workers in

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[57] The Mayo Clinic. (2021). U.S. COVID-19 vaccine tracker: See your state's progress. Retrieved on June 16, 2021 from https://www.mayoclinic.org/coronavirus-covid-19/vaccine-tracker

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

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

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

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

[62] Not seasonally adjusted.

[63] Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved on July 8, 2021 from www.tracktherecovery.org

[64] Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved on July 8, 2021 from www.tracktherecovery.org

other sectors, such as financial services, have seen virtually no change.[65] In April 2020, the estimated unemployment rates (including individuals who were employed but absent from work and those not in the workforce but who wanted employment) for the Black and Hispanic populations were as high as 32 and 31 percent, respectively, compared to 24 percent for the White population.[66] Hispanic populations specifically are more likely to be affected due to their disproportionate representation in industries such as hospitality and construction, which have been most affected by the pandemic-related layoffs.[67,68,69]

Moreover, pandemic-related national job and income losses have also been more acute among the low-income population—those with the least wherewithal to withstand economic shocks, and who are disproportionately enrolled in Medicaid.[70] In fact, 52 percent of lower income (annual income below $37,500) adults nationwide live in households where someone has lost a job or taken a pay cut due to the pandemic.[71] Understandably, households with a job or income loss were two-to-three times more likely to experience economic hardship than those who did not experience such a loss.[72,73] Fifty-nine percent of lower-income adults in the country said they worry every day or almost every day about paying their bills.[74] There are also racial and ethnic disparities in the likelihood of reporting hardships; for example, compared to White households, Black households reported significantly higher chances of putting off filling prescriptions and

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

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

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

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

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

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

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

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

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

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

difficulties making housing and other bill payments. Also, Hispanic households were more likely to experience food insecurity compared to White households.[75,76]

Existing disparities in access to computers and reliable internet may also exacerbate issues in finding and maintaining employment during the pandemic. For example, 29 percent of adults in households with annual incomes below $30,000 did not own a smartphone, and 44 percent did not have home broadband services in 2019.[77] Moreover, fewer than 8 percent of Americans with earnings below the 25th percentile have the capabilities to work remotely.[78] In South Carolina, there is an unequal distribution of the availability in latest internet technologies, as not all residents have equal access to high-speed, affordable internet, and 171,000 individuals had no access to a wired connection as of April 2021.[79] These disparities will result in fewer opportunities for beneficiaries to satisfy a community engagement requirement, particularly as more jobs have shifted to telework or "work from home" during the public health emergency. Therefore, implementation of the community engagement requirement approved in this demonstration increases the risk of inability to access coverage and coverage loss for these low-income individuals.[80,81]

In addition to the challenges that the COVID-19 pandemic has presented for the labor market, it likely has also exacerbated the difficulty of participating in community or public service and volunteering activities that beneficiaries could use to meet the community engagement requirement instead of (or in combination with) paid work.[82] Many community or public service opportunities require individuals to help in-person, and oftentimes these activities involve working with the elderly, individuals with disabilities, or other vulnerable populations. Social distancing requirements, restrictions on visiting elderly individuals, and limited access to

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

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

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

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

[79] BroadBand Now. (2021). Internet Service in South Carolina. Retrieved on June 24, 2021 from https://broadbandnow.com/South-Carolina

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

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

[82] Fidelity Charitable. (2020). The Role of Volunteering in Philanthropy. Retrieved from https://www.fidelitycharitable.org/content/dam/fc-public/docs/resources/the-role-of-volunteering-in-philanthropy.pdf

physical locations where many such activities take place, all have potentially either reduced the number of available community or public service opportunities or made engaging in community or public service more challenging.

The pandemic also has disproportionately impacted the physical and mental health of racial and ethnic minority groups, who already experience disparities in health outcomes. Racial minorities and people living in low-income households are more likely to work in industries that are considered "essential services," which have remained open during the pandemic.[83] Additionally, occupations with more frequent exposure to COVID-19 infections, and that require close proximity to others (such as personal care aides and bus drivers) employ Black individuals at higher rates than White individuals.[84] As a result, Black people may be at higher risk of contracting COVID-19 through their employment. The pandemic's mental health impact also has been pronounced among populations experiencing disproportionately high rates of COVID-19 cases and deaths. Specifically, Black and Hispanic adults have been more likely than White adults to report symptoms of anxiety and/or depressive disorder during the pandemic.[85]

Further a recent study found that low-wage work is associated with the spread of COVID-19.[86] Therefore, low-wage workers, such as those who would be subject to the community engagement requirement, are potentially at higher risk of COVID-19 morbidity and mortality, particularly since low-wage workers also have higher prevalence of preexisting conditions like diabetes, asthma, and heart disease, which can increase the likelihood of serious illness from COVID-19.[87] Additionally, those infected may continue to experience prolonged adverse health effects, since according to recent research, as many as 30 percent of COVID-19 survivors still experience symptoms at least six months after their infections.[88,89]

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

[84] Hawkins, D. (2020). Differential Occupational Risk for COVID-19 and Other Infection Exposure According to Race and Ethnicity. American Journal of Industrial Medicine, 63(9):817-820. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7323065/

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

[86] Padilla, A. & Orozco, E. (2020). Hidden Threat: California COVID-19 Surges and Worker Distress. Community and Labor Center at the University of California Merced. Retrieved from https://news.ucmerced.edu/news/2020/low-wage-work-linked-spread-covid-19-study-finds

[87] 165 Koma, W., Artiga, S., Neuman, T., Claxton, G., Rae, M., Kates, J. & Michaud, J. (2020). Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/

