CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITIES

NUMBER: 11-W-00206/4

TITLE: Florida Managed Medical Assistance

AWARDEE: Agency for Health Care Administration

All requirements of the Medicaid program expressed in law, regulation and policy statement—and not expressly waived in the title XIX waivers list below—shall apply to the demonstration project.

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act ("the Act") to enable the state to continue its Florida Managed Medical Assistance Program section 1115 demonstration (formerly titled "Medicaid Reform") consistent with the approved Special Terms and Conditions (STCs). The state has acknowledged that it has not asked for, nor has it received, a waiver of Section 1902(a)(2).

These waivers are effective beginning the date of approval through June 30, 2030, unless otherwise specified.

Title XIX Waivers

1. Statewideness/Uniformity — Section 1902(a)(1)

To enable Florida to operate the demonstration and provide managed care plans or certain types of managed care plans, including provider service networks, only in certain geographical areas.

2. Amount, Duration, and Scope and Comparability — Section 1902(a)(10)(B) and 1902(a)(17)

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits.

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

To enable Florida to require mandatory enrollment into managed care plans with restricted networks of providers. This does not authorize restricting freedom of choice of family planning providers.

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

Effective February 1, 2019, to enable Florida to only provide medical assistance beginning the month in which a beneficiary's Medicaid application is filed, for adult beneficiaries who are not pregnant or within the 60-day period after the last day of the pregnancy, and are aged 21 and older. The waiver of retroactive eligibility does not apply to pregnant women (or during the 60-day period beginning on the last day of the pregnancy), infants under one year of age, or individuals under age 21. Annually, 60 days after the state legislative process has concluded, the state must submit a letter to CMS indicating Florida legislative approval. Absent this documentation the waiver of retroactive eligibility will be suspended until such time the letter is provided to CMS.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITIES

NUMBER: 11-W-00206/4

TITLE: Florida Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration from the date of the extension approval through June 30, 2030, be regarded as expenditures under the state's title XIX plan, unless otherwise specified.

The following expenditure authorities shall enable Florida to operate the Florida Managed Medical Assistance program section 1115 demonstration.

1. Expenditures for payments to managed care organizations, in which individuals who regain Medicaid eligibility within six months of losing it may be re-enrolled automatically into the last plan in which they were enrolled, notwithstanding the limits on automatic re-enrollment defined in section 1903(m)(2)(H) of the Act.

2. Expenditures made by the state for uncompensated care costs incurred by providers for health care services for the uninsured. Such funds may be used by providers to offset the uncompensated costs of treating the uninsured, but this expenditure authority does not make uninsured patients eligible for any benefits under the demonstration.

3. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program.

4. Expenditures for services provided to individuals in the MEDS-AD Eligibility Group, as described in STC 17, effective January 1, 2018.

5. Expenditures for services provided to individuals in the AIDS CNOM Eligibility Group, as described in STC 18 effective January 1, 2018.

6. Expenditures for behavioral health and supportive housing assistance services to individuals in MMA, as described in STC 54, effective as of the approval date of the amendment (March 26, 2019) through June 30, 2025. The state will implement this pilot less than statewide and institute annual enrollment limits of 50,000 member months each demonstration year.

    a. **REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 6.** All title XIX requirements that are waived for Medicaid eligible groups are also not

applicable to the behavioral health and supportive housing assistance services. In addition, the following Medicaid requirement is not applicable:

i. Statewide Operation **Section 1902(a)(1)**

To the extent necessary to enable the state to operate on less than a statewide basis for behavioral health and supportive housing assistance services.

ii. Amount, Duration and Scope **Section 1902(a)(10)(B)**

To the extent necessary to enable Florida to limit the amount, duration, and scope of behavioral health and supportive housing assistance pilot services to restrict this benefit to those individuals diagnosed with a serious mental illness (SMI), substance use disorder (SUD), or an SMI with a co-occurring SUD, who are homeless or at risk of homelessness due to their disability, as described in the STC 54.

iii. Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary to enable the state not to provide behavioral health and supportive housing assistance pilot services when the enrollment cap for this benefit is reached, as specified in the STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00206/4**

TITLE: **Florida Managed Medical Assistance Program**

AWARDEE: **Agency for Health Care Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Florida Managed Medical Assistance Program (MMA) section 1115(a) demonstration (hereinafter “demonstration”) to enable Florida to operate the demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (“the Act”), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable (CNOM) under section 1903 of the Act, which are separately enumerated. The parties to this agreement are the Agency for Health Care Administration (Florida) and CMS. The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by those set forth below and in the foregoing waivers and expenditure authorities. The effective date of the demonstration extension is no earlier than the date of the extension approval through June 30, 2030.

These STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility Derived from the Demonstration
V. Enrollment For the Managed Medical Assistance Program
VI. Enrollment
VII. Benefit Packages and Plans in Managed Medical Assistance Program
VIII. Cost-sharing
IX. Delivery Systems
X. Consumer Protections
XI. Choice Counseling
XII. Healthy Behaviors Program Under the MMA Program
XIII. Additional Programs
XIV. Low Income Pool
XV. Low Income Pool Participation Requirements and Deliverables
XVI. General Reporting Requirements
XVII. General Financial Requirements

XVIII. Monitoring Budget Neutrality
XIX. Evaluation of the Demonstration
XX. Measurement of Quality of Care and Access to Care Improvement
XXI. Schedule of State Deliverables

Attachment A: Comprehensive Program Description
Attachment B: Developing the Evaluation Design
Attachment C: Preparing the Evaluation Report
Attachment D: Monitoring Protocol (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

Florida's current 1115 demonstration allows the state to operate a comprehensive Medicaid managed care program and a Prepaid Ambulatory Health Plan (PAHP). Under the demonstration, most Medicaid-eligibles are required to enroll in one of the MMA managed care plans (MMA plans) contracted with the state under the MMA Program. MMA plans are MCOs as defined under 42 CFR 438.2. Several populations may also voluntarily enroll in the MMA program. Applicants for Medicaid are given the opportunity to select a MMA plan prior to receiving a Florida Medicaid eligibility determination. If they do not choose a plan, they are auto-assigned into a MMA plan upon an affirmative eligibility determination and subsequently provided with information about their choice of plans with the auto-assignment. MMA plans are able to provide customized benefits to their members that differ from, but are not less than, the state plan benefits—and participating Medicaid-eligibles have access to Healthy Behaviors Programs that provide incentives for healthy behaviors.

Additionally, upon implementation of the prepaid dental health program (PDHP), dental managed care plans (dental plans) will provide State Plan dental services and provide services statewide to recipients required to enroll in a dental plan. The dental plans are PAHPs as defined under 42 CFR 438.2.

The demonstration also establishes a Low Income Pool (LIP) to ensure continuing support for the safety net providers that furnish uncompensated care (UC) to uninsured populations.[1]

The renewal approved in August 2017 allowed the state to continue operating the MMA program while increasing the LIP to $1.5 billion annually. This prior renewal also removed historical information about implementation of the MMA program from the STCs and modified the frequency of state-reported demonstration activities—based on the long-standing nature of the demonstration, the consistency in its operations, and the lack of significant issues or corrective actions needed. All reporting modifications, at that time, provided CMS and the public with the information necessary to effectively monitor and evaluate the MMA demonstration.

On November 30, 2018, an amendment was approved to the demonstration that, allows the state to operate a statewide Prepaid Dental Health Program, modifies the LIP to add Regional

[1] 1 For the "Comprehensive Program Description and Objectives," see Attachment B.

Perinatal Intensive Care Centers (RPICCs) as an eligible hospital ownership subgroup and community behavioral health providers as a participating provider group, and waives retroactive eligibility for all beneficiaries under the demonstration, except for pregnant women, women 60 days or less post-partum, and beneficiaries under age 21 (non-pregnant adults). The approval of the waiver of retroactive eligibility will encourage Medicaid beneficiaries to obtain and maintain health coverage, even when healthy, or to obtain health coverage as soon as possible after becoming eligible (if eligibility depends on a finding of disability or a certain diagnosis).

On March 26, 2019, an amendment was approved to the demonstration to implement a pilot program that provides additional behavioral health services and supportive housing assistance services for persons aged 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, who are homeless or at risk of homelessness due to their disability. The pilot program will be operated in two regions of the State, Regions 5 (Pasco and Pinellas counties) and Region 7 (Brevard, Orange, Osceola and Seminole counties).

On February 18, 2020, an amendment was approved to the demonstration that enables Florida to increase the behavioral health and supportive housing assistance services annual enrollment limit, modify the LIP permissible expenditures related to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), and memorializes some budget neutrality-related edits to the Supportive Housing Pilot table.

Under the demonstration, Florida seeks to continue building on the following objectives:

- Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The demonstration seeks to improve care for Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate of customer satisfaction. The state will provide oversight focused on improving access and increasing quality of care.
- Improving program performance, particularly improved scores on nationally recognized quality measures (such as Healthcare Effectiveness Data and Information Set [HEDIS] scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving access to coordinated care, continuity of care, and continuity of coverage by enrolling all Medicaid enrollees in managed care in a timely manner, except those specifically exempted.
- Increasing access to, stabilizing, and strengthening providers that serve uninsured, low- income populations in the state by targeting LIP funding to reimburse UC costs for services provided to low-income uninsured patients at hospitals, federally qualified health care centers (FQHC) and rural health clinics (RHC) that are furnished through charity care programs that adhere to the Healthcare Financial Management Association (HFMA) principles.[2]

[2] Available at http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589

- Improving continuity of coverage and care and encouraging uptake of preventive services, or encouraging individuals to obtain health coverage as soon as possible after becoming eligible, as applicable, as well as promoting the fiscal sustainability of the Medicaid program, through the waiver of retroactive eligibility.
- Improving integration of all services, increased care coordination effectiveness, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

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

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in 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 as needed to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STCs 6 and 7. CMS will notify the state within 30 days 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 as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the

earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

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

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

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

    a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
    b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
    c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
    d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the Evaluation Design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

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

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

    a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
    b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will redetermine Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
    c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
    d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to determining the individual ineligible as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR

435.1200(e) and 457.350. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.

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

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

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

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

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

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

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

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

15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

16. **Managed Care Requirements.** The state must comply with the managed care regulations published at 42 CFR 438, except as explicitly provided to the contrary in this STC 16. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.4. The capitation rates shall be developed according to 42 CFR 438.5 and 438.6, and the certification submitted pursuant to 42 CFR 438.7.

    The state must maintain:

    a. Policies to ensure an increased stability among capitated managed care plans and fee-for- service (FFS) PSNs and minimize plan turnover. This could include a limit on the number of participating plans in the MMA program. Plan selection and oversight criteria must include: confirmation that solvency requirements are being met; an evaluation of prior business operations in the state; and financial penalties for not completing a contract term.

    b. These STCs provide additional refinements and detail on the state's existing obligations under 42 CFR Part 438 and are intended to be consistent with the

requirements of 42 CFR Part 438; except where expressly noted otherwise, these STCs are not wholly new and distinct requirements on the state. The state must maintain policies to ensure network adequacy and access requirements which address travel time and distance, which are appropriate for the enrolled population. Policies must include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations.

c. The state must ensure that each managed care entity calculates and reports a Medical Loss Ratio (MLR) for each contract and rating year. Such MLR calculation and reporting must be consistent with the standards specified in 42 CFR 438.8.

The state shall monitor each plan's financial solvency, appropriateness of capitation rates, and provision of Medicaid services. As an addition to the requirements in the underlying regulations in 42 CFR Part 438, the state shall submit to CMS annual MLR reports with notation of concerns and actions taken by the state for each managed care plan or PSN that has a MLR above 95 percent or below 85 percent.

i. For plans with a MLR above 95 percent, the state shall report any concerns about the plans' financial viability, plan performance, and continuation with the MMA program.

ii. For plans with a MLR below 85 percent, the state shall report any concerns with beneficiary access to care and utilization, capitation rates, or MCO reporting.

d. Policies that provide for an improved transition and continuity of care when enrollees are required to change plans (e.g. transition of enrollees under case management and those with complex medication needs, and maintaining existing care relationships). Policies must also address beneficiary continuity and coordination of care when a physician leaves a health plan and beneficiary requests to seek out of network care.

e. Policies to ensure adequate choice of providers when there are fewer than two plans in any rural county, including contracting on a regional basis where appropriate to assure access to physicians, facilities, and services, consistent with 42 CFR 438.52.

f. Policies that result in a network of appropriate dental providers sufficient to provide adequate access to all covered dental services, consistent with 42 CFR 438.68, 438.206 and 438.207.

IV. ELIGIBILITY DERIVED FROM THE DEMONSTRATION

This section governs the state's exercise of the expenditure authorities 4 and 5 listed on

page 3 of these STCs. These groups derive their eligibility by virtue of the expenditure authorities expressly granted in this demonstration—eligibility and coverage for these groups are subject to Medicaid laws, regulations and policies, except as expressly identified as not applicable under expenditure authority granted herein.

17. **MEDS AD Eligibility Group.** The MEDS AD eligibility group consists of individuals who are not otherwise eligible for Medicaid benefits and who meet the following qualifying criteria:

    a. Aged or disabled individuals
        i. Income at or below 88% FPL
        ii. Assets that do not exceed $5,000 (individual) or $6,000 (couple)
        iii. Medicaid-only eligibles not receiving hospice, HCBS, or institutional care services

    b. Aged or disabled individuals
        i. Income at or below 88% FPL
        ii. Assets that do not exceed $5,000 (individual) or $6,000 (couple)
        iii. Medicaid-only eligibles receiving hospice, HCBS, or institutional care services

    c. Aged or disabled individuals
        i. Income at or below 88% FPL
        ii. Assets that do not exceed $5,000 (individual) or $6,000 (couple)
        iii. Medicare Eligible receiving hospice, HCBS, or institutional care services

18. **AIDS CNOM Eligibility Group.** The AIDS CNOM eligibility group consists of individuals who are not otherwise eligible for Medicaid benefits and who meet the following qualifying criteria:

    a. Have a diagnosis of Acquired Immune Deficiency Syndrome (AIDS); and
    b. Have an income at or below 222% of the federal poverty level (or 300% of the federal benefit rate);
    c. Have assets that do not exceed $2,000 (individual) or $3,000 (couple); and
    d. Meet hospital level of care, as determined by the State of Florida.

V. ELIGIBILITY FOR THE MANAGED MEDICAL ASSISTANCE PROGRAM

19. **Waiver of Retroactive Eligibility Population.** The state will not provide medical assistance for any month prior to the month in which a beneficiary's Medicaid application is filed, except for a pregnant woman (including during the 60-day period beginning on the last day of the pregnancy), or a beneficiary under age 21. The waiver of retroactive eligibility applies to all recipients aged 21 and older who are not pregnant or in the 60-day period after the last day of the pregnancy (non-pregnant adults), effective February 1, 2019. The waiver applies to non-pregnant adults who are eligible for Medicaid under the state plan (including all modified adjusted gross income (MAGI) and Non-MAGI related groups), as well as the MEDS AD Eligibility Group

defined in STC 17 and the AIDS CNOM Eligibility Group defined in STC 18.

a. The state assures that it will provide outreach and education about how to apply for and receive Medicaid coverage to the public and to Medicaid providers, particularly those who serve vulnerable populations that may be impacted by the retroactive eligibility waiver.

b. The state currently has state legislative authority for this waiver through June 30, 2021. In the event the state legislature does not authorize the state to continue the waiver of retroactive eligibility or the state does not timely submit a letter to CMS, the authority for the waiver of retroactive eligibility will end.

