CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY LIST

NUMBER: 11-W-00185/4

TITLE: Healthier Mississippi Medicaid Section 1115 Demonstration

AWARDEE: Mississippi Division of Medicaid

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Mississippi for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, from the date of the approval letter through September 30, 2029, be regarded as expenditures under the state's title XIX plan.

The following expenditure authority shall enable Mississippi to implement its section 1115 Healthier Mississippi demonstration.

1. **Demonstration Population 1.** Expenditures for health care services provided to individuals with income at or below 135 percent of the federal poverty level who are aged, blind, or disabled, are not eligible for Medicare, and are not eligible under the Medicaid state plan.

Title XIX Requirements Not Applicable

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

   To enable the state to provide a different benefit package to individuals covered under the demonstration.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00185/4**

TITLE: **Healthier Mississippi Demonstration**

AWARDEE: **Mississippi Division of Medicaid**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Healthier Mississippi section 1115(a) Medicaid demonstration extension (hereinafter "demonstration"). The parties to this agreement are the Mississippi Division of Medicaid (state) and the Centers for Medicare & Medicaid Services (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. The STCs for the demonstration extension are effective as of October 1, 2024, through September 30, 2029, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid 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 one-hundred and twenty (120) days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a) 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 shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

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

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

8. **Extension of the Demonstration**. States that intend to request an extension of the demonstration must submit an application to CMS at least twelve (12) months in advance from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 9.

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

    a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. At least six (6) months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the thirty (30) day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the received comments into the transition and phase-out plan submitted to CMS.

    b) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices including information on the beneficiary's appeal rights, the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

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

    d) Transition and Phase-out Procedures: The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1), or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures

set forth in 42 CFR 435.1200(e) or for CHIP found at 42 CFR 457.340(e), including information about a right to review consistent with 42 CFR 457.1180. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

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

f) Enrollment Limitation during Demonstration Phase-Out: If the state elects to suspend, terminate, or not extend this demonstration, during the last six (6) months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

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

10. **Withdrawal of Waiver/Expenditure Authority.** CMS reserves the right to amend or withdraw waiver 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. CMS will promptly notify the state in writing of the determination and the reasons for the amendment or 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 or amended, 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 participants.

11. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; 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 section 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, managed care organizations (MCOs), and any contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies of the demonstration.

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

IV. ELIGIBILITY, BENEFITS AND COST SHARING

16. Demonstration Eligibility.

a) The group described in STC 16(b), which is made eligible for the demonstration by virtue of the expenditure authority expressly granted in this demonstration, is subject to all applicable Medicaid laws or regulations in accordance with the state plan, except as specified as not applicable in the expenditure authority for this demonstration.

b) Eligibility for the Healthier Mississippi demonstration is limited to aged, blind, or disabled individuals who are not eligible for Medicare and do not otherwise qualify

for Medicaid, who are not inpatients in a long term care institution, and whose:

i. Income is at or below 135 percent of the FPL for an individual or couple, calculated using a methodology based on the Supplemental Security Income (SSI) program, as well as income exclusions approved under the state plan under the authority of section 1902(r)(2) of the Social Security Act; and,

ii. Resources are below $4,000 for an individual and $6,000 for a couple.

17. **Enrollment Cap.** The Healthier Mississippi enrollment cap is 6,000. When enrollment reaches 6,000, further enrollment is suspended and individuals making an application are placed on a waiting list. Individuals are moved off the waiting list and enrolled in the demonstration as openings become available.

18. **Benefit Package.** Children (ages 0 through 20) enrolled in the demonstration receive all Medicaid state plan benefits, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Adults (ages 21 and older) enrolled in the demonstration receive most services covered under the Medicaid state plan with the same service limits per the Medicaid state plan. Maternity and newborn care are available to individuals who need them by enrolling in Medicaid on a different basis.

Services Not Covered for Adults
Swing bed in a skilled nursing facility
Long-term care services (nursing facility, home and community-based waiver, and ICF/IID services)
Maternity and Newborn Care

Admission to Nursing Facilities: Expenditures incurred for any services received while a Healthier Mississippi enrollee is an inpatient in a long-term care institutional setting will not be claimed under the demonstration. Any individual enrolled in Healthier Mississippi who is admitted to a nursing facility or other long term care setting, either temporarily (for less than 30 days) or for a longer admission, will be assessed for eligibility under a Medicaid State Plan covered category. Such individuals will be disenrolled from the demonstration upon admission to an institution and assessed for re-enrollment into the demonstration upon discharge from the institutional setting.

19. **Cost Sharing.** There are no cost-sharing requirements for children enrolled in the demonstration. Adult recipients are subject to cost sharing requirements that would be applicable if they were provided coverage under the state plan. A family's total annual out-of-pocket cost sharing cannot exceed five percent of the family's gross income. There is no premium charged for any recipient under the demonstration.

V. DELIVERY SYSTEMS

20. Service Delivery. Demonstration services are delivered through the state's fee-for-service provider network.

VI. MONITORING AND REPORTING REQUIREMENTS

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

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

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

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

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

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

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

22. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline. The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.

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

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

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

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

24. Annual Monitoring Reports. The state must submit one Annual Monitoring Report each demonstration year (DY). The Annual Report is due no later than ninety (90) calendar days following the end of the DY. The state must also submit a revised Monitoring Report within sixty (60) calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and must be provided in a structured manner that supports federal tracking and analysis.

a) **Operational Updates.** Per 42 CFR 431.428, the Annual Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends;

legislative updates; and descriptions of any public forums held. In addition, Annual Monitoring Reports should describe key achievements, as well as conditions and efforts to which these successes can be attributed. The Annual Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b) **Performance Metrics**. The performance metrics will provide data to demonstrate how the state is progressing toward meeting the demonstration's goals. Per 42 CFR 431.428, the Annual Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as the impact of the demonstration on beneficiaries' utilization of services, outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. .

The state and CMS will work collaboratively to finalize the list of metrics to be reported in the Annual Monitoring Reports. The required monitoring and performance metrics must be included in the Annual Monitoring Reports and will follow the CMS framework provided by CMS to support federal tracking and analysis. The reporting of the monitoring metrics must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and by demonstration component, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

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

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

25. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid,

CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing preventive services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

26. Close out Report. Within one-hundred and twenty (120) calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

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

b) In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 56 and 57, respectively.

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

d) The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e) A revised Close-Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS's comments.

f) A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 21.

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

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

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

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

28. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state 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 Medicaid website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

VII. GENERAL FINANCIAL REQUIREMENTS

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

30. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 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.

31. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect

approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

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

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

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

32. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a) If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b) To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c) The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d) Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e) The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

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

a) Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b) Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

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

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

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

34. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than sixty (60) days after demonstration approval. This deliverable is subject to the deferral as described in STC 21. This report must include:

a) A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b) Number of providers in each locality of the taxing entities for each locality tax;

c) Whether or not all providers in the locality will be paying the assessment for each locality tax;

d) The assessment rate that the providers will be paying for each locality tax;

e) Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f) Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g) The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h) Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

35. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section VIII:

a) Administrative costs, including those associated with the administration of the demonstration;

b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

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

36. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

37. Medicaid Expenditure Groups (MEGs). MEGs) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring

and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 1: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Demonstration Population 1	Hypo	X		X	Aged, blind, or disabled individuals enrolled in the demonstration at or below 135 percent of the FPL who are not eligible for Medicare and do not otherwise qualify for Medicaid

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

38. 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-00185/4). 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.

a) **Cost Settlements**. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

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

demonstration year for determination of the state's compliance with the budget neutrality limits.

c) **Pharmacy Rebates.** Because pharmacy rebates are 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 the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. 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. Unless indicated otherwise on the MEG Charts and in the STCs in section VIII, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e) **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in STC 24 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 per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

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

Table 2: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Demonstration Population 1	Aged, blind, or disabled individuals enrolled in the demonstration at or below 135 percent of the FPL who are not eligible for Medicare and do not otherwise qualify for Medicaid.	None	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	09/10/04	09/30/29

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

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

Table 3: Demonstration Years		
Demonstration Year 21	October 1, 2024 to September 30, 2025	12 months
Demonstration Year 22	October 1, 2025 to September 30, 2026	12 months
Demonstration Year 23	October 1, 2026 to September 30, 2027	12 months
Demonstration Year 24	October 1, 2027 to September 30, 2028	12 months
Demonstration Year 25	October 1, 2028 to September 30, 2029	12 months

40. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the

demonstration's actual expenditures to the budget neutrality expenditure limits described in section VIII. CMS will provide technical assistance, upon request.[1]

41. 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.

42. 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 guidance, 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

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

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.

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

a) **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 42.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within one-hundred and twenty (120) days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b) **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c) **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

VIII. MONITORING BUDGET NEUTRALITY

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

45. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart and Table 2, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

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

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

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

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

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

Table 4: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 21	DY 22	DY 23	DY 24	DY 25
Demonstration Population 1	PC	Both	4.84%	$1,923.69	$2,016.72	$2,114.25	$2,216.50	$2,323.69

50. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share 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 Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

51. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 5: Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 21	Cumulative budget neutrality limit plus:	2.0 percent
DY 21 through DY 22	Cumulative budget neutrality limit plus:	1.5 percent
DY 21 through DY 23	Cumulative budget neutrality limit plus:	1.0 percent
DY 21 through DY 24	Cumulative budget neutrality limit plus:	0.5 percent

DY 21 through DY 25	Cumulative budget neutrality limit plus:	0.0 percent

IX. EVALUATION OF THE DEMONSTRATION

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

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

53. 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.

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

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 56 and 57.

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

In the event of demonstration extensions, for components that are continuing from the prior demonstration approval period, the state's Evaluation Design must reframe and refocus as needed the evaluation hypotheses and research questions to appropriately factor in where it can reasonably expect continued improvements, and where the demonstration's role might be more to help stabilize outcomes. Likewise, for continuing policies, the state must revisit its analytic approaches compared to those used in the prior approval period evaluation activities, to ensure that the evaluation of those policies taps into the longer implementation time span.

55. Evaluation Design Approval and Updates. The state must submit to CMS a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments, if any. Upon CMS approval of the final Evaluation Design, the document will be included as Attachment C to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Annual Monitoring Reports as required by STC 24, including any required rapid cycle assessments specified in these STCs. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

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

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate

and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of preventive services. Proposed measures should be selected from nationally-recognized sources and national measure sets, where possible. Measures sets could include those from the Dental Quality Alliance;[2] CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by National Quality Forum (NQF).

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the demonstration, and beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography), and by demonstration component, to the extent feasible. Such stratified analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes and help inform how the demonstration's various policies might support reducing such disparities.

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

a) The Interim Evaluation Report, in alignment with the CMS-approved Evaluation Design, will discuss evaluation progress and present findings to date.

b) For demonstration authority or any components within the demonstration that

[2] https://www.ada.org/resources/research/dental-quality-alliance/dqa-dental-quality-measures

expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

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

d) Unless otherwise agreed upon in writing by CMS, the state must submit a revised Interim Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft Interim Evaluation Report, if any.

e) Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within thirty (30) calendar days.

f) The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs. ’“”

58. Summative Evaluation Report. ’“”The state must submit to CMS a draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs.

a) The Summative Evaluation Report, in alignment with the Evaluation Design, will evaluate the entirety of the demonstration period.

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

c) Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within thirty(30) calendar days.

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

59. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval.

These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A state corrective action plan could include a temporary suspension of implementation of demonstration initiatives, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

60. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report. Presentation may be conducted remotely.

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

62. **Additional Publications and Presentations.** For a period of twelves (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 thirty (30) calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Quarterly Expenditures Reports	Within 30 days following the end of each quarter using Form CMS-64	STC 38
Annual Monitoring Report	Annual Deliverable – Due 90 calendar days following the end of each demonstration year	STC 24
Draft Evaluation Design	Within 180 calendar days after demonstration approval	STC 54
Revised Evaluation Design	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 55
Draft Interim Evaluation Report	Within one year prior to the end of the demonstration or with submission of a demonstration extension request.	STC 57
Revised Interim Evaluation Report	Within 60 calendar days following receipt of CMS comments on the Draft Interim Evaluation Report.	STC 57
Summative Evaluation Report	Within 18 months following the end of the demonstration approval period identified in these STCs.	STC 58
Revised Summative Evaluation Report	Within 60 calendar days after receipt of CMS comments on the Draft Summative Evaluation Report.	STC 58

ATTACHMENT A
Developing the Evaluation Design

Introduction

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

Expectations for Evaluation Designs

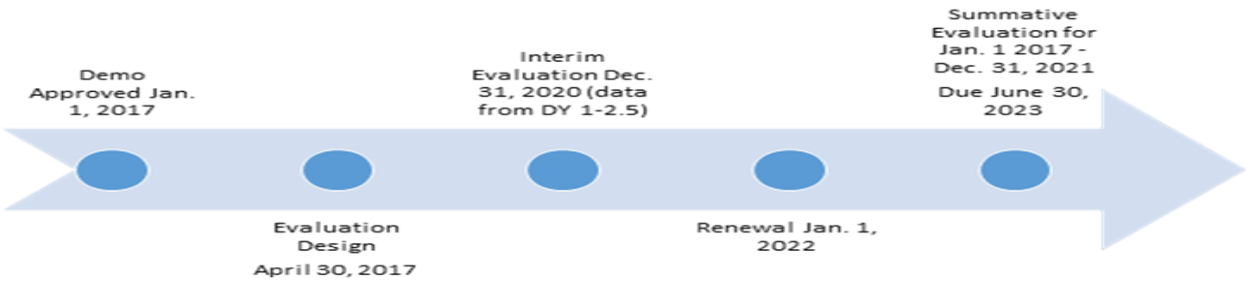
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, 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; and
E. Attachments.