[88] Logue, J.K., Franko, N.M., McCulloch, D.J, McDonald, D., Magedson, A. Wolf, C.R. & Chu, H.Y. (2021). Sequalae in Adults at 6 Months After COVID-19 Infection. JAMA Network;4(2). doi:10.1001/jamanetworkopen.2021.0830. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776560

[89] del Rio C., Collins L.F. & Malani P. (2020). Long-term Health Consequences of COVID-19. JAMA, 324(17):1723–1724. doi:10.1001/jama.2020.19719. retrieved from https://jamanetwork.com/journals/jama/fullarticle/2771581

Since the start of the pandemic, individuals have delayed or postponed seeking care, either due to concerns with out-of-pocket expenses or to avoid risk of contact with infected individuals in health care settings. For example, one study showed that screenings for breast, colon, prostate, and lung cancers were between 56 and 85 percent lower in April 2020 than in the previous year.[90] Results of another survey-based study show that 40 percent of respondents canceled upcoming health care appointments due to the pandemic, and another 12 percent reported they needed care but did not schedule or receive services.[91] These unmet health care needs may lead to substantial increases in subsequent mortality and morbidity.[92] With the estimated calendar year 2020 age-adjusted death rates increasing for the first time since 2017,[93,94] evidence also shows that Black, American Indian, and Hispanic individuals disproportionately experienced higher COVID-19-related mortality rates and deaths at younger ages than White individuals.[95] In addition to the health and mortality consequences associated with delaying care, pandemic-related delays in seeking care are estimated to increase annual health care costs nationwide by a range of $30 to $65 billion.[96]

The impact of the COVID-19 public health emergency on the economy has been significant, and, importantly, experience with previous recessions suggests the impact is likely to persist for an extended period of time. The unemployment rate went up from 3.5 percent in February 2020, prior to when the pandemic hit, to 14.8 percent in April 2020, and has subsequently fallen to 5.8 percent in May 2021.[97] The labor force participation rate (i.e., the percentage of the civilian non-institutional population age 16 or older who are working or actively seeking work during the prior month) likewise dipped from 63.3 percent in February 2020 to 60.2 percent in April 2020

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

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

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

[93] During January–December 2020, the estimated 2020 age-adjusted death rate increased for the first time since 2017, with an increase of 15.9 percent compared with 2019, with 113.5 more deaths per 100,000 population (from 715.2 in 2019 to 828.7 in 2020). COVID-19 was the underlying or a contributing cause of 377,883 deaths (91.5 deaths per 100,000). See Ahmad F.B. et al. (2021).

[94] Ahmad F.B., Cisewski J.A., Miniño A. & Anderson R.N. (2021). Provisional Mortality Data — United States, 2020. MMWR and Morbidity and Mortality Weekly Report 2021;70:519–522. DOI: http://dx.doi.org/10.15585/mmwr.mm7014e1

[95] Alsan, M., Chandra, A. & Simon, K. (2021). The Great Unequalizer: Initial Health Effects of COVID-19 in the United States. National Bureau of Economic Research. Retrieved from http://www.nber.org/papers/w28958

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

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

only to recover somewhat to 61.6 percent in May 2021.[98,99] Compared to pre-pandemic conditions, these data suggest that the labor force is still down in May 2021 by approximately 3.6 million individuals.[100,101] State-level data for these labor market indicators are available most recently for March 2021, and in South Carolina, the unemployment rate increased from 2.6 percent to 5.1 percent from January 2020 to March 2021, while the labor force in the state is still 36,742 individuals less over the same period.[102]

Evidence shows that losing a job can have significant long-term effects on an individual's future earnings. Studies have found that workers who lose their jobs in mass layoffs still earn 20 percent less than similar workers who kept their jobs, 15 to 20 years after the layoff, and the impacts are greater for individuals who lose their jobs during a recession. On average, men lost 2.8 years of pre-layoff earnings when the mass layoff occurred in a time when the unemployment rate was above eight percent.[103] Further, workers who enter the labor market during a recession also face long-term consequences for their earnings.[104] Additionally, non-White individuals and individuals with lower educational attainment have experienced larger and more persistent earning losses than other groups who enter the labor market during recessions.[105]

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[98] The numerator of the labor force participation rate, i.e., the total labor force, consists of those employed and unemployed, where the unemployed are individuals without a job but actively looking for work during the past month. The labor force does not include individuals who would like to and are available for work but may have given up looking for work altogether (known as discouraged workers, or more broadly as, marginally attached workers), usually because they believe that there are no jobs available for them or there are none for which they would qualify. Recessions, such as the one that resulted as a consequence of the COVID-19 pandemic, often lead to a sharp rise in the number of discouraged workers, and therefore, the size of the labor force shrinks resulting in a sharp decline in labor force participation rates. These individuals who leave the labor force *discouraged* are not represented either in the employment or unemployment rates. Therefore, in addition to the employment and unemployment rates, the labor force participation rate is another important measure of the labor market, particularly during times of economic shocks. For more information, for example, see: https://fred.stlouisfed.org/series/LNU05026645, https://www.bls.gov/charts/employment-situation/civilian-labor-force-participation-rate.htm, and https://www.bls.gov/opub/btn/archive/ranks-of-discouraged-workers-and-others-marginally-attached-to-the-labor-force-rise-during-recession.pdf.