20. **Consistency with State Plan Eligibility Criteria.** There is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan. There is no expansion or reduction of eligibility under the state plan as a result of this demonstration, with the exception of the waiver of retroactive eligibility as specified in STC 19.

21. **Enrollment in MMA Plans**. MMA program enrollees are individuals eligible under the approved state plan or as a demonstration-only group, and who are described below as "mandatory enrollees" or as "voluntary enrollees." Mandatory enrollees are required to enroll in a MMA plan as a condition of receipt of Medicaid benefits. Voluntary enrollees are exempt from mandatory enrollment, but have the option to enroll in a demonstration MMA plan to receive Medicaid benefits.

a. Mandatory Managed Care Enrollees – Individuals who belong to the categories of Medicaid-eligibles listed in the following table, and who are not listed elsewhere in this section V as excluded from mandatory participation, are required to be MMA program enrollees.

Table 1. Mandatory and Optional State Plan Eligibility Groups

Mandatory State Plan Eligibility Groups	**Population Description**	**Funding Stream**	**CMS-64 Eligibility Group Reporting**
Infants under age 1	No more than 206% of the FPL.	Title XIX	TANF & Related Grp
Children 1-5	No more than 140% of the FPL.	Title XIX	TANF & Related Grp
Children 6-18	No more than 133% of the FPL.	Title XIX	TANF & Related Grp
Blind/Disabled Children	Children eligible under Supplemental Security Income (SSI) or deemed to be receiving SSI.	Title XIX	Aged/Disabled

IV-E Foster Care and Adoption Assistance	Children for whom IV-E foster care maintenance payments are made or an adoption assistance agreement is in effect – no Medicaid income limit.	Title XIX	TANF & Related Grp
Pregnant women	Income no more than 191% of FPL.	Title XIX	TANF & Related Grp
Section 1931 parents or other caretaker relatives	No more than Aid to Families with Dependent Children (AFDC) Payment Standard in effect as of 7/16/1996 (Families whose income is no more than about 31% of the FPL).	Title XIX	TANF & Related Grp
Aged/Disabled Adults	Persons receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by the Social Security Administration (SSA).	Title XIX	Aged/Disabled
Former foster care children up to age 26	Individuals who are under age 26 and who were in foster care and receiving Medicaid when they aged out.	Title XIX	TANF & Related Grp
Optional State Plan Groups			
State-funded Adoption Assistance under age 18	Who have an adoption assistance agreement not under title IV-E.	Title XIX	TANF & Related Grp
Individuals eligible under a hospice-related eligibility group	Up to 300% of SSI limit.	Title XIX	Aged/Disabled

Institutionalized individuals eligible under the special income level group specified at 42 CFR 435.236	This group includes institutionalized individuals eligible under this special income level group who do not qualify for an exclusion, or are not included in a voluntary participant category in STC 21(c).	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special home and community-based waiver group specified at 42 CFR 435.217	This group includes non-institutionalized individuals eligible under this special HCBS waiver group who do not qualify for an exclusion, or are not included in a voluntary participant category in STC 21(c).	Title XIX	Aged/Disabled
Demonstration Only Groups			
Aged or disabled Individuals	• Income at or below 88% FPL • Assets that do not exceed \$5,000 (individual) or \$6,000 (couple) • Medicaid-only eligibles **not** receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD
Aged or disabled Individuals	• Income at or below 88% FPL • Assets that do not exceed \$5,000 (individual) or \$6,000 (couple) • Medicaid-only eligibles receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD
Aged or disabled Individuals	• Income at or below 88% FPL • Assets that do not exceed \$5,000 (individual) or \$6,000 (couple) • **Medicare** Eligible receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD

Individuals diagnosed with AIDS	• Have an income at or below 222% of the federal poverty level (or 300% of the federal benefit rate), • Have assets that do not exceed $2,000 (individual) or $3,000 (couple), and • Meet hospital level of care, as determined by the State of Florida	Title XIX	AIDS CNOM

b. Medicare-Medicaid Eligible Participants – Individuals fully eligible for both Medicare and Medicaid are required to enroll in an MMA plan for covered Medicaid services. These individuals will continue to have their choice of Medicare providers as this program will not impact individuals' Medicare benefits. Medicare-Medicaid beneficiaries will be afforded the opportunity to choose an MMA plan. However, to facilitate enrollment, if the individual does not elect an MMA plan, then the individual will be assigned to an MMA plan by the state using the criteria outlined in STC 24.

c. Voluntary enrollees – The following individuals are excluded from mandatory enrollment into the MMA program under subparagraph (a) but may choose to voluntarily enroll under the demonstration, in which case the individual would be a voluntary participant in an MMA plan and would receive its benefits:

   i. Individuals who have other creditable health care coverage, excluding Medicare;

   ii. Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;

   iii. Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID);

   iv. Individuals with developmental disabilities enrolled in the home and community- based waiver pursuant to state law, and Medicaid recipients waiting for waiver services;

   v. Children receiving services in a Prescribed Pediatric Extended Care (PPEC) facility; and

   vi. Medicaid-eligible recipients residing in group home facilities licensed under section(s) 393.067 F.S.

d. Excluded from MMA Program Participation - The following groups of Medicaid eligibles are excluded from enrollment in managed care plans.

   i. Individuals eligible for emergency services only due to immigration status;

   ii. Family planning waiver eligibles;

   iii. Individuals eligible due to breast or cervical cancer; and,

   iv. Services for individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in state law. (These individuals are inmates not eligible for covered services under the state plan, except as inpatients in a medical institution).

22. Indian Health Care Providers and Managed Care Protections.

a. The state will assure compliance by the state with the requirements of section 1911 of the Social Security Act and 25 USC §1647a(a)(1), to accept an entity that is operated by the Indian Health Service (IHS) an Indian tribe, tribal organization, or urban Indian health program as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program, if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.

b. The state will assure compliance by the state with 42 CFR 431.110(b), which specifies that an IHS facility meeting state requirements for Medicaid participation must be accepted as a Medicaid provider on the same basis as any other qualified provider, and also specifies that when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure. In determining whether a facility meets these standards, the state may not take into account an absence of licensure of any staff member of the facility.

VI. ENROLLMENT

This section describes enrollment provisions that are applicable to Medicaid-eligible individuals in Medicaid managed care plans. All Medicaid recipients, except those specified in STC 55, must enroll in the Prepaid Dental Health Program (PDHP) in order to receive dental services covered under the Florida Medicaid program. The state will implement the PDHP in three phases by region, beginning December 1, 2018, with completion by March 1, 2019.

23. **New Enrollees.** 42 CFR § 438.71 requires choice counseling as part of the beneficiary support system. At the time of their application for Medicaid, individuals who are mandated to enroll in an MMA or dental plan must receive information about MMA and dental plan choices in their area. They must be informed of their options in selecting an authorized MMA/dental plan. Individuals must be provided the opportunity to meet or speak with a choice counselor to obtain additional information in making a choice, and to indicate a plan choice selection if they are prepared to do so. Eligible individuals will be enrolled in a MMA and dental plan upon eligibility determination. If the individual has not selected a plan at the time of the approval of eligibility, the state may auto-assign the individual into a MMA/dental plan. Upon enrollment, individuals will receive information on their MMA and dental plan assignments or selection and information about all plans in their area. Individuals may actively select a plan or change their plan selection during a 120-day change/disenrollment- period without cause post-enrollment. All individuals will be provided with information regarding their rights to change plans. Once the plan selection is registered and takes effect, the plan must communicate to the enrollee, in accordance with 42 CFR 438.10, the benefits covered under the plan, and how to access those benefits.

24. **Auto-Enrollment Criteria.** Each enrollee must have an opportunity to select a MMA and dental plan before or upon being determined eligible. Individuals must be provided information to encourage an active selection electronically or in print. Enrollees who fail to choose a plan by the time their eligibility is determined will be auto-assigned to a MMA and/or dental plan. At a minimum, the state must use the criteria listed below when assigning an enrollee to a MMA or dental plan, in addition to criteria identified in 42 CFR 438.54. When more than one plan meets the assignment criteria, the state will make enrollee assignments consecutively by family unit.

    MMA criteria include but are not limited to:

    a. Whether the plan has sufficient provider network capacity to meet the needs of the enrollee;

    b. Whether the recipient has previously received services from one of the plan's primary care providers; and

    c. Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

    PDHP criteria include but are not limited to:

    a. Whether the plan has sufficient network capacity to meet the needs of the recipients such as geographic accessibility based on beneficiary's residence;

    b. Whether the recipient has a family member enrolled in one of the PDHP plans.

    c. A newborn of a mother enrolled in a plan at the time of the child's birth shall be

enrolled in the mother's plan. Upon birth, such a newborn is deemed enrolled in the dental plan, regardless of the administrative enrollment procedures, and the dental plan is responsible for providing Medicaid services to the newborn. The mother may choose another dental plan for the newborn within 120 days after the child's birth.

25. **Auto Enrollment for Special Populations.** For an enrollee who is also a recipient of Supplemental Security Income (SSI), prior to auto-assigning the SSI beneficiary to an MMA plan, the state must determine whether the SSI beneficiary has an ongoing relationship with a provider or managed care plan; and if so in addition to complying with § 438.54(d), the state must assign the SSI recipient to that managed care plan whenever feasible. Assignment based on an ongoing relationship with a provider or managed care plan is the first priority in assigning enrollees pursuant to this STC. Those SSI recipients who do not have such a provider relationship must be assigned to a managed care plan using the assignment criteria previously outlined. In addition to complying with § 438.54(d), the state must use the following parameters when auto-assigning recipients who are members of the indicated special populations to a plan. The analogous requirements for auto enrollment into both MMA and PDHP plans are mentioned above in STC 24.

    a. To promote alignment between Medicaid and Medicare, each beneficiary who is enrolled with a Medicare Advantage Organization, must first be assigned to any MMA plan in the beneficiary's region that is operated by the same parent organization as the beneficiary's Medicare Advantage Organization. If there is no match of parent organization or plan within the organization, then the beneficiary should be assigned as in sub-STC 24 above.

    b. If an applicable specialty plan is available, as described in STC 37, the recipient should be assigned to the specialty plan.

    c. Newborns of eligible mothers enrolled in a plan at the time of the child's birth will be automatically enrolled in that plan, unless it is a specialty plan; however, the mother may choose another plan for the newborn within 120 days after the child's birth.

    d. Foster care children will be assigned/re-assigned to the same plan to which the child was most recently assigned in the last 12 months, if applicable.

    e. Lock-In/Disenrollment. Once a mandatory enrollee has selected or been assigned an MMA or dental plan, the enrollee shall be enrolled for a total of 12 months, until the next open enrollment period, unless the individual is determined ineligible for Medicaid. The 12-month period includes a 120-day period to change or voluntarily disenroll from a plan without cause and select another plan. If an individual chooses to remain in a plan past 120 days, the individual will be permitted no further changes in enrollment until the next open enrollment period, except for cause. Good cause reasons for disenrollment from a plan are defined in Rule 59-G-8.600, Florida Administrative Code. Voluntary enrollees may disenroll

from the MMA plan at any time and enroll in another managed care plan or receive their services through Florida FFS Medicaid. This Florida rule is compliant with § 438.56(c) and (d)(2).

f. The choice counselor or state will record the plan change/disenrollment reason for all recipients who request such a change. The state or the state's designee will be responsible for processing all enrollments and disenrollments.

26. **Re-enrollment.** In instances of a temporary loss of Medicaid eligibility, which the state is defining as 6 months or less, the state will re-enroll demonstration enrollees in the same MMA or dental plan they were enrolled in prior to the temporary loss of eligibility unless enrollment into the entity has been suspended due to plan requested or Agency-imposed enrollment freeze. The individual will have the same change/disenrollment period without cause as upon initial enrollment.

VII. BENEFIT PACKAGES AND PLANS IN THE MMA PROGRAM

27. **Customized Benefit Packages**. MMA plans have the flexibility to provide customized benefit packages for demonstration enrollees as long as the benefit package meets certain minimum standards described in this STC, and actuarial benefit equivalency requirements and benefit sufficiency requirements described in STCs 28 through 31, in accordance with section 409.973 F.S. For other plans, customized benefit packages must include all state plan services otherwise available under the state plan for pregnant women and children including all EPSDT services for children under age 21. The customized benefit packages must include all mandatory services specified in the state plan for all populations. The amount, duration and scope of optional services, may vary to reflect the needs of the plan's target population as defined by the plan and approved by the Agency for Health Care Administration (AHCA). These plans can also offer additional services and benefits not available under the state plan. The plans contracted with the state shall not have service limits more restrictive than authorized in the state plan for children under the age of 21, pregnant women, and emergency services.

    Policies for determining medical necessity for children covered under the EPSDT benefit must be consistent with Federal statute at §1905(r) of the Act in authorizing vision, dental, hearing services, and other necessary health care, diagnostic services, treatment and other measures described in §1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not such services are covered in the state plan. EPSDT provisions apply as well to the PDHPs.

28. **Overall Standards for Customized Benefit Packages for MMA Plans.** All benefit packages must be prior-approved by the state and CMS and must be at least actuarially equivalent to the services provided to the target population under the current state plan benefit package. In addition, the plan's customized benefit package must meet a sufficiency test to ensure that it is sufficient to meet the medical needs of the target

population. Consistent with 42 CFR 438.3, customized benefit packages, as analyzed through the Plan Evaluation Tool (PET) discussed below, must be submitted to CMS for approval as part of the standard CMS contract review process.

29. **Plan Evaluation Tool.** The state will utilize a Plan Evaluation Tool (PET) to determine if a plan that is applying for, or has been awarded, an MMA plan contract meets state requirements. The PET measures actuarial equivalency and sufficiency. Specifically, the PET: (1) compares the value of the level of benefits (actuarial equivalency) in the proposed package to the value of the current state plan package for the average member of the population; and (2) ensures the sufficiency of benefits consistent with 42 CFR 438.210(a)(3) and STC 30. The state will evaluate service utilization on an annual basis and use this information to update the PET to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

30. **Plan Evaluation Tool: Sufficiency**. In addition to meeting the actuarial equivalence test, each health plan's proposed customized benefit package must meet or exceed, and maintain, a minimum threshold of 98.5 percent. The sufficiency test provides a safeguard when plans elect to vary the amount, duration and scope of certain services. This standard is based on the target-population's historic use of the applicable Medicaid state plan services (e.g. outpatient hospital services, outpatient pharmacy prescriptions) identified by the state as sufficiency-tested benefits. Each proposed benefit plan must be evaluated against the sufficiency standard to ensure that the proposed benefits are adequate to meet the needs of 98.5 percent of enrollees.

31. **Evaluation of Plan Benefits.** The state will review and update the PET for assessing a plan's benefit structure to ensure actuarial equivalence and that services are sufficient to meet the needs of enrollees in the given service area. At a minimum, the state must conduct the review and update on an annual basis. The state will provide CMS with 60-days advance notice and a copy of any proposed changes to the PET.