Submission Timelines

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



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

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

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

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

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

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

5) Describe the population groups impacted by the demonstration.

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

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

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

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

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

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

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

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

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

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

a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
b. Qualitative analysis methods may be used, and must be described in detail.
a. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
b. 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).
c. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

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

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

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

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

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

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

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

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

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 budget neutrality; and
d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

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

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

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

ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration 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 improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

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

Intent of this Attachment

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

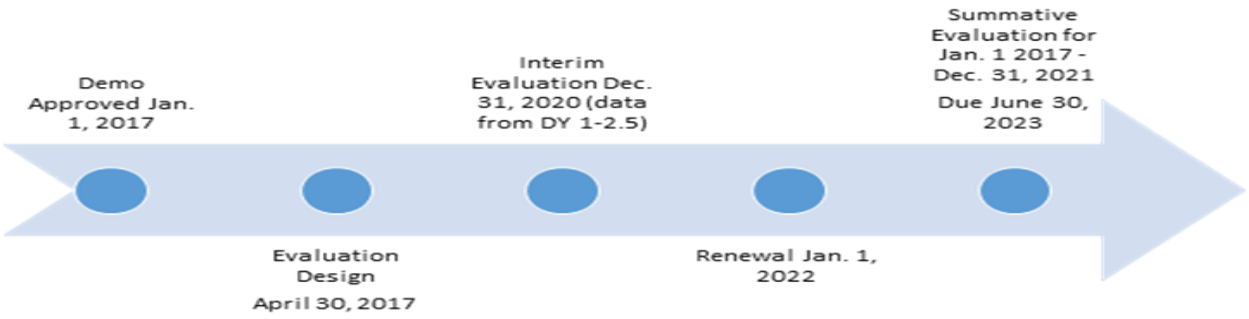
The format for the Interim and Summative Evaluation reports are as follows:

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 this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

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

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

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

i. 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.
ii. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
iii. 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;
iv. 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.
v. Describe the population groups impacted by the demonstration.

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

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

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

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

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

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

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

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

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

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

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

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

E. Methodological Limitations

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

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

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

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

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

a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

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

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

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

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

J. Attachment

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

ATTACHMENT C:
Evaluation Design

Healthier Mississippi Project

Section 1115 Demonstration

Project Number 11-W-00185/4

Evaluation Design

December 10, 2025

550 High Street, Suite 1000

Jackson, Mississippi 39201

Website: medicaid.ms.gov

The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

Table of Contents

Healthier Mississippi Project
Section 1115 Demonstration
Project Number 11-W-00185/4

Evaluation Design

December 10, 2025

I. Historical Background of the Demonstration

Legislation passed during the Mississippi 2004 Legislative Session discontinued the optional Poverty Level Aged & Disabled (PLAD) category of eligibility, effective June 30, 2004. Due to concerns that this population was at risk for costly adverse events, such as institutional placement if medical regimens were not maintained, the state applied and received approval for a section 1115 demonstration to continue coverage for this population. The Healthier Mississippi Waiver (HMW) was originally approved by the Centers for Medicare & Medicaid Services (CMS) for a five (5) year period beginning on October 1, 2004 through September 30, 2009. The HMW demonstration continued to operate under a series of temporary approvals for an additional five (5) years from October 1, 2009 through July 23, 2015. The Division of Medicaid received an approval for a five (5) year extension for the period of July 24, 2015 through September 30, 2018. Beginning with the July 24, 2015 through September 30, 2018 extension, the HMW enrollment limit increased from 5,500 to 6,000 and provided coverage for podiatry, eyeglasses, dental, and chiropractic services which were excluded from previous demonstration years. Currently, the demonstration's special terms and conditions (STCs) are approved from October 1, 2024 through September 30, 2029. There were no changes in the eligibility requirements or covered services from the previous demonstration.

Eligibility for the Healthier Mississippi demonstration is limited to aged, blind, or disabled individuals who are not eligible for Medicare, do not qualify for Medicaid, and are not in a long-term care institution, and whose:

- Income is at or below 135% of the Federal Poverty Level (FPL) for an individual or a couple calculated using a methodology based on the Supplemental Security Income (SSI) program, as well as income exclusions approved under the State Plan under the authority of Section 1902(r)(2) of the Social Security Act, and
- Resources are below $4,000 for an individual and $6,000 for a couple.

Children (ages 0 through 20) enrolled in the demonstration receive all Medicaid state plan benefits, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Adults (ages 21 and older) enrolled in the demonstration receive all services covered under the Medicaid state plan with the same service limits with the exception of the following services:

- Long-term care services (nursing facility, home and community-based waiver, and Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) services),

- Swing bed services in a skilled nursing facility, and
- Maternity and newborn care services.

HMW beneficiaries who require long-term care, swing bed services in a skilled nursing facility, or maternity and newborn care services would qualify for Medicaid and, therefore, would be deemed ineligible for the waiver. HMW enrollees are assigned to a specific category of eligibility (045) to ensure the population is easily identifiable and to ensure the number of enrollees does not exceed the cap of 6,000.

II. Demonstration Goals, Research Questions and Evaluation Hypotheses

On September 24, 2024, the demonstration was extended for five years through September 30, 2029, with no programmatic changes. During this extension period, Mississippi expects to achieve the following goals and objectives with quantifiable target percentages:

Goal: To prevent hospitalizations and increase access to ambulatory and preventive healthcare by providing insurance coverage, for individuals who are aged, blind or disabled, not eligible for Medicare and do not qualify for Medicaid.

Objective 1: Decrease hospitalizations by two percent for the duration of the demonstration.

Objective 2: Increase the utilization of ambulatory/preventive health visits by two percent each demonstration year.