[99] U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/cps/ and https://www.bls.gov/charts/employment-situation/civilian-labor-force-participation-rate.htm

[100] For May 2021 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved on June 10, 2021 from https://www.bls.gov/web/empsit/cpseea08b.pdf

[101] For February 2020 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (March, 2020). The Employment Situation – February 2020. News Release.
Table A-1. Retrieved from https://www.bls.gov/news.release/archives/empsit_03062020.pdf

[102] U.S. Bureau of Labor Statistics. Databases, Tables & Calculators by Subject. Retrieved on June 23, 2021 from https://data.bls.gov/timeseries/LASST450000000000006?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true

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

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

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

Layoffs can also impact an individual's mortality and morbidity risks.[106] For example, one study found that male workers experienced mortality rates that were 50-100 percent higher than expected in the year after a layoff occurred, and 20 years later, mortality rates remained 10-15 percent higher for these individuals.[107] Furthermore, workers experiencing layoff have reductions in health care utilization, especially among those who lose coverage, which suggests that access to coverage, and continuity of care, could be important in alleviating the long-term ill effects of layoffs on mortality.[108]

In summary, the short-to-long-term adverse implications of the COVID-19 pandemic on the economic opportunities for Medicaid beneficiaries, potential beneficiaries, and other low-income individuals amplifies the risks of attaching a community engagement requirement to eligibility for coverage. The potential long-term adverse health effects resulting from the economic and non-economic consequences of the pandemic also exacerbate the risk of denial or loss of coverage for Medicaid beneficiaries or potential beneficiaries, including of Medicaid demonstration projects. The likely ramifications of losing timely access to necessary health care also can be long lasting. As such, CMS believes that the potential denial or loss of coverage among potential beneficiaries of Palmetto Pathways to Independence—especially from a requirement that is difficult for beneficiaries to understand and administratively complex for states to implement—would be particularly harmful in the aftermath of the pandemic, and makes the community engagement requirement under the Palmetto Pathways to Independence demonstration impracticable.

Evidence Submitted by South Carolina

On March 11, 2021, South Carolina submitted a response to CMS's letter of February 12, 2021. As noted above, the February 12, 2021 letter informed South Carolina that CMS preliminarily determined that allowing the community engagement requirement under the Palmetto Pathways to Independence demonstration to take effect in South Carolina would not promote the objectives of the Medicaid program. The February 12, 2021 letter explained that the potential impact of the COVID-19 public health emergency on economic opportunities, as well as on access to transportation and affordable child care, has increased the risks that South Carolinians who would be the intended beneficiaries of the Palmetto Pathways to Independence demonstration would find it unreasonably difficult or impossible to meet the community engagement requirement.

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

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

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

South Carolina's response does not resolve the concerns we raised in the February 12, 2021 letter. In its response, the state noted that "incentivizing those who are able to contribute to their community by participating in a wide variety of activities of their own choosing … will improve beneficiary health outcomes, increase the financial independence of beneficiaries and strengthen communities across the state."[109] However, there is no evidence offered by the state establishing that the Palmetto Pathways to Independence community engagement requirement is likely to lead to greater economic well-being and financial independence, or better health outcomes. There is overwhelming evidence that individuals must be healthy to work, and consistent access to health coverage is vital to being healthy enough to work.[110,111,112,113] In contrast, there is no evidence of a causal effect of employment on health outcomes, particularly for the population likely to be subject to the community engagement requirement.

In addition, the challenge of finding full-time or even part-time employment has likely become further complicated due to a lack of affordable child care that has only compounded during the pandemic in all states.[114] Individuals who meet the criteria of P/CR with incomes above 62 percent of the FPL up to and including 95 percent of the FPL—one of the primary target population of the Palmetto Pathways to Independence demonstration—in particular, may continue to experience substantial obstacles to meeting the community engagement requirement due to shortages in affordable child care centers in the state. A survey from late-2020 found that nearly half of child care centers surveyed had reduced the number of children served to allow for distancing.[115] The study identified staffing challenges, including difficulty hiring new staff, issuing temporary layoffs, or having staff miss work due to COVID-19 exposure.[116] According

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[109] Healthy Connections Medicaid. (2021). Letter Re: Feb, 12, 2021, Healthy Connections Works and Palmetto Pathways to Independence Letters. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/sc-cms-ltr-from-state-03112021.pdf

[110] Gehr, J. & Wikle, S. (2017). The Evidence Builds: Access to Medicaid Helps People Work. CLASP. Retrieved from https://www.clasp.org/sites/default/files/publications/2017/04/The-Evidence-Builds-Access-to-Medicaid-Helps-People-Work.pdf

[111] Tipirneni R., Ayanian J., Kullgren J., Goold S., Kieffer E., Chang T., Haggins A., Clark S. & Lee S. (2017). Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches. The Institute for Healthcare Policy and Innovation (IHPI). Retrieved from https://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches

[112] Musumeci M., Rudowitz R. & Lyons B. (2018). Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees. Kaiser Family Foundation. Retrieved from https://www.kff.org/report-section/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees-issue-brief/

[113] The Ohio Department of Medicaid. (2018). 2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment. Retrieved from https://www.medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf . Beneficiaries participating in substance use disorder treatment are exempt from the community engagement requirement.

[114] McGrath, J. (2021). Child Care in Crisis. Third Way. Retrieved from https://www.thirdway.org/memo/child-care-in-crisis#:~:text=Child%20care%20in%20America%20was,now%20it's%20a%20deep%20crisis.&text=Thirty%2Dfive%20states%20are%20seeing,tune%20of%201.2%20million%20workers

[115] Carolan, M. (2021). Child Care Staffing a Major Challenge in South Carolina as Providers Do More with Less. Institute for Child Success. Retrieved from https://www.instituteforchildsuccess.org/child-care-staffing-major-challenge-in-south-carolina/

[116] Carolan, M. (2021). Child Care Staffing a Major Challenge in South Carolina as Providers Do More with Less. Institute for Child Success. Retrieved from https://www.instituteforchildsuccess.org/child-care-staffing-major-challenge-in-south-carolina/

to an interactive cost calculator, the costs of center-based child care in the state were estimated to have increased by 13 percent during the pandemic compared to the pre-pandemic scenario.[117,118] Additionally, caregivers across the United States have experienced intensified caregiving responsibilities both in terms of the types of care provided and hours spent in caregiving during the pandemic, all of which can affect the physical and mental health of caregivers.[119] Research has also shown that women in front-line roles in health care and service industries (e.g., grocery store clerks), where telecommuting is not an option, faced difficult decisions choosing between paid employment and caring for children due to the closure of child care centers and schools.[120] These increased barriers in accessing affordable child care could make it unreasonably difficult for the intended beneficiaries of the demonstration to meet the community engagement requirement.