VIII. COST-SHARING

32. **Premiums and Co-Payments.** The state must pre-approve all cost sharing allowed by MMA or dental plans. Cost-sharing must be consistent with the state plan except that managed care plans may elect to assess cost-sharing that is less than what is allowed under the state plan.

33. **American Indians.** Indians who receive services directly by an Indian Health Care Provider (IHCP) or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premium, or similar charge. No deduction, copayment, cost sharing or similar charges shall be imposed against any such Indian. Payments due to an IHCP or to a health care provider through referral under Purchased/Referred Care services for services provided to an eligible Indian shall not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing or similar charges, that would be due from the Indian but for the prohibition on charging the Indian.

IX. DELIVERY SYSTEMS

34. Health Plans. The final contracts and, as applicable, capitation rates developed to implement selective contracting by the state with any MCO, provider group, Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) shall be subject to CMS approval prior to implementation. The state may enter into contracts for Medicaid managed care plans with the following entities:

a. Managed Care Organization (MCO) – An entity (such as Health Maintenance Organization, Accountable Care Organization, capitated Provider Service Network, or Exclusive Provider Organization) that meets the definition of MCO as described in 42 CFR 438.2, and which must conform to all of the requirements in 42 CFR 438 that apply to MCOs.

b. Provider Service Network (PSN) – An entity established or organized by a health care provider or group of affiliated health care providers that meet the requirements of FS 409.912. A PSN may be reimbursed on a FFS or capitated basis as specified in state statute. Capitated PSNs are categorized as MCOs, and must meet the requirements as described in 42 CFR 438.

c. Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP)- Entities that meet the definition or PIHP or PAHP as described in 42 CFR 438.2 and which must conform to all requirements in 42 CFR 438 that apply to PIHPs and PAHPs.

35. Eligible Plan Selection. The state will procure a specified number of MMA plans per region in accordance with section 409.974, Florida Statutes. A minimum and maximum number of plans are specified by region, with a minimum of two plans choices in each region. Issuance and award of the procurements will provide for a choice of plans, as well as market stability.

Should the state not be able to contract with at least two MMA plans in a region that is not rural, the state will issue another procurement to obtain a second plan and meet the federal requirements in 42 CFR §438.52(a). Until two MMA plans are available in the impacted region, beneficiaries may voluntarily choose to enroll in the available MMA plan or to access services through a FFS delivery system.

In addition to regional plans, the state will also seek to contract with specialty plans, as discussed in STC 37. Participation of specialty plans will be subject to competitive procurement requirements but will not be considered in assessing regional plan availability. Specialty plans are subject to 42 CFR 438.52 choice requirement. However, the state may not enter into contracts with additional specialty plans in a region if total enrollment in all specialty plans in the region is greater than ten percent of demonstration enrollees in the region.

The state will procure at least two statewide dental plans for the PDHP in accordance with

section 409.973(5), Florida Statutes. To qualify for a contract under the PDHP, an entity must be licensed as a prepaid limited health service organization under Part I of Chapter 636, Florida Statutes, or as a health maintenance organization under Part I of Chapter 641, Florida Statutes.

Should the state undergo another Medicaid managed care procurement for MMA or dental plans during the demonstration period, the state must submit a report to CMS no later than 30 days after the selection of new managed care plans that will include the following, as applicable in addition to 42 CFR 438.66(d):

a. The name of the managed care plans selected for each region;

b. For the selected plans, please identify those plans that also provide LTSS under the 1915(b)/(c) waivers;

c. The names of any managed care plans that will not be continuing by region; and,

d. The number of enrolled beneficiaries in each plan that will not be continuing.

36. MMA Plan Selection when beneficiary also has Medicare Advantage.

a. While beneficiaries are encouraged to select the same MMA plan as their Medicare Advantage or Long-term Care (LTC) Plan, if applicable, it is not a requirement.

b. Should a beneficiary choose an MMA plan that is different from their Medicare Advantage or LTC plan, if applicable, the two entities must coordinate the beneficiary's care to ensure that all needs are met. The state must monitor such care coordination through its contract with the MCO and with the MAO under 42 CFR 422.107.

37. Specialty Plans. A specialty plan is defined as a plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs individuals and that has been approved by the state as a specialty plan to provide medical services. Specialty plans are designed for a target population, for example, children with chronic conditions, or recipients who have been diagnosed with HIV/AIDS. Participation of specialty plans will be subject to competitive procurement and the aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the demonstration enrollees of that region. The state will freeze enrollment for specialty plans if the aforementioned enrollment limit is reached in a region. The Children's Medical Services Plan, a specialty plan operated by the Florida Department of Health, is not subject to competitive procurement.

38. The state may approve specialty plans on a case-by-case basis using criteria that include appropriateness of the target population and the presence of clinical programs and/or providers with special expertise to serve that target population in the specialty plan's provider network. The state may not approve plans that discriminate against members of

the target population with greater health care needs.

The state may also contract with Medicare Advantage Organizations (MAO) to serve Medicare-Medicaid enrollees as a dual eligible special needs plan (D-SNP) under 42 CFR 422.107.

In addition to meeting the solvency (42 CFR 438.116) and network adequacy and sufficiency (42 CFR 438.68, 438.206 and 438.207) requirements, specialty plans must also meet enhanced standards developed by the state that may include but are not limited to:

a. Appropriate integrated provider network of primary care physicians and specialists who are trained to provide services for a particular condition or population. The network should include an integrated network of PCPs and specialists appropriate for the target population (e.g., nephrologists for kidney disease; cardiologists for cardiac disease; infectious disease specialists and immunologists for HIV/AIDS).

b. In recognition that many individuals will have multiple diagnoses, plans should have sufficient capacity of additional specialists to manage the co-occurring diagnoses that may occur within the target population.

c. Defined network of facilities that are used for inpatient care, including the use of accredited tertiary hospitals and hospitals that have been designated for specific conditions (e.g., end stage renal disease centers, comprehensive hemophilia centers).

d. Availability of specialty pharmacies, where appropriate.

e. Availability of a range of community-based care options as alternatives to hospitalization and institutionalization.

f. Clearly defined coordination of care component that links and shares information between and among the primary care provider, the specialists, and the patient to appropriately manage co-morbidities.

g. Use of evidence-based clinical guidelines in the management of the disorder.

h. Development of a care plan and involvement of the patient in the development and management of the care plan, as appropriate.

i. Development and implementation of a disease management program specific to the specialty population(s) or disease state(s), including a specialized process for transition of enrollees from disease management services outside of the plan to the plan's disease management program.

39. Requirements for Special Populations.

a. HIV Specialty Plans

i. The state will auto-enroll Medicaid beneficiaries identified with a diagnosis of HIV or AIDS to a specialty plan, where available, if the beneficiary does not select an MMA plan. These beneficiaries may be identified with a combination of diagnosis codes on claims; HIV or AIDS prescription medications; and laboratory tests and results.

ii. The state will notify beneficiaries identified with a diagnosis of HIV or AIDS in writing that the beneficiary must select an MMA plan or the beneficiary will be auto- assigned to a specialty plan, if available, in his or her region. The notification will provide the beneficiary with information regarding the benefits of enrolling in a specialty plan. The enrollee will have 120-day period following enrollment to change plans or disenroll without cause.

iii. When making assignments to an HIV/AIDS specialty plan, the state will consider the beneficiary's PCP and/or current prescriber of HIV or AIDS medications.

iv. When making assignments to HIV/AIDS specialty plans and the beneficiary's PCP or current prescriber of HIV or AIDS medications is not known or is not an enrolled provider with a specialty plan, the state will assign the beneficiary to a specialty plan available on a rotating basis.

v. When making assignments to HIV/AIDS specialty plans of beneficiaries who are determined to have co-morbid conditions, the state may assign the beneficiary to the most appropriate specialty plan available in the beneficiary's region.

b. Children's Specialty Plans

i. The state may elect to contract with Children's Specialty Plans to serve Foster Care Children. These plans will have special requirements for immediate assessment, care coordination, and treatment of Foster Care Children. The Children's Specialty Plans are required to furnish EPSDT for Foster Care Children and follow the state's medication formulary.

ii. The Foster Care child's legal guardian may enroll the child in an MMA plan, or any specialty plan for which the child is eligible, that are available in the child's region.

iii. Should a Foster Care child's legal guardian fail to make an affirmative selection of an MMA plan, the state may enroll the foster care child into a Children's Specialty Plan available in the region.

40. **Compliance with Medicaid and CHIP Managed Care Regulations**. The state must comply with all Medicaid and CHIP managed care requirements set forth in 42 CFR Parts

431, 433, 438, 440, 457 and 495, including the Indian specific provisions at 42 CFR §438.14 unless waived or identified as not applicable in the waiver and expenditure authority documents, of which these STCs are a part. This includes:

a. **Definitions of Indians and Indian Health Care Provider (IHCP).** Indians and IHCPs are defined in 42 CFR §438.14(a).

b. **Access to IHCP.** Indians will be able to access covered benefits through the IHCP of their choice, regardless of whether the IHCP is a participating or non-participating provider.

c. **Referrals and Prior Authorization.** Managed care entities must permit nonparticipating IHCP to refer an Indian to a network provider without having to obtain an additional referral or a prior authorization from a participating provider.

d. **Access to Out of State IHCPs.** A managed care entity must allow Indian enrollees to access out-of-state IHCPs where timely access to covered services cannot be ensured because there are few or no IHCPs in the state.

e. **Disenrollment from Managed Care Entity.** Lack of access to in-network IHCP constitutes good cause for disenrollment from the managed care entity.

f. **Prompt Payment.** A managed care entity must make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 438.14, 447.45 and 447.46.

g. **Payment Rates and Supplemental Payment.**

   i. **Non-FQHC.** An IHCP not enrolled in Medicaid as an FQHC, regardless of whether it participates in the network of an MCO, PIHP, PAHP and PCCM entity or not, has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.

   ii. **FQHC.** An IHCP that is enrolled in Medicaid as an FQHC, but that is not a participating provider of the MCO, PIHP, PAHP or PCCM entity, must be paid an amount equal to the amount the MCO, PIHP, PAHP, or PCCM entity would pay an FQHC that is a network provider but is not an IHCP, including any supplemental payment from the state to make up the difference between the amount the MCO, PIHP, PAHP or PCCM entity pays and what the IHCP FQHC would have received under FFS.

   iii. **Supplemental Payment.** The state must make a supplemental payment to the IHCP to make up the difference between the amount the MCO, PIHP, PAHP, or PCCM entity pays and the amount the IHCP would have

received under FFS or the applicable encounter rate.

X. CONSUMER PROTECTIONS

41. **Outreach and Education.** The state must provide outreach and education regarding potential Medicaid eligibility and the application/enrollment process, to mitigate the potentially harmful effects of the waiver of retroactive eligibility.

42. **Medical Care Advisory Committee.** In accordance with 42 CFR §431.12, the state must maintain its Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical care services. The state must ensure that the MCAC is comprised of the representatives set forth in 42 CFR §431.12(d). The state must ensure that the MCAC includes representation of at least four beneficiaries at all times, and report to CMS any vacant beneficiary slots that are not filled within 90 days of becoming vacant. Beneficiary representation may include former Florida Medicaid recipients, current Florida Medicaid recipients or family members of former or current Florida Medicaid recipients who had direct experience with helping beneficiaries access Florida Medicaid eligibility, benefits, or services. The state may submit justification to CMS for an unfilled beneficiary slot after 90 days and CMS may grant an exception to this requirement at CMS' discretion.

    a. **Subpopulation Advisory Committees.** In addition to the MCAC and 42 CFR 438.110, the state must convene smaller advisory committees that meet on a regular basis (at least quarterly) to focus on subpopulations, including, but not limited to: beneficiaries receiving managed LTSS; beneficiaries with HIV/AIDS; children, including safeguards and performance measures related to foster children and the provision of dental care to all children; and beneficiaries receiving behavioral health/substance use disorder (SUD) services.

       Each advisory committee must include representation from relevant advocacy organizations, as well as beneficiaries.

43. **Appointment Assistance.** The state must provide, or ensure the provision of, necessary assistance with transportation and with scheduling appointments for medical, dental, vision, hearing, and mental health services.

44. **Attempts To Gain an Accurate Beneficiary Address**. The state shall implement the CMS- approved process for return mail tracking. The state will use information gained from return mail to make additional outreach attempts through other methods (phone, email, etc.) or complete other beneficiary address analysis from previous claims to strengthen efforts to obtain a valid address.

45. **Verification of Beneficiary's Health Plan Enrollment.** The state shall utilize and publicize for health plan network and non-network providers the following eligibility verification processes for beneficiaries' eligibility to be verified so that beneficiaries will not be turned away for services if the beneficiary does not have a card or presents

the incorrect card. Providers with a valid Medicaid provider number may use any of the following options to determine enrollee eligibility:

a. Utilize the Medicaid Eligibility Verification System (MEVS): eligibility transactions may be submitted using computer software supplied by the vendor, via a point of sale device similar to those used for credit card transactions, over the telephone using a voice response system, or other possibilities depending on what the MEVS vendor offers;

b. Perform single transactions (individual verifications) or batch transactions via a secure area on the Medicaid fiscal agent's web portal;

c. Utilize the Automated Voice Response System (AVRS): providers enter information via a touchtone telephone and it generates a report with all of the eligibility information for a particular recipient, which can be faxed to the provider's fax machine;

d. Submit eligibility transactions via the Electronic Data Interchange (EDI);

46. **Operated Call Center Operations.** The state must operate a call center(s) independent of the managed care plans for the duration of the demonstration. This can be achieved either by providing the call center directly or through the enrollment broker or other state contracted entities. Call center operations should be able to help enrollees in making independent decisions about plan choice, and enable enrollees to voice complaints about each of the health plans independent of the health plans.

47. **State Review of Beneficiary Complaints, Grievances and Appeals.** The state must review complaint, grievance, and appeal logs for each health plan and data from the state or health plan operated incident management system, to understand what issues beneficiaries and providers are having with each of the health plans. The state will use this information to implement any immediate corrective actions necessary. The state will continue to monitor these statistics throughout the demonstration period and report on them in the annual monitoring reports as specified in STC 75. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

XI. CHOICE COUNSELING

The state must comply with 42 CFR 438.71(b) to provide choice counseling as an additional benefit to beneficiaries. This is additional instruction about how the state must comply with this regulation.

48. **Choice Counseling Defined.** The state shall contract for choice counselor services in the MMA program regions to provide full and complete information about managed care plans choices. The state will ensure a choice counseling system that promotes and improves health literacy and provides information to reduce minority health disparities

through outreach activities.

49. **Choice Counseling Materials**. Through the choice counselor the state offers an extensive enrollee education and plan rating system so individuals will fully understand their choices and be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan using the plan report card, and information about the plan report card will be provided to the recipients.

50. **Choice Counseling Information.** The state or the state's administrator provides information on selecting a managed care plan. The state or the state's designated choice counselor provides information about each plan's coverage in accordance with federal requirements. Information includes, but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. In addition, the state may supplement coverage information by providing performance information on each plan. The supplement information may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance data. To ensure the information is as helpful as possible, the state may synthesize information into a coherent rating system.

51. **Delivery of Choice Counseling Materials**. Choice counseling materials will be provided in a variety of ways including the internet, print, telephone, and face-to-face. All enrollee communications, including written materials, spoken scripts and websites shall be at the fourth (4th)-grade comprehension level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY, without charge to the enrollee.