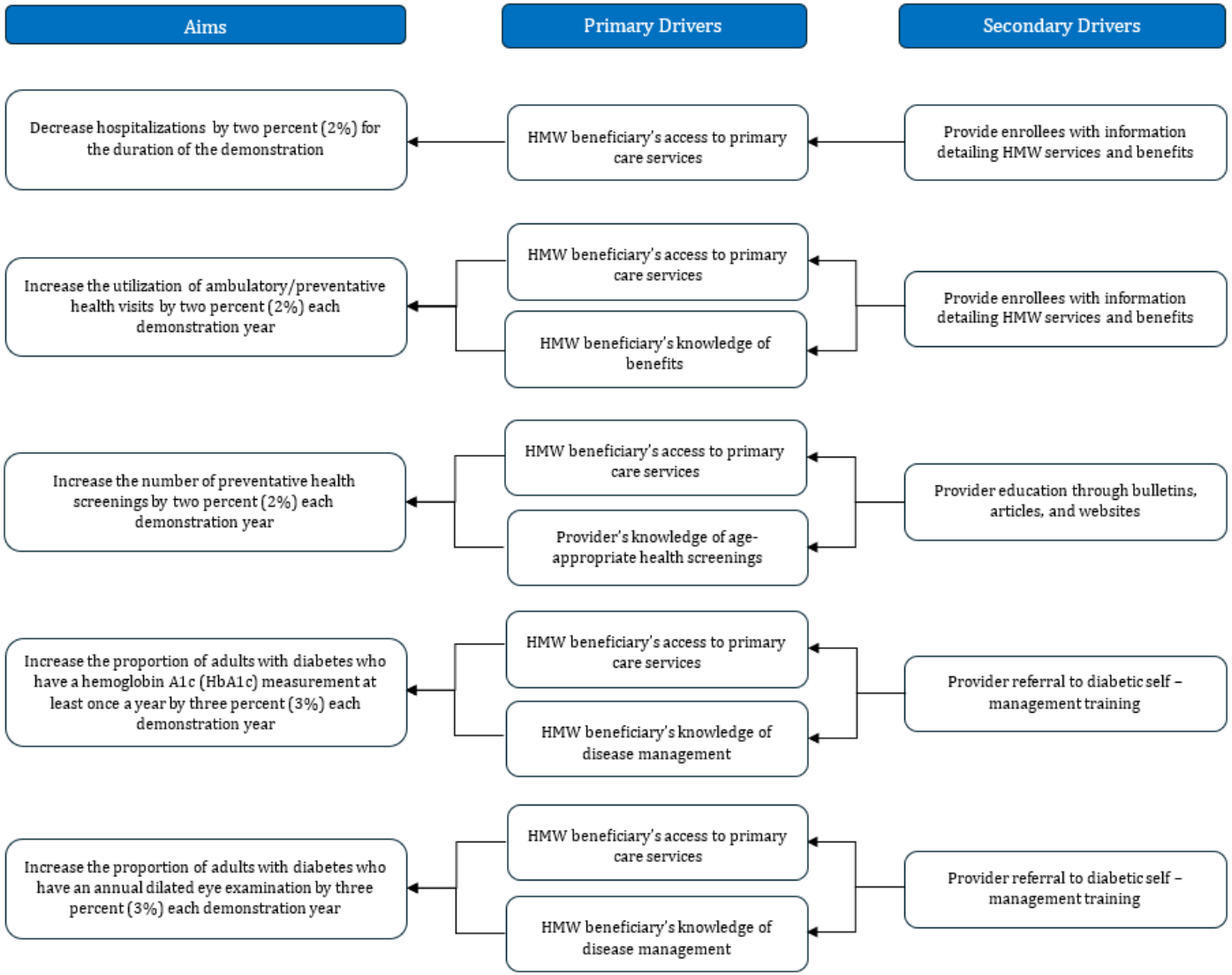
Objective 3: Increase the number of preventive health screenings by two percent each demonstration year.

Objective 4: Increase the proportion of adults with diabetes who have a hemoglobin A1c (HbA1c) measurement at least once a year by three percent each demonstration year.

Objective 5: Increase the proportion of adults with diabetes who have an annual dilated eye examination by three percent each demonstration year.

The rationale for achieving these five objectives is illustrated in Figure 1.

Figure 1: Healthier Mississippi Waiver Driver Diagram



The evaluation questions and hypotheses are designed to measure the program's performance in achieving its stated goals and objectives, ensuring alignment with the broader objectives of Titles XIX and XXI, which include:

- Providing financial support to medical assistance to low-income individuals who are aged, blind, or disabled and are not eligible for Medicaid or Medicare; and
- Providing access to preventive and necessary medical services for the low-income population.

Medicaid intends to measure the performance of the demonstration goals through the following quantitative evaluation questions:

Evaluation Question 1: How does the hospitalization rate among HMW beneficiaries change over time? Specifically, do hospitalizations decline as the duration of HMW enrollment increases? Additionally, do beneficiaries who utilize ambulatory and preventive services experience fewer hospitalizations compared to those who do not?

- **Hypothesis 1**: Beneficiaries who receive ambulatory and preventive care will have lower hospitalization rates than those who do not utilize these services. As HMW provides access to these services, hospitalizations among HMW beneficiaries are expected to decrease over time.

Evaluation Question 2: How does the rate of ambulatory or preventive health visits change over time? Specifically, does utilization of these services increase as the duration of HMW enrollment increases? Additionally, does the utilization of ambulatory and preventive health visits vary across different age groups of beneficiaries?

- **Hypothesis 2**: As HMW provides access to ambulatory and preventive healthcare services, their utilization among HMW beneficiaries is expected to increase over time. Additionally, utilization rates may differ across age groups.

Evaluation Question 3: Does the number of HMW beneficiaries receiving age-appropriate preventive screenings (e.g., mammograms, cervical cancer screenings, and colorectal cancer screenings) increase over time? Does the proportion of HMW beneficiaries receiving preventive screenings increase as beneficiaries age? Does this proportion increase as the duration of HMW enrollment increases?

- **Hypothesis 3**: As HMW provides access to preventive screenings, the number of HMW beneficiaries receiving recommended preventive screenings will increase over time. Additionally, older HMW beneficiaries are more likely to receive preventive screenings compared to younger beneficiaries. Furthermore, beneficiaries are more likely to receive preventive screening as the duration of enrollment increase.

Evaluation Question 4: Does the proportion of HMW beneficiaries diagnosed with diabetes who receive an annual HbA1c test increase over time? Specifically, does this proportion increase as the duration of HMW enrollment increases? Additionally, does the utilization of annual HbA1c testing vary by gender and race?

- **Hypothesis 4**: As HMW provides access to HbA1c test, HMW beneficiaries with diabetes receiving an annual HbA1c test are expected to increase over time. Additionally, beneficiaries with diabetes are more likely to receive annual HbA1c test as the duration of enrollment increase. Furthermore, the utilization of annual HbA1c testing may differ across gender and race groups.

Evaluation Question 5: Does the proportion of HMW beneficiaries diagnosed with diabetes who receive an annual dilated eye examination increase over time? Specifically, does this proportion increase as the duration of HMW enrollment increases? Additionally, does the utilization of annual dilated eye examinations vary by gender and race?