Research on potential beneficiary coverage loss from community engagement requirements indicates that most of those affected would be individuals who are already working or should be exempt, but who would be unable to access or maintain coverage because of challenges around beneficiary understanding and policy awareness as well as the increased administrative and reporting challenges inherent in community engagement requirements.[121,122,123] The Kaiser Family Foundation, for example, estimated that if community engagement requirements were to be implemented nationwide, coverage loss due to non-reporting of qualifying activities or exemptions would account for 77-83 percent of total Medicaid disenrollments due to such a requirement, with the rest potentially attributable to actually not participating in sufficient hours of qualifying activities to meet work or community engagement requirements.[124] The challenges of successfully reporting compliance with community engagement requirements estimated and observed in other states that led to coverage losses could also lead to sizable numbers of low-

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[117] Choi, A. (2021). How Much Child Care Went Up in Your State. Politico Nightly. Retrieved from https://www.politico.com/newsletters/politico-nightly/2021/05/26/how-much-child-care-went-up-in-your-state-493017

[118] Workman, S. & Brady, M. (2020). The Cost of Child Care During the Coronavirus Pandemic. Center for American Progress. Retrieved from https://www.americanprogress.org/issues/early-childhood/news/2020/09/03/489962/cost-child-care-coronavirus-pandemic/

[119] Cohen, S., Kunicki, Z., Drohan, M. & Greaney, M. (2021). Exploring Changes in Caregiver Burden and Caregiving Intensity due to COVID-19. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7919204/

[120] Raile, A., Raile, E. Parker, D., Shanahan, E. Haines, P. (2020). Women and the Weight of the Pandemic: A Survey of Four Western US States Early in the Coronavirus Outbreak. Feminist Frontiers. https://doi.org/10.1111/gwao.12590. Retrieved from https://onlinelibrary.wiley.com/doi/full/10.1111/gwao.12590#gwao12590-bib-0001

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

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

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

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

income South Carolinians being denied, suspended, or disenrolled from coverage, possibly by a much larger magnitude than that projected by the state itself, and somewhere in the range indicated by the independent estimates from the Georgetown University Health Policy Institute.[125,126] Furthermore, there have been pronounced job losses in the state's public and social benefit nonprofit sector during the pandemic, with a 20.6 percent decrease in full-time employees from March 2020 to March 2021.[127] This loss in public and social benefit employees could further complicate staffing and other resources available to help beneficiaries apply for and maintain coverage through required reporting of community engagement activities.

Once implemented, under the Palmetto Pathways to Independence demonstration, non-exempt beneficiaries without circumstances giving rise to good cause would be required to participate in sufficient hours of community engagement as a condition of initial and continued Medicaid eligibility. Beneficiaries would have been required to report if they no longer participated in community engagement activities or qualified for an exemption, and would have 90 days to report that they were meeting the requirement again, qualified for an exemption or good cause exception. If a beneficiary did not report compliance within 90 days, the beneficiary would have been considered non-compliant and would have had their coverage suspended until they came into compliance.[128] However, evidence shows that a community engagement requirement can create barriers to coverage not only when current and potential beneficiaries do not satisfy the required hours of participation or qualify for an exemption, but also because they are not aware of the requirement, do not understand the reporting requirements or are otherwise unable to complete timely reporting, including for qualifying exemptions and good cause exceptions.[129] There is also evidence that such reporting requirements could be burdensome for beneficiaries, who might find it difficult to report work hours due to documentation requirements, such as paystubs and timesheets, possibly from multiple employers, and other bureaucratic hurdles.[130,131]

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[125] CMS. (2019). Palmetto Pathways to Independence Section 1115 Demonstration Approval. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-palmetto-pathways-ca.pdf

[126] Georgetown University Health Policy Institute. (2019). Low-Income Families with Children Will Be Harmed by South Carolina's Proposed Medicaid Work Reporting Requirement. Retrieved from https://ccf.georgetown.edu/wp-content/uploads/2019/01/SC-work-requirement-update_FINAL.pdf

[127] Kahle, R.W. & Roderick, G. (2021). Nonprofit COVID-19 Impact Survey: Top-Line Report. Kahle Strategic Insights. Retrieved from https://assets.noviams.com/novi-file-uploads/tsc/pdfs-and-documents/TSC_Nonprofit_COVID_Impact_March_19_.pdf

[128] CMS (2019). Palmetto Pathways to Independence Section 1115 Demonstration Approval. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-palmetto-pathways-ca.pdf

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

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

[131] Hahn, H., Sullivan, L., Tran, V., Blount, D. & Waxman, E. (2019). SNAP Work Requirements in Arkansas for Adults without Dependents or Disabilities. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101112/snap_work_requirements_in_arkansas_for_adults_without_dependents_or_disabilities_5.pdf

This would be more challenging for individuals who are self-employed and therefore might not have such documentation readily available.[132] Furthermore, with increased administrative requirements, and burdens on the state agency, it is possible that a backlog in processing paperwork could develop and result in delays or mistakes affecting coverage of individuals subject to the community engagement requirement.[133]

Further, there remains significant uncertainty about the pandemic's aftermath in terms of its lingering economic and health impacts, especially in the context of the newer and more transmissible variants of COVID-19. The state indicated that it would include exemptions for individuals residing in regions that experience an unemployment rate of eight percent or greater, and that only one county was above that threshold at the time of the March 11, 2021 letter. By the state's own estimates, the demonstration was estimated to target only a small percentage of the state's population because the vast majority of beneficiaries subject to the community engagement requirement were already working or would have qualified for an exemption.[134] While qualifying exemptions are important in the design of the community engagement requirement, they also limit the number of potential beneficiaries who might newly engage in community engagement activities, including gainful employment, as a result of the requirement.