52. **Contacting the Choice Counselor**. Individuals contact the state or the state's designated choice counselor to obtain additional information. Choice counseling and enrollment information is available at the AHCA's website or by phone. The state or the choice counselor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees. The state must ensure mechanisms are in place to monitor and evaluate choice counseling call center metrics and the individual performance of choice counseling personnel.

XII. HEALTHY BEHAVIORS PROGRAM UNDER THE MMA PROGRAM

53. **Healthy Behaviors Programs.** The state must require the MMA plans operating in the MMA program to establish Healthy Behaviors programs to encourage and reward healthy behaviors. For Medicare and Medicaid recipients who are enrolled in both an MMA plan and a Medicare Advantage plan, the MMA plan must coordinate their Healthy Behaviors programs with the Medicare Advantage plan. Dental plans may opt to provide Agency-approved healthy behavior programs related to dental services.

a. The state must monitor to ensure that each MMA plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program, and an alcohol or substance abuse treatment program that meet all state requirements.

b. Programs administered by plans (including MMA plans and dental plans) must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services, Office of Inspector General (OIG). Plans are encouraged to seek an advisory opinion from OIG once the specifics of their Healthy Behaviors programs are determined**.**

XIII. ADDITIONAL PROGRAMS

54. Behavioral Health and Supportive Housing Assistance Pilot. The state will operate a voluntary pilot program for Medicaid recipients for whom these pilot services are appropriate through this section 1115 demonstration through June 30, 2025, in order to provide additional behavioral health services and supportive housing assistance services for persons aged 21 and older with serious mental illness (SMI), substance use disorder (SUD), or SMI with co-occurring SUD, and who are homeless or at risk of homelessness due to their disability. The pilot program will provide enrollees with additional tools necessary to improve health outcomes and achieve stable tenancy, and should have the effect of reducing state costs related to unnecessary beneficiary service utilization. The demonstration provides 1115(a)(2) expenditure authority for the state to implement the pilot in specific geographic areas of the state, less than statewide, and to institute annual enrollment limits. The state will evaluate the extent to which provision of these services results in improved integration of all services, increased care coordination effectiveness, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care.

a. BH Supportive Housing Pilot Eligibility is available to individuals who meet one of the following target groups and meet the following needs-based criteria that would otherwise be allowable under a 1915(i) SPA:

Targeting Criteria:

1. **Serious Mental Illness** - General descriptor for one, or a combination of the following diagnostic categories: psychotic disorders, bipolar disorder, major depression, schizophrenia, delusional disorder, or obsessive-compulsive disorder. Members must be identified using the Agency's SMI algorithm and be flagged as such on the plan's 834 enrollment file.
2. **Substance Use Disorder** - General descriptor for the recurrent use of alcohol and/or drugs that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. (Substance Abuse and Mental Health Services Administration). *Members must have a diagnosis code in the range of F10-F16 and F18-F19.*

3. **Co-occurring Disorders** – The coexistence of both a serious mental illness and a substance use disorder.

b. Needs-Based Criteria:

The individual is assessed to have a behavioral or substance use health need, which is defined as a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness and/or substance use disorder; and the individual meets at least one of the following risk factors:

1. Homelessness, defined as living in a place not meant for human habitation, a safe haven, or an emergency shelter, as these terms are understood or defined in 24 CFR 578.3.

OR

2. At risk of homelessness as defined in 24 CFR 578.3 due to their disability.

c. The Behavioral Health and Supportive Housing Assistance Pilot will be available in MMA regions 5 and 7 only. The state may institute annual enrollment limits as specified in the table below:

Demonstration Year (DY)	**Enrollment Member Months Limit**
DY 13 (SFY 2018; July 1, 2018 through June 30, 2019)	N/A
DY 14 (SFY 2019; July 1, 2019 through June 30, 2020)	50,000
DY 15 (SFY 2020; July 1, 2020 through June 30, 2021)	50,000
DY 16 (SFY 2021; July 1, 2021 through June 30, 2022)	50,000
DY 17 (SFY 2022; July 1, 2022 through June 30, 2023)	50,000
DY 18 (SFY 2023; July 1, 2023 through June 30, 2024)	50,000
DY 19 (SFY 2024; July 1, 2024 through June 30, 2025)	50,000

d. Participating MMA Plans in the pilot program must either be a plan that provides MMA services or a specialty plan that provides MMA services, serving individuals diagnosed with an SMI, SUD or an SMI with a co-occurring SUD, who are homeless or at risk of homelessness due to their disability, who meet enrollment requirements as stated in STC 21, and who meet all of the following requirements:

i. Provide services under the MMA program in regions five and/or seven,

ii. Include providers furnishing services in accordance with Chapters 394 and 397 of Florida Statues Substance Abuse Services in its provider network,

iii. Have the capability to provide supportive housing assistance services specified in STC 54(c) below through agreements with housing providers specified in STC 54 (c)(iii) and (iv), and have relationships with local housing coalitions. Plans must have agreements with local housing community partners, including local housing authorities, community action organizations, and local housing providers, in order to enhance coordination at the local level and prevent duplication of services. The state is working with the Florida Housing Finance Corporation and the Florida Supportive Housing Coalition to identify all available stable housing options for the target population, and will communicate with the participating managed care plans about these housing options to assist the plans in identifying local housing community partners. Participating managed care plans must have relationships with the local housing entities (housing authorities, community action organizations, local housing providers, etc.), to ensure the overall needs of the population are addressed and met and to ensure that Medicaid is not paying for services that are otherwise available.

e. <u>Services provided:</u>

i. Transitional housing services: Services that support a recipient in the preparation for, and transition into, housing. This is an intensive service that includes activities such as conducting a tenant screening and housing assessment, developing an individualized housing support plan, assisting with the search for housing and the application process, identifying resources to pay for on-going housing expenses such as rent, and ensuring that the living environment is safe and ready for move-in.

ii. Tenancy sustaining services: Services that support a recipient in being a successful tenant. Tenancy support services include activities such as early identification and intervention for behaviors that may jeopardize housing such as late rental payment or other lease violations; education and training on the roles, rights and responsibilities of the tenant and landlord; coaching on developing and maintaining key relationships with landlord/property managers; assistance (that may not include legal or financial assistance) in resolving disputes with landlords and/or neighbors to reduce risk of eviction; advocacy and linkage with community resources to prevent eviction, assistance; with the housing assistance eligibility recertification process; and coordinating with the enrollee to review, update, and modify their housing support and crisis plans.

iii. Mobile crisis management: The delivery of immediate de-escalation services for acute maladaptive symptoms and/or behaviors (such as altered mental

status, psychosis, irritability, inability to make decisions, actual or threatened harm to self or others, and behavior that creates an inappropriate risk of harm) at the Florida location in which the crisis occurs, even if the location is outside the region in which the plan is operating. Mobile crisis management is provided to enrollees participating in the pilot who are experiencing a behavioral health crisis. This service is provided by a team of behavioral health professional who are available at all times for (1) the purpose of preventing the need for emergency inpatient psychiatric services, when possible, or (2) the loss of a housing arrangement, when possible. Services will be available for eligible enrollees regardless of residence. Recipients residing in an IMD or who are inmates in a correctional institution are not eligible to participate. The agency is not seeking, and CMS has not approved, a waiver of IMD exclusion or the prohibition against the provision of FFP for services provided to inmates in a correctional institution. If needed, these individuals may receive housing assistance services once they are no longer residents in an IMD or once released into the community.

iv. Self-help/peer support: Person centered service promoting skills for coping with and managing symptoms while utilizing natural supports (such as family and friends) and the preservation and enhancement of community living skills with the assistance of state certified peer support specialist. These are (1) mental health substance abuse recovery peer specialists and (2) recovery support specialists that are certified by the state. The peer specialists are required to complete a 40-hour curriculum that covers four content learning areas identified by the state: mentoring, advocacy, recovery support, and professional responsibility.

f. Enrollee Appropriateness Criteria. This pilot program is designed to provide necessary services for Florida Medicaid recipients age 21 year and older with an SMI, SUD or an SMI with a co-occurring SUD, who are homeless or at risk of homelessness due to their disability. The state will use the Department of Housing and Urban Development definition listed in 24 CFR 576.2 to determine risk of homelessness.

g. HCBS Assurances.

1. As a part of its approved Quality Improvement Strategy, the state must develop performance measures for services that could have been authorized to individuals under a 1915(i) HCBS State plan within 90 days following approval of the 1115 waiver amendment to address the following requirements of the transitional housing services, tenancy sustaining services, mobile crisis management, and self-help/peer support:

A. Service plans that:

I. address assessed needs of participants;

II. are updated annually; and

III. document choice of services and providers.

B. Appropriateness Evaluation Requirements: The state will ensure that:

I. an evaluation for transitional housing services and tenancy services eligibility is provided to all applicants for whom there is reasonable indication that transitional housing services and tenancy services may be needed in the future;

II. the processes and instruments described in the approved program for determining transitional housing services and tenancy support services needs are applied appropriately; and

III. appropriateness of services for enrolled individuals is reevaluated at least annually (end of DY) or more frequently, as specified in the approved program.

C. Providers meet required qualifications. See STC 54(c)(iii) and (iv).

D. Settings meet the home and community-based setting requirements as specified in STC 54 and in accordance with 42 CFR 441.710(a)(1) and (2).

E. The SMA retains authority and responsibility for program operations and oversight by MCOs as required in the MCO contract.

F. The SMA maintains financial accountability through payment of claims by MCOs for services that are authorized and furnished to participants by qualified providers

G. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.

H. The state must report annually the actual number of unduplicated individuals served and the estimated number of individuals for the following year. Submission due at the end of the DY.

I. To the extent housing support services are available and accessible for a beneficiary under other programs, those services that might otherwise be available through this demonstration will not be authorized for that particular beneficiary. The transitional housing-services and tenancy support services authorized under this demonstration, however, could cover connecting the beneficiary to

such program and helping them secure supportive housing through that program.

J. The state will submit a report to CMS which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. NOTE: This information will be captured in the 1115 Annual Monitoring Reports detailed in STC 75.

K. CMS will evaluate each evidentiary report to determine whether the assurances have been met

L. During the demonstration period, the state must conduct an evaluation to accomplish the following: assess if the pilot program can be transitioned to a 1915(i) HCBS State plan benefit and how such transition is consistent with the state's program goals including consideration for the impact to services, members, waiver allocation process and budget implications; and, consistent with the assessment, develop a transition plan of the pilot program to a 1915(i) authority. By July 1, 2024, the state must submit a plan to CMS for transition of the pilot program to a 1915(i) HCBS State plan benefit.

2. Pilot Evaluation. The state must develop an Evaluation Design for the pilot program in collaboration with CMS. The draft Evaluation Design should be submitted to CMS for review and approval within 180 calendar days of approval of this demonstration.

i. The State will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

ii. HCBS Beneficiary Protections:

(1) Person-centered planning: The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.725 and the written person-centered service plan meets federal requirements at 42 CFR 441.725(b). The person-centered service plan is reviewed and revised upon reassessment of functional need as required by 42 CFR 365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

(2) Conflict of Interest: The state agrees to ensure that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also agrees to ensure that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

(3) The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

55. **The Prepaid Dental Health Program (PDHP).** PDHP is a statewide Prepaid Ambulatory Health Program (PAHP) as defined under 42 CFR 438.2. The PDHP will provide Florida State Plan Medicaid dental services to all Florida Medicaid recipients and the MEDS AD and AIDS CNOM Eligibility Groups as described above, except the following populations which are excluded because they are either not eligible to receive State plan dental services, or they receive dental services through the institution in which they reside or the program in which they are enrolled:

    i. Individuals eligible for emergency services only due to immigration status;
    ii. Family Planning Waiver recipients;
    iii. Presumptively eligible pregnant women;
    iv. Individuals residing in one of the following institutional settings:
        a. State mental health hospital if under the age of 65 years,
        b. Psychiatric Residential Treatment Facility (PRTF);
    v. Program of All-Inclusive Care for the Elderly enrollees; and
    vi. Partial dual eligibles.

    a. The state will implement the PDHP in three phases by region, beginning December 1, 2018, with completion by March 1, 2019. In order to provide services to recipients, each dental plan operating under the PDHP must meet readiness and network requirements specified at 42 CFR 438.66(d)(1).
    b. Dental plans are required to continue previously authorized services at the authorized levels, and through the existing provider, for at least the first sixty days of enrollment. For orthodontia services, dental plans are required to continue previously authorized services at the authorized levels, and through the existing provider, until the care is completed.
    c. During transition to the PDHP, the state will auto-assign individuals into their existing dental plan that was subcontracted as a dental benefits manager for their current MMA plan. If an individual's existing plan is not a participating dental plan under the PDHP or if the recipient does not have an existing plan, the Agency will auto-assign based on the criteria specified in STC 24. Individuals may choose a different dental plan prior to enrollment and during the 120-day change/disenrollment-period without cause post-enrollment.

56. **MEDS AD Program.** The MEDS AD program provides coverage for certain aged and disabled individuals with incomes up to 88 percent of the federal poverty level (FPL). Individuals enrolled in the program receive all services offered through the state plan as well as the community-based services provided in the programs identified below which are

operated by the state under the authority of 1915(c) of the Act.

a. Availability of the community-based services is subject to any numeric limitations on enrollment in such programs and the requirements that the individual meets the eligibility and level of care criteria for the services in these programs:

i. Program of All-inclusive Care for the Elderly (PACE)

ii. Developmental Disabilities Individual Budget Home and Community Based Waiver

iii. Model Waiver

iv. Long-term Care Waiver.

57. **AIDS Program.** Recipients enrolled in the AIDS program will receive all services offered through the Florida Medicaid state plan. For beneficiaries transitioning from the 1915(c) PAC Waiver (0194.R05.00), there will be no loss of services.[3] In addition:

a. Recipients ages 21 years and older will continue to access all state plan services that are currently covered for adults and will be eligible to receive case management services through their health plan, medically necessary restorative massage, enteral formulas, and incontinence supplies not otherwise available to adult recipients. These incontinence supplies will be in addition to what is offered under the Medicaid state plan according to the parameters at 42 CFR 440.70—this includes a process whereby individuals can request items that are not on the state's pre-approved list but are coverable under the benefit.
b. Recipients under the age of 21 years will continue to have access to all state plan services and EPSDT benefits that are currently covered for children.

58. **Healthy Start Program.** The Healthy Start program is available statewide for eligible Medicaid recipients. The Healthy Start program is comprised of the following two components:

a. **MomCare**: includes outreach and case management services for all women presumptively eligible and eligible for Medicaid under SOBRA. The MomCare component is a mandatory benefit for these women as long as they are eligible for Medicaid, and offers initial outreach to facilitate enrollment with a qualified prenatal care provider for early and continuous health care, Healthy Start prenatal risk screening and WIC services. Recipients may disenroll at any time. In addition, the MomCare component assists and facilitates the provision of any additional identified

[3] The majority of recipients that were enrolled in the 1915(c) PAC waiver received their medical, dental, behavioral health, and prescribed drug services from an MMA plan; therefore, there will be no change in how these individuals receive MMA services, unless they choose to change plans. There will be no change for recipients who are not enrolled in an MMA plan, and instead receive the aforementioned services through a Medicare Advantage Fully Liable D-SNP. This change will not affect how D-SNP enrollees receive their Medicare or Medicaid benefits

needs of the Medicaid recipient, including referral to community resources, family planning services, and Medicaid coverage for the infant and the need to select a primary care physician for the infant.

b. **Healthy Start Coordinated System of Care**: includes outreach and case management services for eligible pregnant women and children identified at risk through the Healthy Start program. These services are voluntary and are available for all Medicaid pregnant women and children up to the age of 3 who are identified to be at risk for a poor birth outcome, poor health and poor developmental outcomes. The services vary, dependent on need and may include: information, education and referral on identified risks, assessment, case coordination, childbirth education, parenting education, tobacco cessation, breastfeeding education, nutritional counseling and psychosocial counseling. The goal of this component is to increase the intensity and duration of service to Healthy Start beneficiaries.