- **Hypothesis 5**: As HMW provides access to HbA1c test, HMW beneficiaries with diabetes receiving an annual dilated eye examination will increase over time. Additionally, beneficiaries with diabetes are more likely to receive an annual dilated eye examination as the duration of enrollment increase. Furthermore, the utilization of annual dilated eye examinations may differ across gender and race groups.

If the goals of the HMW demonstration are achieved, one anticipated beneficiary-level outcome is a potential reduction in service expenditures driven by decreases in high-cost hospital utilization and increases in comparatively lower-cost preventive and ambulatory services. To assess this potential impact, an additional quantitative evaluation question will be examined:

Evaluation Question 6: Do average service expenditures per beneficiary per month decrease over demonstration years?

- **Hypothesis 6**: With reduced more expensive hospitalization and increased relatively cheaper preventive healthcare, the service expenditure of beneficiaries will reduce.

To gain further insights into the challenges affecting program performance, an additional quantitative evaluation question related to beneficiary satisfaction will be included:

Evaluation Question 7: Are HMW beneficiaries satisfied with the demonstration services?

- **Hypothesis 7**: HMW beneficiaries are more likely to report being satisfied than not with the benefits under the demonstration.

To improve the HMW program and ensure it meets its intended goals and objectives, four qualitative evaluation questions will also be included:

Evaluation Question 8: What factors prevent some HMW beneficiaries from receiving age-appropriate preventive screenings?

Evaluation Question 9: What factors prevent some HMW beneficiaries with diabetes from receiving an annual HbA1c test or an annual dilated eye examination?

Evaluation Question 10: Among HMW beneficiaries who reported dissatisfaction with the program, did they experience any difficulties accessing a doctor or other health care provider through the HMW program? If so, what were the primary issues?

Evaluation Question 11: What improvement do HMW beneficiaries think would make the program more helpful for them?

These evaluation questions and hypotheses align with the program's goal of preventing hospitalizations and increasing access to ambulatory and preventive healthcare. The evaluation results will assess whether the program meets its target objectives, including reducing hospitalizations, increasing preventive care utilization, and improving chronic disease management.

By analyzing healthcare utilization trends, reductions in avoidable hospitalizations, and beneficiary satisfaction, this evaluation will provide data-driven insights to inform policymakers, helping the demonstration meets its intended objectives while contributing to a more effective and sustainable healthcare system.

III. Methodology

Evaluation Design

This evaluation will use a multi-method analytic framework consisting of descriptive trend analysis, longitudinal analysis, subgroup analysis, and qualitative survey evaluation. This mixed-methods approach will allow for a rigorous assessment of changes in healthcare utilization, and beneficiary experiences during the demonstration period. Analyses will rely on HMW administrative enrollment and claims data and structured survey data, and all findings will be benchmarked to the demonstration's measurable goals.

Descriptive Trend Analysis

Descriptive trend analyses will calculate annual healthcare utilization rates across demonstration years and assess how these rates change over time. The interim evaluation will include Demonstration Years (DY)20-DY23, and the summative evaluation will include DY20-DY25.[1] Because no pre-demonstration utilization data are available, DY20 (the final year of the previous demonstration period) will serve as the internal baseline for comparison.

To assess whether utilization changes over time are statistically significant, two trend-testing approaches will be used:

- *Cochran–Armitage test*: this test will be applied to annual utilization rates to assess whether there is a statistically significant increasing or decreasing trend across demonstration years. It is well suited for binary outcomes measured over ordered categories, such as sequential years. Statistical significance will be evaluated using the test's Z- statistic and associated p-value. A p-value below 0.05 indicates a significant trend over time.

[1] DY20 covers period from October 1, 2023, through September 30, 2024; DY23 covers the period from October 1, 2026, through September 30, 2027; and DY25 covers period from October 1, 2028, through September 30, 2029.

- *Multivariable Logistic regression for trend*: trend analysis will also be conducted at the individual level using multivariable logistic regression, which allows adjustment for demographic characteristics such as age, gender, race, and county of residence. The model is specified as:

$$Logit\ (P(Y_i = 1)) = \text{Ln}\ (\frac{P(Y_i=1)}{1-P(Y_i=1)}) = \beta_0 + \beta_1 Year_i + X_i C,$$

where Y_i is an indicator of whether beneficiary i used the service of interest during the demonstration year (1=used; 0=not used). $Year_i$ is a continuous measure of demonstration year with DY20 coded as the baseline year, and X_i represents beneficiary demographic characteristics. β_1 is the coefficient associated with the demonstration year, which captures the direction and statistical significance of the observed trend in service utilization. A p-value of Wald test for β_1 below 0.05 indicates a significant trend over time. Because this model controls for potential confounding factors, it provides a more flexible and robust assessment of trends than the Cochran–Armitage test alone.

Longitudinal Analysis

In an ideal scenario, longitudinal analysis would compare healthcare utilization before and after enrollment in the HMW program to estimate the program's impact. However, pre-enrollment utilization data are not available. Therefore, this evaluation will conduct a longitudinal analysis among beneficiaries enrolled for two consecutive demonstration years. This approach enables within-person comparisons of healthcare utilization between the measurement demonstration year (Year 2) and the immediately preceding enrollment year (the first year of enrollment, Year 1), providing evidence on whether extended exposure to the HMW program is associated with changes in service use.

For hospitalization and ambulatory or preventive visits, individual-level change rates will be calculated as the difference in visit counts between Year 2 and Year 1 divided by the number of visits in Year 1. Average change rates will be reported for each demonstration-year cohort. For preventive screenings—including HbA1c testing and diabetic eye examinations—changes in utilization will be assessed by comparing Year-2 and Year-1 screening indicators.

To formally test whether Year-2 utilization differs significantly from Year-1 utilization, the ordinary least squares (OLS) model will be used on individual-level 2-year panel data:

$$Y_{it} = \beta_0 + \beta_1 Year\ 2_{it} + CX_{it} + \beta_2 month_{it} + \alpha_{year},$$

where Y_{it} represents the number of visits for beneficiary i in year t *for continuous outcomes, (*hospitalizations and ambulatory/preventive visits), and a binary indicator for whether beneficiary *i* received the services in year t for screening or testing outcomes.[2] β_0 is the intercept. $Year\ 2_{it}$ is the indicator of Year 2, which equals 1 for Year 2 and 0 for Year 1. The coefficient β_1 estimates the

[2] For binary screening or testing outcomes, OLS rather than a logistic regression will be used for easier interpreting the rate changes from Year 1 to Year 2.

average within-person change in utilization associated with the HMW enrollment in Year 2. Statistical significance will be assessed using a two-tailed test, where a p-value below 0.05 indicates a meaningful difference between Year 1 and Year 2.