The state has not presented information to suggest that withholding safety net benefits, such as Medicaid coverage, from potential beneficiaries would lead to increased employment or other positive outcomes for low income and vulnerable individuals. Overall, we do not have information before us that suggests that the design and approach of South Carolina's Palmetto Pathways to Independence community engagement requirement are likely to reduce the risks that this demonstration project would result in substantial eligibility denials, suspensions and disenrollments at a time when being denied or losing access to health care coverage would cause significant harm to the individuals intended to benefit from the demonstration. Therefore, given the early experience from states that implemented a community engagement requirement and the health and economic repercussions that are likely to continue from the COVID-19 pandemic, CMS does not believe that the community engagement requirement under Palmetto Pathways to Independence would succeed in generating employment or that conditioning initial and continued eligibility on compliance with a community engagement requirement is likely to be effective in improving health outcomes or financial independence of intended beneficiaries, or in strengthening communities or the Medicaid program.

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

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

[134] South Carolina Department of Health and Human Services Department of Health and Human Services. (2019). Section 1115 Demonstration Application. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf

Withdrawal of Community Engagement Requirement in the December 12, 2019 Approval of the Palmetto Pathways to Independence Demonstration

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

Accordingly, pursuant to our authority and responsibility under applicable statutes and regulations to maintain ongoing oversight of whether demonstration projects are currently likely to promote those objectives, CMS is hereby withdrawing the portion of the December 12, 2019 South Carolina Palmetto Pathways to Independence demonstration approval and the accompanying authorities and Special Terms and Conditions that authorize the state to require and implement the community engagement requirement as a condition of initial and continued eligibility. The withdrawal of these authorities is effective on the date that is thirty days after the date of this letter, unless the state timely appeals, as discussed below.

Procedure to Appeal This Decision

In accordance with Special Terms and Conditions ¶ 10 and 42 C.F.R. § 430.3, the state may request a hearing to challenge CMS's determination prior to the above-referenced effective date by appealing this decision to the Departmental Appeals Board (DAB or Board), following the procedures set forth at 45 C.F.R. part 16. This decision shall be the final decision of the Department unless, within 30 calendar days after the state receives this decision, the state delivers or mails (the state should use registered or certified mail to establish the date) a written notice of appeal to the DAB.

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

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

"File New Appeal-Appellate Division" form. Detailed instructions can be found on the DAB E-File homepage.

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

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

Medicaid is a federal-state partnership and we look forward to continuing to work together. If you have any questions, please contact Judith Cash at (410) 786-9686.

Sincerely,

Chiquita Brooks-LaSure

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00335/4**

TITLE: **Palmetto Pathways to Independence**

AWARDEE: **South Carolina Department of Health and Human Services**

Title XIX Costs Not Otherwise Matchable Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by South Carolina for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from December 12, 2019 through November 30, 2024, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

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

1. **Population I.** Expenditures to provide Medicaid state plan coverage to individuals that meet the criteria for the Parents and Other Caretaker Relatives group with incomes above the Medicaid standard but at or below 95 percent of the federal poverty level (FPL) (effectively 100 percent with the five percent income disregard) who are not otherwise eligible for full Medicaid coverage, as described in these STCs.

2. **Targeted Adult Group.** Expenditures to provide Medicaid state plan coverage to certain individuals, ages 19 through 64, who meet specific criteria, as described in these STCs.

Title XIX Requirements Not Applicable to the Demonstration Eligible Populations

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

1. **Reasonable Promptness** **Section 1902(a)(8)**
   To the extent necessary to enable South Carolina to deny enrollment in the Targeted Adult Group when enrollment is closed, as described in the STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00335/4**

TITLE: **Palmetto Pathways to Independence**

AWARDEE: **South Carolina Department of Health and Human Services**

I. PREFACE

The following are the STCs for the "Palmetto Pathways to Independence" section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the South Carolina Department of Health and Human Services (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. The Palmetto Pathways to Independence demonstration will be statewide and is approved for a 5-year period, from December 12, 2019 through November 30, 2024.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Benefits
VI. Cost Sharing
VII. Delivery System
VIII. General Reporting Requirements
IX. General Financial Requirements Under Title XIX
X. Monitoring Budget Neutrality
XI. Evaluation of the Demonstration
XII. Schedule of Deliverables for the Demonstration

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

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

New Coverage for Parents

With this approval, South Carolina will newly provide full Medicaid coverage to individuals who meet the criteria for the Parents and Other Caretaker Relatives (P/CR) group with incomes above the Medicaid standard of 62 percent of the federal poverty level (FPL) but at or below 95 percent FPL (effectively 100 percent with the five percent disregard) who are not otherwise eligible for full Medicaid coverage. Under this demonstration this group is identified as Population I.