59. Program for All Inclusive Care for Children (Children's Medical Services Network). Participation in the PACC program is voluntary. The PACC program provides the following pediatric palliative care support services to children enrolled in the CMS Network who have been diagnosed with potentially life-limiting conditions and referred by their primary care provider (PCP).

a. Support Counseling – Face-to-face support counseling for child and family unit in the home, school or hospice facility, provided by a licensed therapist with documented pediatric training and experience.

b. Expressive Therapies – Music, art, and play therapies relating to the care and treatment of the child and provided by registered or board certified providers with pediatric training and experience.

c. Respite Support – Inpatient respite in a licensed hospice facility or in-home respite for patients who require justified supervision and care provided by RN, LPN, or HHA with pediatric experience. This service is limited to 168 hours per year.

d. Hospice Nursing Services – Assessment, pain and symptom management, and in-home nursing when the experience, skill, and knowledge of a trained pediatric hospice nurse is justified.

e. Personal Care – This service is to be used when a hospice trained provider is justified and requires specialized experience, skill, and knowledge to benefit the child who is experiencing pain or emotional trauma due to their medical condition.

f. Pain and Symptom Management – Consultation provided by a CMS Network approved physician with experience and training in pediatric pain and symptom management.

g. Bereavement and volunteer services are provided but are not reimbursable services.

60. **Comprehensive Hemophilia Disease Management Program.** The Medicaid Comprehensive Hemophilia Management program operates statewide as a specialized service whereby recipients who have a diagnosis of hemophilia or von Willebrand disease and are enrolled in the FFS system or a MMA plan are required to obtain pharmaceutical services and products related to factor replacement therapy from one of the up to three contracted vendors. In addition to product distribution, the program provides pharmacy benefit management, direct beneficiary contact, personalized education, enhanced monitoring, and direct support of beneficiaries in the event of hospitalization, at no additional cost to the state. Enrollees have access to a registered nurse and licensed pharmacist 24 hours a day, seven days a week. The enrollees also have access to medical care and treatment through their usual and customary networks, with no restrictions on services or providers, and receive pharmacy products other than those related to factor replacement therapy via the usual and customary networks without restriction, as well.

    The populations enrolled in the program have a diagnosis of hemophilia, are currently Medicaid eligible, receive prescribed drugs from the therapeutic MOF Factor IX, and MOE- Antihemophilic Factors, Corifact (MOC therapeutic class), Stimate (P2B therapeutic class), and other therapeutic classes identified by the Agency as treatment for hemophilia or von Willebrand. Medicaid-Medicare eligible individuals may voluntarily enroll in the program.

XIV. LOW INCOME POOL

61. **Low Income Pool Definition**. The LIP provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals who are uninsured. Uncompensated care (UC) includes charity care for the uninsured but does not include UC for insured individuals, “bad debt,” or Medicaid and CHIP shortfall. LIP payments are not associated with particular individuals and are not a form of health coverage or any other benefit inuring to individuals. The resulting total computable (TC) dollar limit is enumerated in STC 62(a).

62. **Availability of Low Income Pool (LIP) Funds**. The following STC presents the TC dollar limit for LIP spending for the current approval period, DY 12 through 16, subject to the assurances that follow.

    a. **Total LIP Amount.** The TC dollar limit for LIP expenditures in each DY will be $1,508,385,773 through DY 16.

    b. **Assurance.** As reflected in the LIP participation requirements in STC 69, the state and providers that are participating in LIP will provide assurance that LIP claims include only costs associated with UC that is furnished through a charity care program and that adheres to the principles of the HFMA operated by the provider.

    c. **Reassessment of Hospitals’ Uncompensated Charity Care in DY17.** Low Income Pool limits for DY 17-21 will be revised based on a reassessment of

the amount of uncompensated charity care cost provided by Florida hospitals, to take place by March 31, 2022. The state and CMS will collaborate on the reassessment, which will be based on information reported by hospitals for federal fiscal year 2019 on schedule S-10 of the CMS 2552-10 hospital cost report, with adjustment to ensure that LIP payments under this demonstration do not offset hospital costs in the calculation, following a methodology approved by CMS. The results of the reassessment will be used to revise the Total LIP Amount for DY 17-21.

i. If the reassessment discussed in in this STC is not completed to produce an updated LIP limit by July 1, 2022, all payments from the LIP will be unavailable until the reassessment is complete.
ii. When the 2019 S-10 data specified above becomes available, the state and CMS will collaborate to recalculate the Total LIP Amount for DY 17-21 based on this updated information. The recalculated Total LIP Amount will become the final Total LIP Amount for DY 17-21.
iii. The revised Total LIP Amount may not exceed $2,167,718,341 per DY, for the period covered by DY 17-21.[4]

d. **Reassessment of Hospitals' Uncompensated Charity Care in DY22.** Low Income Pool limits for DY 22 – DY 24will be revised based on a reassessment of the amount of uncompensated charity care cost provided by Florida hospitals, to take place by March 31, 2027. The state and CMS will collaborate on the reassessment, which will be based on information reported by hospitals for periods beginning in federal fiscal year 2025 on schedule S-10 of the CMS 2552-10 hospital cost report, with adjustment to ensure that LIP payments under this demonstration do not offset hospital costs in the calculation, following a methodology approved by CMS. The results of the reassessment will be used to revise the Total LIP Amount for DY 22 -DY 24.

i. If the reassessment discussed in this STC is not completed to produce an updated LIP limit by July 1, 2027, all payments from the LIP will be unavailable until the reassessment is complete.
ii. When 2025 S-10 data specified above becomes available, the state and CMS will collaborate to recalculate the Total LIP Amount for DY 22 - DY 24 based on this updated information. The recalculated Total LIP Amount will become the final Total LIP Amount for DY 22 - DY24.
iii. The revised Total LIP Amount may not exceed $2,167,718,341 per DY for the period covered by DY 22-24.[5]

63. **Capped Annual Allotments.** All annual LIP funds must be expended by September 30 following each authorized DY. Any amount not expended cannot be rolled over to the next DY. Capped annual allotment amounts that are not distributed because of penalties,

[4] See Comprehensive Program Description and Objectives listed below in attachment A
[5] See Comprehensive Program Description and Objectives listed below in attachment A

recoupment due to payments exceeding UC cost, or are otherwise due to violating the terms of the approved STCs cannot be rolled over to another DY and are not recoverable.

64. **LIP Reimbursement and Funding Methodology.** The Reimbursement and Funding Methodology Document (RFMD) is prepared by the state for approval by CMS and documents LIP permissible expenditures, including the non-federal share and TC expenditures. The RFMD provides that TC LIP payments to providers for UC costs must be supported by UC costs incurred and reported by providers as charity care on the provider's financial records. Through the RFMD, the state must demonstrate that it has reconciled LIP payments to auditable costs. LIP provider payments for UC as charity care are limited to the uncompensated portion of providers' allowable costs and, in the aggregate, the authorized LIP pool amount for the DY.

   a. Prior to August 31 of each DY, the state must submit a draft of the RFMD for that DY to CMS for approval. The state may not claim FFP for LIP payments in that DY until after the RFMD for that DY has been approved by CMS.

   b. For each DY, the state must reconcile LIP payments made to providers to ensure that they do not exceed allowed UC costs, using the CMS approved RFMD cost review protocol. The state must submit a LIP Cost Reconciliation report that has been examined and attested by an independent accountancy firm to CMS within four years after the end of each DY showing cost reconciliation results by provider as required under 42 C.F.R. § 455.304. CMS will review the state's reconciliation and share any findings with the state. To the extent that payments are found to exceed allowed UC costs, the federal portion of any excess payment must be returned to CMS by submitting a decreasing expenditure adjustment (on Form CMS-64, Line 10B). If the state has not submitted its LIP Cost Reconciliation Report for a DY within the timeframe described above, CMS may issue a deferral or disallowance for an amount not to exceed the total of the state's submitted LIP expenditures for the DY for which the LIP Cost Reconciliation Report is overdue.

   c. A provider may at any time during a DY, disclose to the state that LIP payments to that provider exceeded allowed UC costs. If a provider refunds an overpayment to the state, the state must report that refund by including a decreasing expenditure adjustment on Line 10B of the CMS-64 for the quarter that it was received. If the provider reports an overpayment and does not refund that overpayment, the state has one year from the date of discovery, to have the provider refund the overpayment on the CMS-64. If the provider does not refund that overpayment within one year from the date of discovery, the state must refund the overpayment on the CMS-64. Any overpayments that have not been refunded to CMS may be subject to interest as defined under 42 CFR 433.320(a)(4).

   d. A provider is not eligible for an LIP payment or continued LIP payments if (i) the provider is identified in a disallowance notice from CMS to the State as having received an LIP overpayment in a specified amount in a prior year; and (ii) the provider has not entered into a repayment agreement satisfactory to the

State within 30 days after the date by which the State must credit CMS with the federal share of the specified overpayment, or (iii) the provider is in breach of a repayment agreement.

e. A provider that is ineligible for LIP payments on the basis of the above may re-establish eligibility by making repayment arrangements satisfactory to the state. Payments from LIP to hospitals are to be considered Medicaid hospital revenue for the purpose of determining the hospital-specific disproportionate share hospital (DSH) limits defined in section 1923(g) of the Act.

f. For the purposes of this STC, allowed UC cost follows the definitions described in STC 65 below.

65. **Low Income Pool Permissible Expenditures**. Funds from the LIP may be used to defray the actual uncompensated cost of furnishing medical services described in section 1905(a)(1) et seq. of the Act to uninsured individuals incurred by qualifying providers.

   a. These health care costs may be incurred by the state or by providers to furnish uncompensated medical care as charity care for low-income individuals who are uninsured. The costs must be incurred pursuant to a charity care program that adheres to the principles of the HFMA.

      i. Providers may be categorized in up to four groups: hospitals, Medical School Physician Practices, FQHCs/RHCs, and Community Behavioral Health Providers. Each group may be divided into up to five tiered subgroups, any of which may be based on ownership, UC Ratio, or ownership and UC Ratio, or (for purposes of FQHCs/RHCs only) Section 330 Public Health Service Act grant type, or FQHC Look-Alike status. UC Ratio is defined as the amount of a provider's uncompensated uninsured charity care costs (defined in (a) above), expressed as a percentage of its privately insured patient care costs. UC Ratio for FQHCs/RHCs is defined as the amount of a provider's uncompensated uninsured charity care costs (defined in (a) above), expressed as a percentage of its total costs. To define subgroups by UC Ratio, providers must be ranked based on their relative UC Ratios, and may be formed into subgroups based on contiguous ranges of UC Ratios. Hospital ownership subgroups may consist of one or more of the following categories: local government, state government, or private and may be grouped by the hospital's publically owned, statutory teaching, freestanding children's, and Regional Perinatal Intensive Care Center hospital status. For each DY, up to $75,000,000 of the capped annual allotment of the LIP may be apportioned to FQHCs/RHCs. FQHCs/RHCs may be tiered in subgroups by the type of Section 330 Public Health Service Act grant type and FQHC Look-Alike status.

      ii. All providers that must receive some amount of payment (following (1) above) must be paid the same percentage of their charity care cost within each subgroup.

iii. Within each group and ownership subgroup, providers in tiers with a lower range of UC Ratios cannot be paid a greater share of their charity care cost than providers in tiers with higher UC Ratios.

iv. Determination of (1) through (3) may be effectuated using hospital-specific cost data for the DY for which payments are being allocated, or for a prior year not more than three years prior to that DY.

66. **Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid up to cost and are further defined in the RFMD utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs that will be defined in the RFMD. The state shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost.

67. **Low Income Pool Permissible Non-Hospital-Based Expenditures.** To ensure services are paid up to or at cost, the RFMD defines the cost reporting strategies required to support non-hospital based LIP expenditures.

68. **Permissible Sources of Funding Criteria.** Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other federal programs (unless expressly authorized by federal statute to be used for matching purposes) shall be impermissible as sources of non-federal funding.

XV. LOW INCOME POOL PROVIDER PARTICIPATION REQUIREMENTS AND DELIVERABLES

69. **LIP Provider Participation Requirements**. In addition to any other applicable requirements, to be eligible for LIP funding, essential providers, must offer to contract with each managed care plan in the state and must make a good faith effort to enter into a network contract with each statewide Medicaid managed care (SMMC) plan and each SMMC specialty plan. "Essential providers" are defined as faculty plans of Florida medical schools and hospitals licensed as specialty children's hospitals.[6] If the state determines that an essential provider has not offered and negotiated in good faith to enter into a network contract with each managed care plan, then the state will notify the essential provider at least 90 days in advance of the start of the third quarter of the state fiscal year that LIP payments will not be made to the essential provider beginning with the third quarter of the state fiscal year and informing the essential provider how it may avail itself of hearing

[6] As detailed on AHCA's website, "Statewide essential providers include: (1) Faculty plans of Florida medical schools, which include University of Florida College of Medicine, University of Miami School of Medicine, University of South Florida College of Medicine, University of Central Florida College of Medicine, Nova Southeastern University College of Osteopathic Medicine, Florida State University College of Medicine, and Florida International University College of Medicine." Available at https://ahca.myflorida.com/ITNR/REGION%2002/MAGELLAN/Exhibit%20A-4-b,%20MMA%20Submission%20Requirements/Attachments/MMA%20SRC%2009-Attachment%202_Network%20Adequacy%20Standards%20Policy.pdf.

rights. Annually, 60 days after the state legislative process has concluded, the state must submit a letter to CMS indicating Florida legislative approval. The essential provider contracting requirement will be suspended should the Florida legislature no longer require this participation requirement as indicated in the letter submitted to CMS.