The vector X_{it} includes demographic characteristics to account for observable differences across individuals. Because beneficiaries may enroll partway through a demonstration year, the number of months they are enrolled in Year 1 and Year 2 may differ. Longer enrollment periods could allow for greater opportunity to use healthcare services. To account for this variation, the model includes a control variable, $month_{it}$, which adjusts for differences in the number of months each beneficiary is enrolled each year. Because Year 1 and Year 2 may correspond to different demonstration years for different beneficiaries, year fixed effects (α_{year}) will be included to control for unobserved differences across demonstration years. When appropriate, individual fixed effects may also be included to account for unobserved beneficiary characteristics that do not vary over time.

The interim evaluation will include all beneficiaries enrolled in any two consecutive demonstration years between DY20 and DY23, and the summative evaluation will extend this window to DY20–DY25. Based on DY20 data, 1,617 beneficiaries were enrolled in DY19 and DY20, with DY19 serving as their first year of enrollment. When combining data across four measurement years for the interim evaluation, the longitudinal analysis could involve approximately 6,000 beneficiary-year pairs (1,600 × 4). For the summative evaluation, which includes up to six measurement years, the analysis could include roughly 9,600 beneficiary-year pairs (1,600 × 6). If a beneficiary is enrolled in more than one pair of consecutive demonstration years (for example, DY19–DY20 and DY21–DY22), they will contribute multiple observations to the analysis, as each pair represents a distinct Year-1/Year-2 comparison.

Subgroup Analysis

Subgroup analyses will be conducted in three ways.

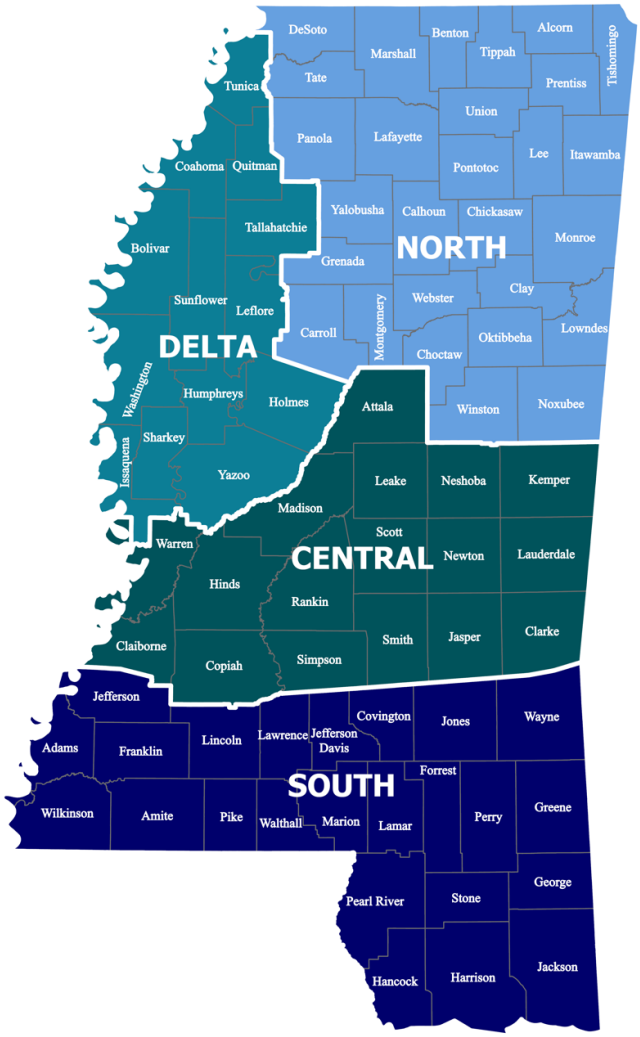
First, in the descriptive analysis, all measures will be reported by key demographic groups, including age, gender, race, and region of residence (see Table 1 for details). Regional classifications will follow the Mississippi Department of Human Services (MDHS) Public Health Region Map, which divides the state into the Central, Delta, North, and South regions (see Figure 2). These descriptive subgroup summaries will help identify potential disparities in access to care, preventive service use, and other utilization outcomes under the HMW demonstration.

Second, for the longitudinal analysis, beneficiaries will be stratified by demographic subgroups, and within-person changes in utilization from Year 1 to Year 2 will be estimated separately for each group. This approach allows the evaluation to assess whether subgroups experience different degrees of improvement or decline in healthcare utilization during their two consecutive enrollment years. When appropriate, interaction terms between subgroup indicators and the Year-2 indicator will be included in regression models to formally test whether utilization changes differ significantly across groups. Because beneficiaries may move across counties between enrollment years, regional

assignments will be based on county of residence in Year 2 to reflect their most recent service environment.

Third, the evaluation will assess whether engagement in ambulatory or preventive services is associated with a lower likelihood of hospitalization. This analysis will compare beneficiaries enrolled for at least six months who used ambulatory or preventive services at least once during the measurement year with those who did not. T-tests or chi-square tests will be used to assess differences in hospitalization rates and demographic characteristics between the two groups. This comparison will provide insight into whether preventive and ambulatory care use under the HMW demonstration is associated with reduced hospitalization risk. According to DY20 data, 5,064 HMW beneficiaries were enrolled for at least six months, providing a sense of the potential sample size for this analysis (see Table VI-11 in Appendix V).

Figure 2: Regions of Healthier Mississippi Waiver Program



Qualitative Analysis

A qualitative evaluation will supplement quantitative findings through structured telephone surveys administered twice during the current demonstration extension period. The first survey will be conducted within two months following the end of the first demonstration year, and the second within two months after the end of the third demonstration year. Survey results will be incorporated into the evaluation reports.

The survey sample will consist of HMW beneficiaries who have been continuously enrolled for at least 12 months and are not incarcerated. If the eligible pool includes fewer than 2,000 beneficiaries, all eligible beneficiaries will be contacted; if it exceeds 2,000, a random sample of 1,500 beneficiaries will be selected proportionally across the four MDHS regions. A minimum completion rate of 10 percent (at least 150 completed surveys) will be required for analytic validity. Multiple contact attempts will be made to improve response rates, and newly enrolled beneficiaries will be informed of the survey through their enrollment welcome materials.

Survey responses will be recorded, converted into structured datasets, and analyzed descriptively and in relation to claims-based utilization measures. The survey includes an overall satisfaction rating on a one-to-five scale, followed by questions related to access to preventive services, barriers to care, and potential program improvements. Response frequencies and percentages will be reported for all items, and satisfaction rate and average satisfaction scores will be calculated for the full sample and for demographic subgroups (e.g. age, gender, race, and region) if appliable. A satisfaction rate greater than 0.5 or an average satisfaction score above 2.5 will be interpreted as indicating general satisfaction with the HMW program.