Targeted Adult Group
This demonstration also allows South Carolina to provide state plan benefits to a Targeted Adult Group for adults, ages 19 through 64, who otherwise would not be eligible for Medicaid, and who meet additional defined criteria, including being chronically homeless, being justice involved and in need of substance use disorder (SUD) treatment, or needing substance use disorder treatment. The Targeted Adult Group will receive full Medicaid state plan benefits for an initial 12 month period. Beneficiaries in the Targeted Adult Group who, at the end of the 12 month period are still engaged in treatment, will continue to receive Medicaid benefits unless the individual becomes eligible under another state plan group.

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

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

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
   a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public

feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;
c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
d. An up-to-date CHIP allotment worksheet, if necessary;
e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

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

9. **Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:
   a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised transition and phase-out plan.
   b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently

enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

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

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

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

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed.

Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

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

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

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

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

IV. ELIGIBILITY

16. **Eligibility.** Only beneficiaries eligible for Medicaid under an eligibility group listed in Table 1 are subject to the provisions within this demonstration. Demonstration eligible populations are not otherwise eligible for Medicaid through the state plan, and are only covered under Medicaid through the section 1115 demonstration.

17. **Populations Affected by the Demonstration.** The demonstration is comprised of the following Eligibility Groups:
    a. <u>Population I:</u> Defined as individuals not otherwise eligible for Medicaid with incomes from 62 percent of the FPL up to and including 95 percent of the FPL (effectively 100 percent of the FPL with a five percent of income disregard) who are U.S. citizens/qualified non-citizens, are residents of South Carolina, and who otherwise

meet the eligibility criteria for the Parents and Other Caretaker Relatives group in the state plan.

b. The Targeted Adult Group: Defined as individuals age 19 up to and including 64 not otherwise eligible for full coverage Medicaid, and who meet any one of the following additional criteria:
   i. Be chronically homeless, defined as:
      1) An individual who has been continuously homeless for at least 12 months; or
      2) An individual has experienced four episodes of homelessness (greater than 30 days) in the past three years; or
      3) An individual currently in supportive housing but who has met the prior definitions of homelessness; and
      4) Have an income of 0 percent FPL (effectively 5 percent with the income disregard); and
      5) The individual must consent to referral to and application for other benefits as may be available, including but not limited to those offered Diagnosed with a SUD or serious mental illness; and
      6) through the Veterans' Affairs Administration (VA) and Social Security Administration (SSA).
   ii. Involved in the criminal justice system and in need of substance use or mental health treatment, defined as:
      1) The individual must demonstrate a need for treatment for a substance use disorder or mental illness; and
      2) Have an income less than 95 percent FPL (effectively 100 percent with the 5 percent income disregard); and
      3) Have been released within the preceding six months from a South Carolina Department of Corrections (SCDC) facility; and
      4) Have been sentenced to a term of imprisonment within a SCDC facility of not more than five years; and
      5) Consent to a health and social determinants screening and risk assessment and agree to a risk mitigation plan prior to release.
   iii. In need of substance use treatment, defined as:
      1) Have an income less than 95 percent FPL (effectively 100 percent with the 5 percent income disregard).
         a. To promote positive fetal maternal health, the state elects to set aside 1,000 slots split evenly between the below criteria.
         b. Women who:
            A. Are otherwise not eligible for Medicaid coverage; and
            B. Have an income less than 194 percent FPL; and
            C. Have a diagnosed SUD, serious mental illness (SMI), or both; and
            D. Are pregnant or up to 12 months postpartum.
         c. Parents of foster children who:
            A. Are otherwise not eligible for Medicaid coverage; and
            B. Have an income less than 133 percent FPL (effectively 138 percent with 5 percent income disregard); and

C. Have not had their parental rights terminated; and
D. Are completing or complying with a SUD treatment program as part of a family reunification plan.

18. **Targeted Adult Group Enrollment.** Individuals applying for Medicaid must be screened for eligibility in other Medicaid programs before being enrolled in the Targeted Adults Group. Enrollment in the Targeted Adult Group may be prioritized based on Opioid use disorder (OUD)/SUD diagnoses. If a beneficiary enrolled in this group continues to be actively engaged in a treatment plan for SUD/OUD at the end of the 12 month period, the state must continue to extend coverage as long as the beneficiary otherwise remains eligible for the Targeted Adult Group.
    a. Enrollment Caps. Each subset of the Targeted Adult Group will have enrollment caps. The Targeted Adult Group or any subset of this group may be closed to new enrollment at the state's election. If this eligibility group is closed to new enrollment, the state will continue to take applications. The state will process these applications to check for eligibility in other Medicaid state plan groups. If the application is only eligible for the Targeted Adult Group, the application will be held for a new enrollment period and the individual will be placed on a waitlist. When the new enrollment period opens the state will conduct a redetermination on held applications. Below outlines the upper limit of enrollment for each subset:
        i. Chronically Homeless: 3,000 beneficiaries;
        ii. Justice-involved and in need of SUD treatment: 5,000 active beneficiaries and up to 20,000 incarcerated beneficiaries who will be in a suspended status prior to release; and
        iii. Beneficiaries in need of SUD treatment: 6,000 beneficiaries

Table 1. Populations Affected by the Demonstration		
Demonstration Feature	**Eligibility Group**	**Citations**
Demonstration Eligible Group	Population I – Individuals who meet the criteria of P/CR with incomes from 62% FPL up to and including 95% FPL	Expenditure Authority
Demonstration Eligible Group	Targeted Adult Group – • Chronically Homeless – 0% FPL • Justice involved in need of SUD treatment- Up to and including 95% FPL • Individuals in need of SUD treatment – Up to and including 95 % FPL	Expenditure Authority

V. BENEFITS

19. **Population I**. Beneficiaries enrolled in this eligibility category with incomes from 62 percent of the FPL up to and including 95 percent of the FPL will receive the same benefits set forth in section 1905(y)(2)(B) of the Act and in 42 CFR 433.204(a)(2) and described in the Medicaid state plan.