Hospitals, Medical School Physician Practices, FQHCs/RHCs, and Community Behavioral Health Providers must meet the participation requirements set forth in this STC to be eligible to receive LIP funds. The state may grant an exemption to a hospital with respect to the requirement in 69(a)(ii) below, upon finding that the hospital has demonstrated that it was refused a contract despite a good faith negotiation with a Specialty Plan. A letter from a Specialty Plan declining to enter a contract, or some other comparable evidence, will be required to make such a finding. The state may grant an exemption to an FQHC/RHC with respect to the requirement in 69(c)(i) below, upon finding that the FQHC/RHC has demonstrated that it was refused a contract despite a good faith negotiation with a Standard Plan. A letter from a Standard Plan declining to enter a contract, or some other comparable evidence, will be required to make such a finding.

a. <u>Hospitals.</u>

i. Must contract with at least fifty percent of the Standard Plan MCOs in their corresponding region.

ii. Must contract with at least one Specialty Plan for each target population that is served by a specialty plan in their corresponding region.

iii. Must participate in the Florida Encounter Notification Service[7] program, except that participation is voluntary for hospitals with 25 or fewer beds.

iv. The state and participating providers will provide assurance that LIP claims include only costs associated with UC furnished through a charity care program and that adheres to the principles of the HFMA and is operated by the provider.

v. Participating hospitals must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization based on the ratio of Medicaid days to total patient days reported on the most recent accepted Florida Hospital Uniform Reporting System (FHURS) data.

vi. This LIP category also includes Regional Perinatal Intensive Care Centers as an eligible hospital subgroup, effective December 1. 2018. Regional Perinatal Intensive Care Centers have special perinatal intensive care capabilities as defined in section 383.16, Florida Statutes.

[7] Available at https://www.florida-hie.net/ens/index.html.

b. Medical School Physician Practices

i. Must participate in the Florida Medical Schools Quality Network.

ii. The state and participating providers will provide assurance that LIP claims include only costs associated with UC through the provider's charity care program and that adheres to the principles of the HFMA

iii. Participating providers must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization. The state will review data submitted by the participating providers to determine the percentage of Medicaid utilization.

c. Federally Qualified Health Centers and Rural Health Clinics

i. Must contract with at least 50 percent of Standard Plan MCOs in their corresponding region.

ii. Must be enrolled in Medicaid.

d. Community Behavioral Health Providers

i. Community Behavioral Health providers are providers in the substance abuse and mental health safety net system (Central Receiving Systems) administered by the Florida Department of Children and Families. A Central Receiving System consists of a designated central receiving facility and other service providers that serve as a single point or a coordinated system of entry for individuals needing evaluation or stabilization under section 394.463 or section 397.675, Florida Statutes, or crisis services as defined in section 394.67, Florida Statutes.

ii. Community Behavioral Health providers is a LIP provider category effective as of December 1, 2018.

iii. Must be enrolled in Medicaid.

70. **Deliverable Requirements**. By June 1 of each year, the state must submit to CMS a report detailing for the upcoming demonstration year, the projected LIP providers, the estimated per provider amount of uncompensated care to be furnished through charity care, and the estimated IGTs associated with each provider. By October 1 of each year, for the demonstration year just ended, the state must submit to CMS the final report of the LIP providers, final uncompensated care claimed through charity care and the final IGTs. Both the estimate and final report must also be posted on the state Medicaid website.

XVI. GENERAL REPORTING REQUIREMENTS

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

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

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

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

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

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

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

72. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as

stipulated by CMS and within the timeframes outlined within these STCs**.**

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

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

2. Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

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

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

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS's templates. Any proposed deviations from CMS's templates should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics, CMS will provide the state with a set of required metrics and technical specifications for data collection and analysis covering reporting topics such as enrollment, access to care, quality of care and health outcomes (see Module #1 of the hyperlinked document above for specific examples). In addition, CMS will provide the state with metrics related to the key policies being tested under this demonstration, including but not limited to, incentives for healthy behaviors, e.g., utilization of programs outlined in STC 53 and 53a (see examples in Module #4) and waiver of retroactive eligibility (see examples in Module #6). The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

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

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

b. Performance Metrics – The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's annual goals and overall targets, where applicable. As will be identified in the approved Monitoring Protocol, Monitoring Reports will cover key policies under this demonstration, including but not limited to incentives for healthy behaviors (e.g., utilization of programs outlined in STC 53 and 53a) and waivers of retroactive eligibility. The performance metrics will also reflect all other components of the state's demonstration. For example, these metrics will cover enrollment, completion of incentivized healthy behaviors and rewards granted, unpaid medical bills at application (if available), access to care, and quality of care and health outcomes.

   Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook

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

d. Evaluation Activities and Interim Findings –Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. 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.

76. 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 indicates indicate substantial and sustained directional change inconsistent with state targets (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 9. CMS will withdraw an authority, as described in STC 9, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

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

a. The draft report must comply with the most current guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the Close-Out report.
c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 71.

78. 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.

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

XVII. GENERAL FINANCIAL REQUIREMENTS

80. **Allowable Expenditures.** This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.[8]

81. **Medicaid Expenditure Groups (MEG).** MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table (Table 2) provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Aged/ Disabled	Main test	X		X	Medical assistance expenditures for Aged and disabled demonstration enrollees.
TANF & related grp	Main test	X		X	Medical assistance expenditures for TANF demonstration enrollees.

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

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
AIDS CNOM	Main test			X	Medical assistance expenditures for AIDS demonstration enrollees
Healthy Start CNOM	Main test			X	Healthy Start expenditures.
PACC CNOM	Main test			X	PACC expenditures
LIP	Hypo 1		X	X	Low Income Pool expenditures
MEDS AD	Hypo 2	X		X	Medical assistance expenditures for MEDS AD demonstration enrollees
BH SH Pilot	Hypo 3		X	X	Behavioral Health and Supportive Housing Assistance Pilot expenditures
ADM	N/A			X	Additional administrative costs that are directly attributable to the demonstration

82. **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-00206/4). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs. The state will work with CMS to develop a method of reporting spending on dental care through the health plans.

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

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

c. Pharmacy Rebates. Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by CMS, and changes to the methodology must also be approved in advance by CMS. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

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, using with the waiver name “ADM”. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in section XX, 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.

g. Excluded Services. The following services are excluded from the demonstration, in that they are excluded from the list of benefits for which MMA managed care plans will provide coverage. Expenditures for these services are not expenditures subject to the BN limit, so should not be reported on any Forms CMS-64.9 Waiver and/or 64.9P Waiver for this demonstration.

   i. Home and Community Based Service Waiver Services (Model Waiver (formerly Katie Beckett Model Waiver Services), Familial Dysautonomia, Development Disabilities Individual Budgeting);
   ii. Long Term Care Waiver;
   iii. ICF/IID Institutional Services;
   iv. School Based Administrative Claiming;
   v. Prescribed pediatric extended care (PPEC) services;
   vi. County matching programs (Substance Abuse and Medicaid Certified School Match Services);
   vii. State Mental Health Hospital services for recipients age 65 and older;
   viii. Certain physician-injectable procedures; and
   ix. Vaccines for Children program for MediKids.

h. Sanctions and Liquidated Damages. If the state imposes monetary sanctions or liquidated damages against an MCO, the state must report the monetary amounts on the CMS-64 Summary Line 9D in the quarter in which the plan has exhausted all administrative appeals or the time to seek an administrative appeal has expired.

i. Expenditures Subject to the Budget Neutrality Limits. The following types of expenditures are subject to the BN limits for this demonstration.

   i. All medical assistance expenditures for Medicaid beneficiaries in the categories listed in STC 21(a), (b), or (c) (regardless of their managed care enrollment status), other than expenditures for services listed in STC

82(e),

ii. All expenditures made under section 1115(a)(2) expenditure authority, including all payments made under LIP, through June 30, 2030.

j. Achieved Saving Rebates and Managed Care Plans. If the state requires the managed care plans to return any monies back to the state for any programs that are setup by the state including the Achieved Saving Rebates program, the state must report the monetary amounts on the CMS-64 Summary Line 9D in the quarter that the state receives these monies.[9]

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
Aged/ Disabled	Medicaid assistance expenditures for all participating individuals defined as Aged/Disabled in Table 1	See Excluded Services STC 82(g) and Excluded from MMA Program Participation STC 21(d). Exclude AIDS CNOM, Healthy Start CNOM, and PACC CNOM	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/06	6/30/30
TANF & related grp	Medicaid assistance expenditures for all participating individuals defined as TANF & related grp in Table 1	AIDS CNOM	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/06	6/30/30

[9] See 42 CFR §438.74.

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
AIDS CNOM	Medicaid assistance expenditures for all participating individuals in AIDS Program	Healthy Start CNOM	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	7/1/17	6/30/30
Healthy Start CNOM	Medicaid assistance expenditures for all participating individuals in Healthy Start Program	PACC CNOM	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	7/1/17	6/30/30
PACC CNOM	Medicaid assistance expenditures for all participating individuals in Program for All Inclusive Care for Children	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	7/1/17	6/30/30

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
LIP	Medical assistance expenditures for categorically needy individuals without Medicare receiving HCBS services (of the kind listed in Table 5) in the STAR+PLUS service areas, per Expenditure Authority 1	None	Use Line 1C Inpatient Hospital - Sup. Payments or Line 5B Physician & Surgical Services - Sup. Payments	Date of payment	MAP	N	7/1/06	6/30/30
MEDS AD	All expenditures that count against UC Pool limits	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/17	6/30/30
BH SH Pilot	All expenditures for the Behavioral Health and Supportive Housing Assistance Pilot	None	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	N	7/1/19	6/30/30
ADM	Additional administrative costs that are directly attributable to the demonstration	None	Follow CMS-64.10 Base Category of Service Definitions	Date of payment	ADM	N/A	7/1/06	6/30/30

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

Table 4: Demonstration Years

Demonstration Year 15	July 1, 2020 to June 30, 2021	12 months
Demonstration Year 16	July 1, 2021 to June 30, 2022	12 months
Demonstration Year 17	July 1, 2022 to June 30, 2023	12 months
Demonstration Year 18	July 1, 2023 to June 30, 2024	12 months
Demonstration Year 19	July 1, 2024 to June 30, 2025	12 months
Demonstration Year 20	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 21	July 1, 2026 to June 30, 2027	12 months
Demonstration Year 22	July 1, 2027 to June 30, 2028	12 months
Demonstration Year 23	July 1, 2028 to June 30, 2029	12 months
Demonstration Year 24	July 1, 2029 to June 30, 2030	12 months

84. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these 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.

85. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the following, subject to the limits described in Section XVIII:

    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;

c. Net expenditures and prior period adjustments, made under 1115 demonstration authority, with dates of service during the operation of the demonstration including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability;

d. Net expenditures and prior period adjustments for MMA Plan premiums paid to managed care entities and fee for service coverage carve-out services and for voluntary MMA populations that choose to stay in FFS;

e. Net Expenditures associated with the LIP, as described in Section XIV; and,

f. Pursuant to standard Medicaid financing rules, FFP is excluded for payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution) pursuant to the payment exclusion in paragraph (A) following section 1905(a)(29) of the Act.

g. In addition, pursuant to standard Medicaid financing rules, FFP is excluded for payments with respect to care or services for any individual who has not attained 65 year of age and who is a patient in an institution for mental diseases pursuant to the payment exclusion in paragraph (B) following section 1905(a)(29) of the Act, except as provided in section 1905(a)(16) for inpatient psychiatric services for individuals under age 21.

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

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

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

c. Without limitation, CMS may request information about the non-federal share

sources for any amendments that CMS determines may financially impact the demonstration.

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

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

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

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

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

89. **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.[10]

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

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

    a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR §438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74.
    b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR §447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

92. **Program Integrity.** The state must have processes in place to ensure that 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.

XVIII. MONITORING BUDGET NEUTRALITY

The following describes the method by which BN will be assured under the demonstration. The demonstration will be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the demonstration period. STCs 86-87 specify the two independent financial caps on the amount of federal Title XIX funding that the state may receive on expenditures subject to the BN limit as defined in STC

[10] 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.

94. Federal financial payments for the MMA aspects of the demonstration are limited by a Per Member Per Month (PMPM) method cap and the payments for the LIP aspects are limited by an aggregate cap.

93. **Budget Neutrality Limit for the LIP (Hypo 1).** The maximum allowable LIP amount is capped annually at $1,508,385,773 (TC). LIP funds not distributed in a DY cannot be rolled over to the next. The federal share of the TC LIP amount is the maximum amount of FFP that the state may receive for the LIP permissible expenditures detailed in STC 65. For each DY, the federal share will be calculated using the FMAP rate(s) applicable to that year.

94. **Limit on PMPM Title XIX Funding**. The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on the Medicaid and demonstration expenditures identified in STC 85 during the approval period of the demonstration. The limit is determined using a PMPM method. The BN targets are set on a yearly basis with a cumulative BN limit for the length of the entire demonstration (see STC 97). All data supplied by the state to CMS is subject to review and audit, and if found to be inaccurate, will result in a modified BN limit. CMS' assessment of the state's compliance with these limits will be done using the CMS-64 Report from the MBES/CBES System.

95. **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.

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

97. **Main Budget Neutrality Expenditure Limit Test**. The following describes the method for calculating the BN expenditure limit for the demonstration. Demonstration expenditures shall be reported under the Medicaid Eligibility

Groups (MEG) listed in STC 81. For the purpose of calculating the overall PMPM expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a DY basis. The annual estimates will then be summed to obtain an expenditure estimate through DY 16. The federal share of this estimate will represent the maximum amount of FFP that the state may receive for the types of Medicaid expenditures described in this section. Budget neutrality calculations for both "With Waiver" (WW) and "Without Waiver" (WOW) expenditures are applied on a statewide basis. The federal share of the BN limit will be the total computable BN limit times Composite Federal Share #1 (described below). For the purpose of monitoring BN, the annual LIP expenditures enumerated in STC 64(a) shall be considered as both WW and WOW expenditures (i.e. pass through costs). In response to the Public Health Emergency, CMS will allow for a one-time adjustment to budget neutrality to account for impacts of COVID-19 on enrollment and expenditures

a. Projecting Service Expenditures - Each yearly estimate of MMA service expenditures will be the cost projections for the MEGs in sub-STC (b) below. The annual budget estimate for each MEG will be the product of the projected PMPM cost for the MEG, times the actual number of eligible member months as reported to CMS by the state under the guidelines set forth in STC 82.

   Specifically,

   1. "Aged/Disabled" MEG PMPM is multiplied by MEG 1 member months

   2. "TANF & Rel Grp" MEG PMPM is multiplied by MEG 2 member months

b. Projected PMPM Cost - The PMPM costs for each MEG used to calculate the annual BN expenditure limit for this demonstration is specified below in Table 2.

Table 2. PMPM Costs by MEG and Demonstration Year

	Aged/Disabled MEG 1	Trend Rate	TANF & Rel Grp MEG 2	Trend Rate
DY15	$1,155.78	4.0%	$306.45	4.6%
DY16	$1,202.01	4.0%	$320.55	4.6%
DY17	TBD	TBD	TBD	TBD
DY18	TBD	TBD	TBD	TBD
DY19	TBD	TBD	TBD	TBD
DY20	TBD	TBD	TBD	TBD
DY21	TBD	TBD	TBD	TBD
DY22	TBD	TBD	TBD	TBD
DY23	TBD	TBD	TBD	TBD
DY24	TBD	TBD	TBD	TBD

98. How the Limit will be Applied. The limits as defined in STCs 97-99 will apply to the

actual expenditures for the demonstration, as reported by the state under Section 95, and specifically, to expenditures reported for the following MEGs: Aged/Disabled, TANF & related grp, AIDS CNOM, Healthy Start CNOM, and PACC CNOM. If at the end of the demonstration period the BN provision has been exceeded, the excess federal funds will be returned to CMS. There will be no new limit placed on the FFP that the state can claim for expenditures for recipients and program categories not listed.