Integration of Qualitative Analysis and Quantitative Analysis

Survey results will be integrated with administrative claims analyses to explore relationships between utilization behavior, perceived access, and satisfaction. Where appropriate, multivariable regressions at may be used to assess the association between beneficiary satisfaction and demographic characteristics, service utilization, and reported barriers to care. A general specification is:

$$Y_i = \beta_0 + X_i C,$$

where Y_i represents the satisfaction scores for beneficiary i. β_0 is the intercept. X_i is a matrix of demographic characteristics, healthcare utilization measures, and survey-reported barriers and facilitators. The coefficient vector C will be used to identify factors associated with higher or lower satisfaction. These analyses will help explain whether beneficiaries who experience improved access or preventive care engagement under the demonstration also report higher levels of satisfaction.

Alignment With Demonstration Objectives

All quantitative and qualitative analyses will be conducted in alignment with the measurable objectives established for the HMW demonstration and in accordance with CMS evaluation standards. By combining enrollment data, claims-based utilization measures, and direct beneficiary

feedback, the evaluation will provide a comprehensive, evidence-based assessment of the demonstration's impact on healthcare utilization, preventive service engagement, chronic disease management, and areas where program improvements may be warranted. This integrated approach ensures that the evaluation addresses both observed outcomes and beneficiary perspectives, offering meaningful insights into the effectiveness of the HMW demonstration and its contribution to improved health outcomes for HMW beneficiaries.

Target and Comparison Populations

The primary target population for this evaluation consists of HMW beneficiaries enrolled in the program during the measurement demonstration year. These beneficiaries include individuals who are aged, blind, or disabled, are not eligible for Medicare or Medicaid, are not inpatients in a long-term care facility, and meet the following financial eligibility criteria:

- Income is at or below 135% of the Federal Poverty Level (FPL) for an individual or a couple, calculated using a methodology based on the Supplemental Security Income (SSI) program, as well as income exclusions approved under the state plan under the authority of Section 1902(r)(2) of the Social Security Act.
- Resources are below $4,000 for an individual and $6,000 for a couple.

Although the state can identify a subset of HMW beneficiaries who previously qualified for Medicaid through SSI, this group is not considered a suitable comparison population. Since HMW provides the same healthcare services as Medicaid – except for swing bed care in a skilled nursing facility, long-term care services, and maternity and newborn care – the transition from Medicaid to HMW is not expected to result in significant changes in healthcare utilization. Therefore, beneficiaries who previously qualified for SSI-based Medicaid will not be used as a comparison group.

Additionally, for HMW beneficiaries who did not qualify for Medicaid through SSI before enrolling in HMW, no pre-enrollment healthcare utilization data is available. As a result, a pre/post comparison is not feasible. Given these constraints, the evaluation will adopt a post-only assessment design, using historical data in DY20 (Federal Fiscal Years 2024), the final year of the prior demonstration period, as the baseline. Trends in healthcare utilization, preventive screening, and chronic disease management will be assessed by comparing outcomes in subsequent demonstration years (DY21–DY25) to this baseline.

Furthermore, a longitudinal comparison will be used for beneficiaries enrolled in two consecutive demonstration years. For these beneficiaries, healthcare utilization in the second year of enrollment will be compared with utilization in the immediately preceding year. This analytic approach will assess within-person changes and evaluate whether extended exposure to HMW is associated with improvements in service utilization. HMW beneficiaries who previously qualified for Medicaid through SSI will be excluded from the longitudinal analyses. Their first year of HMW enrollment does not represent their first exposure to HMW-equivalent benefits, and including them could underestimate the difference in utilization between the first and second years of HMW enrollment.

Lastly, to evaluate whether HMW beneficiaries who utilize ambulatory and preventive healthcare services are less likely to experience hospitalization (a key sub-research question under Research Question 2), the evaluation will identify a target group of beneficiaries enrolled for at least six months who used ambulatory or preventive services at least once during the measurement year. The comparison group will consist of beneficiaries enrolled for at least six months who did not use these services. This subgroup analysis will provide insight into whether preventive and ambulatory care engagement under the demonstration is associated with lower risk of hospitalization.

This evaluation framework ensures a methodologically sound approach to assessing HMW's impact on healthcare utilization, leveraging historical trends, longitudinal comparisons, and subgroup analyses to derive meaningful insights.

Evaluation Period

The evaluation will cover the demonstration period from October 1, 2024, through September 30, 2029. Additionally, historical utilization data from DY20 will be included as the baseline for the trend analysis. For the longitudinal analysis, changes in utilization from DY19 (October 1, 2022–September 30, 2023) to DY20 among beneficiaries enrolled in two consecutive years will be used as a reference point for interpreting longitudinal results during the current demonstration period.

Evaluation Measures

The evaluation measures included in the quantitative analysis of the evaluation are presented in Table 1.

Table 1: Quantitative Evaluation Outcomes Measures

Metric	Description	Numerator/Denominator
Hospitalization Rate	The percentage of beneficiaries who had at least one acute care hospitalization during the measurement demonstration year. The percentage will be conducted at both the statewide and regional levels.	Number of HMW beneficiaries with at least one hospitalization during the measurement demonstration year/Total number of HMW beneficiaries during the measurement demonstration year
Average Hospitalization Reduction Rate Over Two Demonstration Years	The average percentage change in hospitalizations between the first and second demonstration years among HMW beneficiaries who were enrolled in HMW during both the measurement demonstration year and the preceding year. The average percentage change will be calculated at both the statewide and regional levels.	Step 1: Calculate individual hospitalization reduction rate using the follow formula: (Average number of hospitalizations per month in the measurement demonstration year – Average number of hospitalizations per month in the previous demonstration year)/ Number of hospitalizations in the previous demonstration year Step 2: Average hospitalization reduction rates among HMW beneficiaries who were enrolled in HMW during both the measurement demonstration year and the preceding year
Hospitalization Rate Among Beneficiaries Who Accessed Ambulatory and Preventive Services	The percentage of beneficiaries enrolled in HMW for at least six months who accessed ambulatory and preventive services at least once during the measurement demonstration year and were subsequently hospitalized within the same measurement demonstration year. The percentage will be calculated at both the statewide and regional levels.	Number of HMW beneficiaries enrolled for at least six months who accessed ambulatory and preventive services at least once during the measurement demonstration year and were subsequently hospitalized within the same measurement demonstration year/Number of HMW beneficiaries enrolled for at least six months who accessed ambulatory and preventive services at least once during the measurement demonstration year
Hospitalization Rate Among Beneficiaries Who Did Not Access	The percentage of beneficiaries enrolled in HMW for at least six months who did not access ambulatory and preventive services during the measurement demonstration year and were hospitalized within the same	Number of HMW beneficiaries enrolled for at least six months who did not access ambulatory and preventive services and were hospitalized during the measurement demonstration year/Number of HMW beneficiaries enrolled for at least six