20. **Targeted Adult Group.** Beneficiaries enrolled in this eligibility category will receive the same benefits set forth in section 1905(y)(2)(B) of the Act and in 42 CFR 433.204(a)(2) for a 12 month period. If a beneficiary enrolled in this group continues to be actively engaged in a treatment plan for SUD/OUD at the end of the 12 month period, the state must continue to extend coverage consistent with the criteria described in STC 18.

VI. COST SHARING

21. **Cost Sharing for Participants in the Demonstration**. Cost sharing for beneficiaries in this demonstration must be in compliance with federal requirements that are set forth in statute, regulation and policies, including exemptions from cost sharing set forth in 42 CFR 447.56(a).

VII. DELIVERY SYSTEM

22. **Delivery system**. All demonstration beneficiaries except for the Targeted Adults group will receive services through the same managed care and fee-for-service (FFS) arrangement as currently authorized in the state.

23. **Targeted Adults Delivery System.** Benefits will be delivered through FFS.

VIII. GENERAL REPORTING REQUIREMENTS

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

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

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

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

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

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

structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, and how challenges are being addressed. 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. The Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

   Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's goals, and must cover all key policies under this demonstration. Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances, and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the CMS framework provided by CMS to support federal tracking and analysis.

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

c. 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.

28. **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 sustained directional change, inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not

implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

29. **Close Out Report**. Within one hundred twenty (120) calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.
    a. The draft report must comply with the most current guidance from CMS.
    b. The state will present to and participate in a discussion with CMS on the Close-Out Report.
    c. The state must take into consideration CMS's comments for incorporation into the final Close Out Report.
    d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
    e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 24.

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

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

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

32. **Allowable Expenditures.** This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval periods 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.

33. **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

expenditure for services provided under this demonstration following routing 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 thirty (30) days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

34. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section X:
    a. Administrative costs, including those associated with the administration of the demonstration;
    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
    c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

35. **Sources of Non-Federal Share.** The state certifies that its match for non-federal share of funds for this demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.
    a. The state acknowledges that CMS has the authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
    b. The state acknowledges that any amendments that impact the financial status of the demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

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

a. Units of government, including governmentally operated health care providers may certify that state of local monies have been expended as the non-federal share of funds under the demonstration.
b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR §433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR §433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR §447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments related to taxes, including health care provider-related taxes, fees, business relationship 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.

37. **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.

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

Table 2: Master MEG Chart

MEG	To Which BN Test Does This Apply?	Without Waiver (WOW) Per Capita	WOW Aggregate	With Waiver (WW)	Brief Description
Population I	Hypo 1	X		X	See Expenditure Authority #1
Targeted Adult Group	Hypo 2	x		X	See Expenditure Authority #2

39. **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-00332/4). Separate reports must be submitted by MEG (identified by Waiver name) and Demonstration Year (DY) (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.
    a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
    b. Premiums and Cost Sharing Collected by the state. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by 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 for determination of the state's compliance with the budget neutrality limits.
    c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality.

The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

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

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

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

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Population I	Refer to STC 17(a)	N/A	Population I	Date of payment to a provider of service(s)	MAP	Y	December 12, 2019	November 30, 2024
Targeted Adult Group	Refer to STC 17(b)	N/A	Targeted Adult Group	Date of payment to a provider of service(s)	MAP	Y	December 12, 2019	November 3, 2024

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

Table 4: Demonstration Years		
Demonstration Year 1	December 12 , 2019 to November 30, 2020	12 months
Demonstration Year 2	December 12, 2020 to November 30, 2021	12 months
Demonstration Year 3	December 12, 2021 to November 30, 2022	12 months
Demonstration Year 4	December 12, 2022 to November 30, 2023	12 months
Demonstration Year 5	December 12, 2023 to November 30, 2024	12 months

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

42. 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 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.

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

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustment to the budget neutrality limit if any health care related tax that was in effect during the base

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

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 provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditure limit or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulation, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

X. MONITORING BUDGET NEUTRALITY

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

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

46. **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 per member per month (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.

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

48. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that state should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent determined limits to which the state and CMS agree, and that CMS approves, as part of this demonstration approval. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

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

Table 5: Hypothetical Budget Neutrality Test									
MEG	Per Capita (PC) or	WOW Only,	BASE YEAR	TREND	DY 1	DY 2	DY 3	DY 4	DY 5

	Aggregate (Agg)*	WW Only, or Both	2019						
Population I	PC	Both	$476.39	4.5%	$497.83	$520.23	$543.64	$568.66	$593.66
Targeted Adult Group	PC	Both	$767.23	4.5%	$801.76	$837.84	$875.54	$914.94	$956.11

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

51. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from December 12, 2019 to November 30, 2024. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

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

Table 6: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
	Cumulative Target Definition	**Percentage**
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit	0.0 percent

XI. EVALUATION OF THE DEMONSTRATION

53. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirement that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 24.

54. **Independent Evaluator.** Upon approval of the demonstration, the state must arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. 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.

55. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than one hundred eighty (180) calendar days after approval of the demonstration. The draft Evaluation Design also must include a timeline for key evaluation activities, including evaluation deliverables, as outlined in STCs 59 and 60.

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

    a. Attachment A (Developing the Evaluation Design) of these STCs;
    b. Any applicable CMS technical assistance on applying robust evaluation approaches, including establishing appropriate comparison groups and assuring causal inferences in demonstration evaluations; and
    c. All applicable evaluation design guidance, including overall demonstration sustainability.