99. **Hypotheticals & Supplemental Budget Neutrality Test 2: MEDS-AD.** Optional demonstration expenditures that *could have been* covered via the Medicaid state plan, but instead are provided through section 1115(a) expenditure authority, may be designated as "hypotheticals" for the purposes of BN. In these cases, CMS may allow adjustment(s) to the WOW baseline to hold states harmless for the spending which it could have hypothetically provided through the Medicaid state plan. Separate WOW limits are provided below for the costs associated with this demonstration's hypothetical expenditures and, if the limits are exceeded, that excess spending must be "paid for" with overall BN savings.

    a. The MEDS AD MEG listed in Table 3 below is included in the MEDS-AD Supplemental Budget Neutrality Test.

Table 3.1. PMPMs for Supplemental BN Test

	Trend	**DY14**	**DY15**	**DY16**	**DY17 –**	**DY18-DY24**
MEDS AD PMPM	0.00%	$1,004.22	$1,004.22	$1,004.22	TBD	TBD

    b. The MEDS AD expenditures cap for the supplemental BN test is calculated by multiplying the projected PMPM for the MEDS AD MEG, each DY, by the number of actual eligible MEDS AD member months for the same/corresponding MEG/DY—and summing the products together across all DYs. The federal share of the MEDS AD expenditure cap is obtained by multiplying this cap by the Composite Federal Share #2 described in STC 104 below.

    c. If the actual FFP claimed by the state for the MEDS AD MEG for all DYs is greater than the federal share of the MEDS AD expenditure cap defined in sub-STC (b) above, then that overage will be subtracted from the demonstration's overall BN variance.

100. **Hypotheticals & Supplemental Budget Neutrality Test: Behavioral Health and Supportive Housing Assistance Pilot.** Optional demonstration expenditures that could have been covered via the Medicaid state plan, but instead are provided through section 1115(a) expenditure authority, may be designated as "hypotheticals" for the purposes of BN. In these cases, CMS may allow adjustment(s) to the WOW baseline to hold states harmless for the spending which it could have hypothetically provided through the Medicaid state plan. Separate WOW limits are provided below for the costs associated

with this demonstration's hypothetical expenditures and, if the limits are exceeded, that excess spending must be "paid for" with overall BN savings.

a. The BH SH Pilot MEG listed in Table 3.2 below is included in the Behavioral Health and Supportive Housing Assistance Pilot Supplemental Budget Neutrality Test.

Table 3.2. Total Spending for Supplemental BN Test-BH SH Pilot

	Trend	DY12	DY13	DY14	DY15	DY16
BH SH Pilot	0.00%	N/A	N/A	$9,714,500	$9,714,500	$9,714,500

b. The projected BH SH Pilot for each DY is the amount shown in Table 3.2. The BH SH Pilot expenditures cap is the sum of the annual DY-specific amounts for all DY. The federal share of the BH SH Pilot expenditure cap is obtained by multiplying this cap by the Composite Federal Share #3 described in STC 104 below.

c. If the actual FFP claimed by the state for the BH SH Pilot MEG for all DYs is greater than the federal share of the BH SH Pilot expenditure cap defined in sub-STC (b) above, then that overage will be subtracted from the demonstration's overall BN variance.

101. Savings Phase-Out. Each DY, the net variance between the WOW cost and actual WW cost will be reduced for selected population-based MEGs. The reduced variance, to be calculated as a percentage of the total variance, will supersede the total variance in determining overall BN for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the WOW cost estimate.) The formula for calculating the reduced variance is: reduced variance equals total variance multiplied by the applicable percentage. The applicable percentages for each MEG and DY are determined based upon length of time the associated population has been enrolled in managed care; lower percentages are associated with longer established managed care populations. The MEGs affected by this provision and the applicable percentages are shown in Table 4 below, except that if the total variance for a MEG in a DY is negative, the applicable percentage is 100 percent.

Table 4. Savings Phase-Out Percentages

	DY 15	DY 16
MEG 1 and MEG 2	49%	44%

102. Rebasing. On July 1, 2022, the budget neutrality limits for this demonstration will be rebased consistent with the requirements that are outlined in State Medicaid Director

Letter (SMDL) #18-009 and other CMS guidance. To establish the new PMPMs, the state agrees to utilize its most recent 5 years of complete and contiguous historical expenditure data which was reported in MBES through June 30, 2021. In addition, CMS will recalculate the LIP's UC limits as part of the rebasing process. The rebasing processes described in this STC must be recalculated every 5 years and at each renewal of the demonstration.

a. The state must submit a draft budget neutrality workbook with revised PMPMs—and no more than the most recent 5 years of savings rollover—by March 31, 2022 for the DY 17 rebase and March 31, 2027 for the DY 22 rebase.
b. The new PMPMs and UC from the July 1, 2022 rebase will be effective from DY 17 to DY 21.
c. The state must repeat the process outlined in this STC in preparation for another rebase to be implemented on July 1, 2027.
d. The new PMPMs and UC from the July 1, 2027 rebase will be effective from DY 22 to DY 24.
e. Once CMS has approved the state's rebasing workbooks, CMS will reissue STCs with updated PMPMs and publish on Medicaid.gov.
f. CMS will also update budget neutrality monitoring workbooks in PMDA.

103. **Impermissible DSH, Taxes or Donations.** CMS reserves the right to adjust the BN ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through state Medicaid Director Letters, other memoranda or regulations. CMS reserves the right to make adjustments to the BN cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

104. **Composite Federal Share Ratio.** The federal share of the BN expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C, with consideration of allowable demonstration offsets such as premium collections, by TC demonstration expenditures for the same period as reported on the same forms. Composite Federal Share #1 is determined by applying the above calculation to expenditures reported under MEG 1 and MEG 2 combined. Composite Federal Share #2 is determined by applying the above calculation to expenditures reported under MEG 4. Composite Federal Share #3 is determined by applying the above calculation to expenditures reported under MEG 8. For the purpose of interim monitoring of BN, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

105. **Enforcement of Budget Neutrality.** CMS shall enforce BN over the life of the

demonstration. The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration periods comprising DY 11 through 16 (but not from any earlier approval period). However, no later than 6 months after the end of each DY, the state will calculate an annual expenditure target for the completed year and report it to CMS as part of the reporting guidelines in Section XVI. This amount will be compared with the actual FFP claimed by the state under BN. Using the schedule in Table 5 below as a guide for the PCCM budget limit, if the state exceeds the cumulative BN expenditure limit, they shall submit a corrective action plan to CMS for approval. The state will subsequently implement the approved program.

Table 5. Maximum Budget Neutrality Caps

Demonstration Year	Cumulative Target Definition	Percentage
DY12	Cumulative BN Limit Plus:	2.0 percent
DY13	Cumulative BN Limit Plus:	1.5 percent
DY14	Cumulative BN Limit Plus:	1.0 percent
DY15	Cumulative BN Limit Plus:	0.9 percent
DY16	Cumulative BN Limit Plus:	0.8 percent
DY17	Cumulative BN Limit Plus:	0.7 percent
DY18	Cumulative BN Limit Plus:	0.6 percent
DY19	Cumulative BN Limit Plus:	0.5 percent
DY20	Cumulative BN Limit Plus:	0.4 percent
DY21	Cumulative BN Limit Plus:	0.3 percent
DY22	Cumulative BN Limit Plus:	0.2 percent
DY23	Cumulative BN Limit Plus:	0.1 percent
DY24	Cumulative BN Limit Plus:	0.0 percent

106. **Annual Budget Neutrality Report.** On or before June 30, 2021, and on or before June 30 of each year thereafter, the state shall submit to CMS an Annual BN Monitoring Report, which will include an assessment of the demonstration's BN status based on actual expenditures to-date (including complete or nearly complete actual expenditures for the immediately preceding DY), the cumulative BN limit to-date, and updated projections for both the BN limit and WW expenditures through the end of the current approval period. If the state's actual expenditures are found to have exceeded the cumulative BN limit by more than the percentages described in Table 5 above, or if the state's projections indicate that that actual cumulative spending are likely to exceed the BN limit for the approval period, the state must include corrective actions to ensure BN for the demonstration

107. **Budget Neutrality Monitoring Tool**. The state will provide CMS with quarterly BN status updates via the reporting of demonstration expenditures in the BN Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool will be jointly developed with the state and incorporate the "Schedule C Report" for comparing demonstration's actual expenditures to the caps which are subject to BN expenditure limits described in STC 93-94. CMS will provide technical assistance, upon request.

108. Exceeding Budget Neutrality. If the BN expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the BN agreement, the BN test shall be based on the time elapsed through the termination date.

XIX. EVALUATION OF THE DEMONSTRATION

109. 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 and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 70.

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

111. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design pertinent to this demonstration extension period, no later than one hundred eighty (180) calendar days after the approval of this extension. The draft Evaluation Design must be developed in accordance with Attachment B (Developing the Evaluation Design) of these STCs, and must include timeline for key evaluation activities including evaluation deliverables, as outlined in STCs 115 and 116. The state may choose to use the expertise of the independent party in the development of the draft Evaluation Design.

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

(a) Attachment B (Developing the Evaluation Design) of these STCs, and all applicable technical assistance on applying robust evaluation approaches, including how to establish causal inference and comparison groups in developing

a strong Evaluation Design.

(b) All applicable Evaluation Design guidance, including guidance about waiver of retroactive eligibility and 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, including those outlined in subparagraphs STC 111. The draft design will discuss:

i. The outcome measures to be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population;
ii. The data sources and sampling methodology for assessing these outcomes; and
iii. A detailed analysis plan that describes how the effects of the demonstration are isolated from other initiatives occurring in the state.

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

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

a. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
b. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;

c. Participation in the Healthy Behaviors programs and its effect on participant behavior or health status;
d. The impact of LIP funding on hospital charity care programs;
e. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals;
f. The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner;
g. The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services;
h. The impact of the waiver of retroactive eligibility on beneficiaries and providers. Hypotheses for the waiver of retroactive eligibility must relate to (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, enrollment when people are healthy, and health status (as a result of greater enrollment continuity).
i. The impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, and are homeless or at risk of homelessness due to their disability.
j. In addition, the state must investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs. Finally, the state must use results of hypothesis tests and cost analyses to assess demonstration effects on Medicaid program sustainability.

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.

114. **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.

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

a. The Interim Evaluation Reports will discuss evaluation progress and

present findings to date as per the approved Evaluation Design, and address the evaluation questions described in STC 113.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report(s) must include an evaluation of the authority as approved by CMS.

c. The state must provide draft Interim Evaluation Reports for the corresponding years described below. The state must submit a revised Interim Evaluation Report for each Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the corresponding draft report. The final version of each of the Interim Evaluation Reports must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

    i. A Draft Interim Evaluation Report for demonstration years 15-17 (July 1, 2020 – June 30, 2023) will be due no later than December 31, 2024.

    ii. A Draft Interim Evaluation Report for demonstration years 15-19 (July 1, 2020 – June 30, 2025) will be due no later than December 31, 2026.

    iii. A Draft Interim Evaluation Report for demonstration years 15-22 (July 1, 2020 – June 30, 2028) will be due no later than December 31, 2029.

d. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report, representing demonstration years 15-22 (July 1, 2020 – June 30, 2028) is due when the application for renewal is submitted. If the state is not requesting a demonstration extension, the last draft Interim Evaluation Report, as noted in c(iii) above, 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.

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

116. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment C (Preparing the Evaluation Reports) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period by December 31, 2031 (i.e., within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

    a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 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.

117. **Corrective Action Plan Related to Evaluation**. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report(s). A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with state targets (such as substantial and sustained trends indicating increased difficulty accessing services, increases in provider uncompensated care costs). 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.

118. **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 Reports, and/or the Summative Evaluation Report. Presentation may be conducted remotely.

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

120. **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.

XX. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

121. **External Quality Review (EQR).** The state is required to meet all requirements for external quality review (EQR) found in 42 CFR Part 438, subpart E. In addition to routine encounter data validation processes that take place at the MCO/PIHP and state level, the state must maintain its contract with its external quality review organization (EQRO) to

require the independent annual validation of encounter data for all MCOs and PIHPs.

122. **Consumer Health Plan Report Cards.** On an annual basis, the state must create and make readily available to beneficiaries, providers, and other interested stakeholders, a health plan report card, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), that is based on performance data on each managed care plan included in the annual EQR technical report. Each health plan report card must be posted on the state's website and present an easily understandable summary of quality, access, and timeliness regarding the performance of each participating plan. The report cards must also address the performance of subcontracted dental plans.

123. **Performance Improvement Projects (PIP).** In accordance with 42 CFR §438.330, the state must require each managed care plan, including each dental plan, to commit to improving care. In lieu of Performance Improvement Projects (PIPs) identified by CMS as described in § 438.330(a)(2), the state must require each managed care plan, including each dental plan to complete PIPs in the following focus areas, which have the significant potential for achieving the demonstration's goals of improving patient care, population health, and reducing per capita Medicaid expenditure. Specialty plans that do not have sufficient numbers of eligible recipients for the PIP topics identified in 126(a) or 126(b) may conduct alternative PIPs on topics more relevant to their enrolled population in place of the required focus areas, subject to approval by the state.

    a. A PIP combining a focus on improving primary C-section rates, pre-term delivery rates, and neonatal abstinence syndrome rates;

    b. A PIP focused on reducing potentially preventable events, including hospital admissions, readmissions, and emergency department visits;

    c. An administrative PIP focusing on the administration of the transportation benefit, specifically focusing on the rate of trips resulting in the enrollee arriving to their scheduled appointment on time; and

    d. A PIP focused on improving follow-up after hospitalizations for mental illness, emergency department visits for mental illness, and emergency department visits for alcohol and other drug abuse or dependence.

    e. Dental plans shall perform three PIPs as follows:

        i. A PIP focused on increasing the rate of enrollees accessing preventive dental services;

        ii. A PIP focused on reducing potentially preventable dental-related emergency department visits in collaboration with the Statewide Medicaid Managed Care (SMMC) plans.

        iii. An administrative PIP focused on coordination of transportation services with the SMMC plans.

    f. The state must conduct each PIP in accordance with 42 CFR §438.330 and 438.340. The state will meet its obligations under the regulations.