At a minimum, the draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested. The draft Evaluation Design will discuss:

a. The outcome measures to be used in evaluation the impact of the demonstration during the period of approval, particularly among the target population;

b. The data sources and sampling methodology for assessing these outcomes; and
c. A detailed analysis plan that describes how the effects of the demonstration are isolated from other initiatives occurring in the state.

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

57. **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 documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. 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 also its effectiveness in achieving the goals. The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs.

    The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS's measure sets for eligibility and coverage, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF).

    The findings from each evaluation component must be integrated to help inform whether the state met the overall demonstration goals, with recommendations for future efforts regarding all components.

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

59. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Interim Evaluation Report should be posted to the state's website with the application for public comment.
    a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted, should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
    d. The state must submit a revised Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
    e. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

60. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.
    a. Unless otherwise agreed upon in writing by CMS, the state shall submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.
    b. The final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

61. **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. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial, sustained directional change, inconsistent with demonstration goals, such as substantial, sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC

10. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

62. **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.

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

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

XII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION

Table 7: Schedule of Deliverables for the Demonstration Period		
Date	**Deliverable**	**STC**
30 calendar days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
180 calendar days after approval date	Draft Evaluation Design	STC 55
60 days after receipt of CMS comments	Revised Draft Evaluation Design	STC 55
30 calendar days after CMS Approval	Approved Evaluation Design published to state's website	STC 56
November 30, 2023, or with renewal application	Draft Interim Evaluation Report	STC 59
60 days after receipt of CMS comments	Revised Interim Evaluation Report	STC 59

Within 18 months after November 30, 2024	Draft Summative Evaluation Report	STC 60
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 60
Monthly Deliverables	Monitoring Call	STC 30
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter.	Quarterly Monitoring Reports, including implementation updates	STC 27
	Quarterly Budget Neutrality Reports	STC 27(c)
Annual Deliverables - Due 90 calendar days after end of each 4th quarter	Annual Monitoring Reports	STC 27

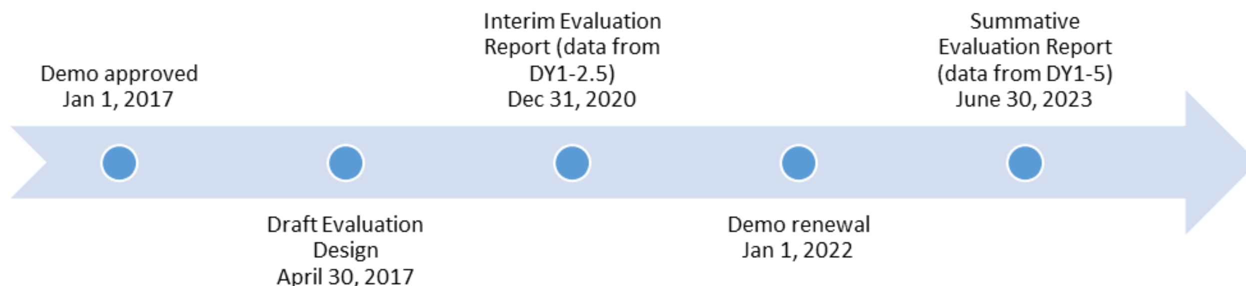
Attachment A
Developing the Evaluation Design

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 what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. 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 Design and Reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

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

All states with Medicaid section 1115 demonstrations are required to conduct 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 brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
4) A description of the population groups impacted by the demonstration; and
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 research questions / hypotheses of this demonstration 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 could be measured.
4) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working

to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

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

This section also provides the 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 a pre/post comparisons, or pre-test or post-test only assessment. If qualitative assessments 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 where the data will be obtained, and efforts to validate and clean the data. 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 reviewed with CMS for approval before implementation.

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

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
    c. Include a discussion of how propensity score matching and difference-in-differences design may be used to adjust for differences in comparison populations over time, if applicable.
    d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design 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
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

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

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; and

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

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, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include a "No Conflict of Interest" statement signed by the independent evaluator.
2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed, 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 an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

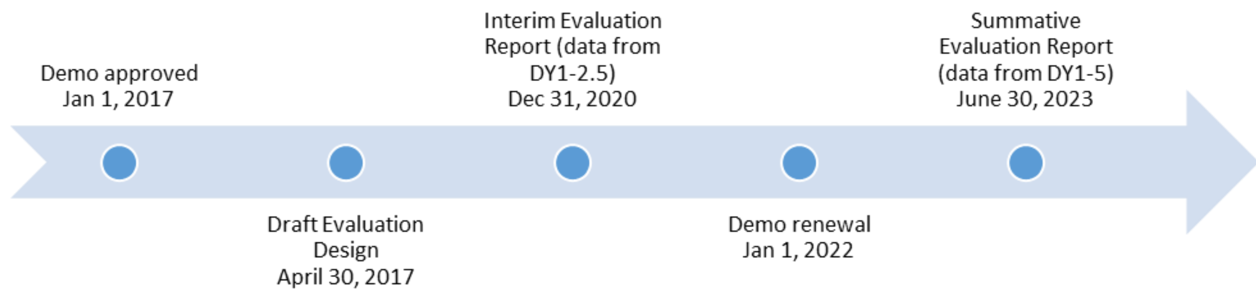
Attachment B:
Preparing the Interim and Summative Evaluation Reports

Introduction

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

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within thirty (30) 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 an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and

CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

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 submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

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

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

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;

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

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/s, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) A description of the population groups impacted by 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.

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

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation 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 should also 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 was measured and how. 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;
2) *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria;
3) *Evaluation Period* – Describe the time periods for which data were 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 be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.); and
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

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

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

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

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

   a. If the state did not fully achieve its intended goals, why not?

   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 interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

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

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

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

J. Attachment

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

Attachment C:
Evaluation Design (reserved)