124. Measurement Activities. The state must ensure that each participating managed care plan is accountable for metrics on quality and access, including measures to track progress in identified quality improvement focus areas, measures to track quality broadly, and measures to track access. The state must set performance targets that equal or exceed the 75th percentile national Medicaid performance level. In addition to requirements set forth at 42 CFR § 438.330 through 438.334, the state must collect data and information on dental care utilization rates, the CMS Medicaid and CHIP adult and child core measures, and must align with other existing federal measure sets where possible to ensure ongoing monitoring of individual well-being and plan performance. The state will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

XXI. SCHEDULE OF STATE DELIVERABLES

Date	Deliverable	STC Reference
Within 150 calendar days of the demonstration approval	Monitoring Protocol	Section XVI, STC 74
60 days following the end of the quarter	Quarterly Monitoring Report	Section XVI, STC 75
90 days following the end of the DY	Annual Monitoring Report	Section XVI, STC 75
30 days following the end of the quarter	Quarterly Expenditure Reports	Section XVII, STC 84
Before August 31, Annually	LIP Draft RFMD	Section XIV, STC 64
Within 4 years of the end of each DY	LIP Cost Reconciliation Report	Section XIV, STC 64b
June 1, Annually	LIP Provider UC and IGT estimate report	Section XV, STC 70
October 1, Annually	LIP Provider, UC and IGT final report	Section XV, STC 70
Within 180 calendar days of the demonstration approval	Draft Evaluation Design	Section XIX, STC 111
No later than December 31, 2024	Draft Interim Evaluation Report 1 (DY15 – DY17)	Section XIX, STC 115
No later than December 31, 2026	Draft Interim Evaluation Report 2 (DY15 – DY19)	Section XIX, STC 115
No later than December 31, 2029 or with application for renewal	Draft Interim Evaluation Report 3 (DY15 – DY 22)	Section XIX, STC 115
Within 18 months of the end of the approval period	Draft Summative Evaluation Report	Section XIX, STC 116
March 31, 2021	Draft Budget Neutrality with LIP Data Rebasing Workbook	STC 102
March 31, 2027	Draft Budget Neutrality with LIP Data Rebasing Workbook	STC 102

ATTACHMENT A
HISTORICAL COMPREHENSIVE PROGRAM DESCRIPTION AND OBJECTIVES

The Florida Medicaid Reform demonstration was approved October 19, 2005. The state implemented the demonstration July 1, 2006, in Broward and Duval Counties, and then expanded to Baker, Clay, and Nassau Counties July 1, 2007. On December 15, 2011, CMS agreed to extend the demonstration through June 30, 2014.

The December 2011 renewal included several important improvements to the demonstration, such as; enhanced managed care requirements to ensure increased stability among managed care plans, minimize plan turnover, and provide for an improved transition and continuity of care when enrollees change plans and to ensure adequate choice of providers. The renewal also included a Medical Loss Ratio (MLR) requirement of 85 percent for Medicaid operations. Finally, the renewal included the continuation of the Low Income Pool (LIP) of $1 billion (TC) annually to assist safety net providers in providing health care services to Medicaid, underinsured and uninsured populations.

On June 14, 2013, CMS approved an amendment to the demonstration, which retains all of the improvements noted above, but allowed the state to extend an improved model of managed care to all counties in Florida subject to approval of an implementation plan and a determination of readiness based on the elements of the approved plan. The amendment also changed the name of the demonstration to the Florida Managed Medical Assistance (MMA) program. CMS authorized implementation to begin no earlier than January 1, 2014, with the Medicaid Reform demonstration continuing to operate in the five Medicaid Reform counties until the MMA program was implemented there.

Under the June 2013 amended demonstration, most Medicaid eligibles were required to enroll in a managed care plan (either a capitated managed care plan or a FFS Provider Service Network (PSN)) as a condition for receiving Medicaid. Enrollment was mandatory for Temporary Assistance for Needy Families (TANF)-related populations and the aged and disabled, with some exceptions. The demonstration continued to allow plans to offer customized benefit packages and reduced cost sharing, although each plan must cover all mandatory services, and all state plan services for children and pregnant women (including Early and Periodic Screening, Diagnostic and Treatment (EPSDT)). The demonstration provided incentives for healthy behaviors by offering Enhanced Benefits Accounts that were replaced by the plan's Healthy Behaviors program upon implementation of the MMA program as described in STC 54.
Beneficiaries in counties transitioning from Medicaid Reform to MMA continued to have access to their accrued credits under Enhanced Benefit Account Program (EBAP) for one year.

The June 2013 amended terms and conditions included improvements such as:

- A phased implementation to ensure readiness including a readiness assessment for each region and a requirement for CMS approval of the state's implementation plan which will include identified risks, mitigation strategies, fail safes, stakeholder engagement

and rapid cycle improvement strategies;

- Strengthened auto-enrollment criteria to ensure consideration of network capacity, access, continuity of care, and preservation of existing patient-provider relationships when enrolling all beneficiaries into the MMA program, including special populations;
- STCs tailored to special populations, should the state choose to include specialty plans in the final selection of managed care entities and PSNs;
- Strong consumer protections to ensure beneficiary assistance and continuity of care through the MMA transition. Additional STCs to ensure beneficiary choice, including a comprehensive outreach plan to educate and communicate with beneficiaries, providers, and stakeholders and annual Health Plan Report Cards for consumers, which will allow beneficiaries to be more informed on health plan performance and assist beneficiaries in making informed decisions related to plan selection;
- Enhanced Medical Care Advisory Committee (MCAC) requirements to ensure beneficiary and advocate group participation as well as inclusion of sub-population advisory committees;
- Performance Improvement Projects (PIP) to be performed by all health plans;
- Clarification and enhancements of the monitoring and evaluation of plans to ensure a rigorous and independent evaluation, and development of rapid cycle, transparent monitoring in order to ensure continuous progress towards quality improvement; and,
- A Comprehensive Quality Strategy (CQS) that will span the entire Florida Medicaid program.

The approved 2014 extension of the demonstration continued the improvements authorized in the June 2013 amendment and extended all portions of this demonstration for three years, except for the Low Income Pool (LIP). CMS authorized extension of the Low Income Pool for one year, from July 1, 2014 through June 30, 2015.

- During the one-year extension for the LIP, expenditures were authorized to provide stability for providers for a limited time during Florida's transition to statewide Medicaid managed care and a significantly reformed Medicaid payment system. Funding sources were limited only to existing state and local funding arrangements. The total amount of LIP funding could not exceed $2,167,718,341 (TC).
- Florida was required to analyze and develop a plan to reform Medicaid provider payments and funding mechanisms, with the goal of developing sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that ensure quality health care services to Florida's Medicaid beneficiaries throughout the state without the need for LIP funding. Expenditures authorized under the LIP were limited to UC costs of providers, the independent report discussed below, and other categories of expenditure as specified in the STCs.
- UC costs were required to be verified through provider cost reports. CMS indicated that it would disallow unallowable payments to providers in prior DYs as identified on provider cost reports.
- During the one-year LIP extension, the state was required to use a portion of the LIP

funds to commission a report from an independent entity on Medicaid provider payment in the state that reviews the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the State's funding mechanisms for these payments.

The report was required to recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year (SFY) 2015-2016, to move toward Medicaid FFS and managed care payments that ensure access for Medicaid beneficiaries to providers without payments through the LIP. The final report was due no later than March 1, 2015.

On June 30, 2015, pursuant to a letter to the state, CMS granted 60 days of interim expenditure authority under section 1115(a)(2) of the Social Security Act, to make federal funding available to Florida for interim LIP payments to providers from July 1, 2015 through August 31, 2015 of DY (DY) 10, subject to a total spending limit of $166.66 million for the combined federal and state shares of expenditures (with such amount being counted in determining the amount of any further extension of the Low Income Pool).

On October 15, 2015, CMS approved three amendments to the demonstration.

- The first amendment added two populations as voluntary enrollees in managed care: Medicaid-eligible children receiving Prescribed Pediatric Extended Care (PPEC) services, and recipients residing in group home facilities licensed under section(s)
  393.067 Florida Statutes (FS).
- The second amendment authorized changes to managed care enrollment to auto-assign individuals into managed care during a plan choice period immediately after eligibility determination. The amendment also changes the auto-assignment criteria. Individuals will receive both their managed care plan assignment and information about choice of plans in their area. Individuals may actively select a plan during a 120-day change/disenrollment period post-enrollment.
- The third amendment authorized expenditures under the LIP through June 30, 2017. The total amount of LIP funding in DY 10 (July 1, 2015 – June 30, 2016) will not exceed $1 billion (TC). The total amount of LIP funding in DY 11 (July 1, 2016 – June 30, 2017) will not exceed $607,825,452 million (TC). The changes represent a transition to a LIP that reflects the cost to providers of UC for uninsured individuals in the state, and that no longer pays for care that may be or has been provided through available coverage options. The changes set Florida on a path to administering a LIP in 2016-2017 (DY 11) that distributes funds based on the burden placed on providers by services for low- income, uninsured individuals for whom no other coverage options are, or could be, made available.

On October 12, 2016, CMS approved three amendments, which modified the demonstration to: (a) allow Florida flexibility to contract with one to three vendors under the hemophilia program; (b) Include payments for nursing facility (NF) services in MMA capitation rates for recipients under the age of 18 years; and (c) allow flexibility for specialty plans to conduct Performance Improvement Projects (PIP) on topics that have more specific impacts to their

enrollees, with Florida approval.[11]

Under the demonstration, Florida seeks to continue building on the following objectives:

- Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The demonstration seeks to improve care for Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate of customer satisfaction. The state will provide oversight focused on improving access and increasing quality of care.
- Improving program performance, particularly improved scores on nationally recognized quality measures (such as HEDIS scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving access to coordinated care by enrolling all Medicaid enrollees in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care).
- Increasing access to, stabilizing, and strengthening providers that serve uninsured, low- income populations in the state by targeting LIP funding to reimburse UC costs for services provided to low-income uninsured patients at hospitals that are furnished through charity care programs that adhere to the (HFMA) principles.[12]

On August 1, 2017, CMS reauthorized the MMA Medicaid managed care program for the 5-year extension without significant changes to the program. The revised STCs for the extension reflected the state's obligation to follow the Medicaid managed care regulations at 42 CFR 438, and CMS and Florida agreed to several revisions to the STCs that previously governed the state's LIP. The revised LIP calculations reflected in the extension STCs led to a new TC annual LIP limit of $1.5 billion per DY—which was an annual increase of approximately $900 million compared to the previous DY's LIP amount.

There were two changes which led to the increased annual LIP limit:

- CMS' analysis of more recent Florida hospital cost report data led to an increase of $450 million in annual LIP; and
- CMS did not apply the previous LIP reduction for Medicaid expansion which led to an additional increase of $450 million annually—this was the only significant change to CMS' previous methodology for determining UC amounts.

Consistent with CMS' goal of lessening or removing unduly burdensome and/or duplicative state reporting requirements, where appropriate, the extension STCs also omitted the requirement for quarterly reporting on all MMA demonstration activities (although

[11] For the "Comprehensive Program Description and Objectives," see Attachment B.
[12] http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589

expenditures continue to be reported quarterly, and annual reporting is required, consistent with the statutory requirement of periodic state reports). In addition, the requirement for the state to submit the LIP Reimbursement and Funding Methodology (RFMD) document for the first extension DY—with subsequent annual attestations that the methodology remains in effect. CMS also eliminated the requirement for a Comprehensive Quality Strategy in the extension; however, the state still is required to develop and maintain a managed care quality strategy as required under 42 CFR §438.340.

Historical PMPMs and Trend Rates

Demonstration Year	SSI MEG	Trend Rate	TANF MEG	Trend Rate
DY 1 (SFY 2006/7)	$948.79	8.0%	$199.48	8.0%
DY 2 (SFY 2007/8)	$1,024.69	8.0%	$215.44	8.0%
DY 3 (SFY 2008/9)	$1,106.67	8.0%	$232.68	8.0%
DY 4 (SFY 2009/10)	$1,195.20	8.0%	$251.29	8.0%
DY 5 (SFY 2010/11)	$1,290.82	8.0%	$271.39	8.0%
DY 6 (SFY 2011/12)	$1,356.65	5.1%	$285.77	5.3%
DY 7 (SFY 2012/13)	$1,425.84	5.1%	$300.92	5.3%
DY 8 (SFY 2013/14)	$1,498.56	5.1%	$316.87	5.3%
DY 9 (SFY 2014/15)	$786.70	4.1%	$324.13	4.6%
DY 10 (SFY 2015/16)	$830.22	4.1%	$339.04	4.6%
DY 11 (SFY 2016/17)	$876.81	4.1%	$354.64	4.6%

ATTACHMENT B
DEVELOPING THE EVALUATION DESIGN

Introduction

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

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

Expectations for Evaluation Designs

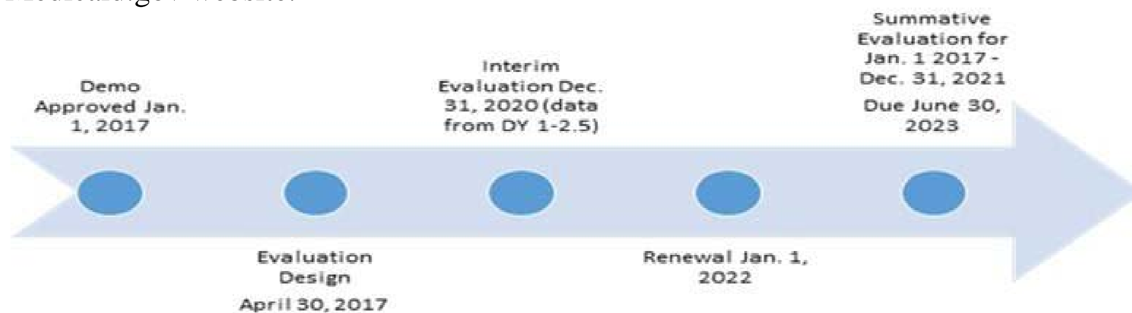
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses,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

The format for the Evaluation Design is as follows:

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

Submission Timelines

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



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

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

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

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

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

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

5. Describe the population groups impacted by the demonstration.

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

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

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

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

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

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

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

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

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
   a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
   b. Qualitative analysis methods may be used, and must be described in detail.
   c. Benchmarking and comparisons to national and state standards should be used, where appropriate.
   d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
   e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
   f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

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

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

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

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

time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

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

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

Research Question	Outcome measures used to address the research	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 FFS and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

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

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

1. When the state demonstration is:
   a. Long-standing, non-complex, unchanged, or
   b. Has previously been rigorously evaluated and found to be successful, or
   c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

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

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

F. Attachments

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

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

Introduction

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

Expectations for Evaluation Reports

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

Intent of this Attachment

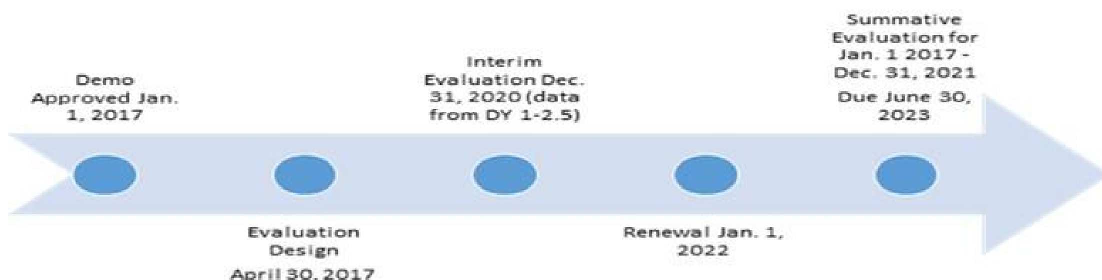
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified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

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

A. Executive Summary;
B. General Background Information;

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

Submission Timelines
There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of a deliverables timeline for a 5-year demonstration). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Evaluation Design and reports to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

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

A. **Executive Summary** – A summary of the demonstration, the principal

results, interpretations, and recommendations of the evaluation.

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

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

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

3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

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

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

2) Identify the state's hypotheses about the outcomes of the demonstration:

   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. **Methodology** – In this section, the state is to provide an overview of the research

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

The interim reports 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 interim evaluations.

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

1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?

2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.

3) *Evaluation Period*—Describe the time periods for which data will be collected.

4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?

5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.

6) *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

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

E. Methodological Limitations

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

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the

demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

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

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

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

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

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

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

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

J. Attachment

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