Ambulatory and Preventive Services	measurement demonstration year. The percentage will be calculated at both the statewide and regional levels.	months who did not access ambulatory and preventive services during the measurement demonstration year
Ambulatory/Preventive Health Visit Rate	The percentage of beneficiaries who had at least one ambulatory or preventive care visit during the measurement demonstration year. This percentage will also be calculated at both the statewide and regional levels.	Number of HMW beneficiaries who had at least one ambulatory or preventive care visit during the measurement demonstration year/Total number of HMW beneficiaries during the measurement demonstration year
Average Change Rate in Ambulatory/Preventive Health Visits Over Two Demonstration Years	The average percentage change in ambulatory and preventive health visits between the first and second demonstration years among HMW beneficiaries who were enrolled in HMW during both the measurement demonstration year and the preceding year. This average percentage change will be calculated at both the statewide and regional levels.	Step 1: Calculate individual ambulatory or preventive health visit change ate using the follow formula: (Average number of ambulatory or preventive health visits per month in the measurement demonstration year – Average number of ambulatory or preventive health visits in the previous demonstration year)/ Average number of ambulatory or preventive health visits per month in the previous demonstration year Step 2: Average change rates in ambulatory or preventive health visits among HMW beneficiaries who were enrolled in HMW during both the measurement demonstration year and the preceding year
Average Ambulatory/Preventive Health Visits	The average number of ambulatory/preventive health visits per beneficiary, calculated separately for different age groups (<18, 18-44, 45-64, 65-75, >75) and for the four different regions.	For each age group, the average number of ambulatory and preventive health visits is calculated as follows: Total number of ambulatory or preventive health visits during the measurement demonstration year/ Total number of beneficiaries in the age group
Cervical Cancer Screening Rate	The percentage of female beneficiaries aged 21-64 who received a cervical cancer screening during the measurement demonstration year. This metric will also be calculated separately for the 21–29 and 30–	Number of female HMW beneficiaries aged 21-64 who received a cervical cancer screening during the measurement demonstration year (excluding beneficiaries receiving hospice care)/Total number of female HMW beneficiaries aged 21-64

	64 age groups, and for the four different regions.	during the measurement demonstration year (excluding beneficiaries receiving hospice care)[3] For each age group, the percentage will be calculated using the same formula, with both the numerator and denominator adjusted to reflect the respective age group.
Change in Cervical Cancer Screening Rate Over Two Demonstration Years	The difference in the percentage of female beneficiaries aged 21–64 who received a cervical cancer screening between the measurement demonstration year and the preceding demonstration year, among those enrolled in HMW during both years. This metric will be analyzed at both the statewide and regional levels.	Cervical cancer screening rate in measurement demonstration year − Cervical cancer screening rate in preceding demonstration year
Breast Cancer Screening Rate	The percentage of female beneficiaries aged 50-74 who received a mammogram during the 27 months prior to the end of measurement demonstration year. This metric will also be calculated separately for the following age groups: 50–64, and 65–74, and for the four regions.	Number of female HMW beneficiaries aged 52-74 who received a mammogram during the 27 months prior to the end of measurement demonstration year/Total number of female HMW beneficiaries aged 52-74 during the measurement demonstration year[4] For each age group, the percentage will be calculated using the same formula, with both the numerator and denominator adjusted to reflect the respective age group.
Colorectal Cancer Screening Rate	The percentage of beneficiaries aged 45-75 who received a colorectal cancer screening during the measurement demonstration year. This metric will also be calculated for the 45–64 and 65–75 age groups, and for the four regions.	Number of HMW beneficiaries aged 46-75 who a colorectal cancer screening during measurement demonstration year (excluding beneficiaries receiving hospice care)/Total number of HMW beneficiaries aged 46-75 during the measurement

[3] Because hysterectomy status is not available for all beneficiaries, this measure does not exclude female beneficiaries aged 21–64 who may have had a hysterectomy. As a result, the measure varies slightly from the corresponding measure in the Medicaid Adult Core Set.

[4] The age criteria for the denominator (ages 50 to 74) are different from the measure description (ages 52 to 74) to account for a two-year lookback period. This approach is consistent with the specification used in the Medicaid Adult Core Set.

		demonstration year (excluding beneficiaries receiving hospice care)[5] For each age group, the percentage will be calculated using the same formula, with both the numerator and denominator adjusted to reflect the respective age group.
Change in Colorectal Cancer Screening Rate Over Two Demonstration Years	The difference in the percentage of female beneficiaries aged 45-75 who received a colorectal cancer screening between the measurement demonstration year and the preceding demonstration year, among those enrolled in HMW during both years. This metric will be calculated at both the statewide and regional levels.	Colorectal cancer screening rate in measurement demonstration year − Colorectal cancer screening rate in preceding demonstration year
Diabetes Care: Hemoglobin A1c (HbA1c) testing Rate	The percentage of beneficiaries aged 18-75 with diabetes who received an HbA1c test during the measurement demonstration year. This metric will also be calculated by gender, race, and region.	Number of HMW beneficiaries aged 18-75 with diabetes (type1 and type 2) who received an HbA1c test during the measurement demonstration year (excluding beneficiaries receiving hospice care)/Total number of HMW beneficiaries aged 18-75 with diabetes during the measurement demonstration year (excluding beneficiaries receiving hospice care)[6] For each gender and racial subgroup, the percentage will be calculated using the same formula, with both the numerator and denominator adjusted to reflect the respective subgroup.
Change in Hemoglobin A1c (HbA1c) testing Rate Over Two Demonstration Years	The difference in the percentage of beneficiaries aged 18-75 with diabetes who received an HbA1c test between the measurement demonstration year and the	Hemoglobin A1c (HbA1c) testing rate in measurement demonstration year − Hemoglobin A1c (HbA1c) testing rate in preceding demonstration year

[5] The age criteria for the denominator (ages 46 to 75) are different from the measure description (ages 45 to 75) to account for a one-year lookback period. This approach is consistent with the specification used in the Medicaid Adult Core Set.

[6] This measure differs from the corresponding Medicaid Adult Core Set measure in two ways. First, the Core Set numerator includes beneficiaries aged 18–75 with a most recent HbA1c level greater than 9.0% or those without an HbA1c test. Because HbA1c values are not available for this evaluation, the numerator includes only beneficiaries aged 18–75 with diabetes who did not receive an HbA1c test during the measurement year. Second, while the Core Set denominator excludes beneficiaries receiving palliative care, such data are not available for this evaluation. Instead, beneficiaries receiving hospice care are excluded to approximate the Core Set specifications.

	preceding demonstration year, among those enrolled in HMW during both years. This metric will be calculated at both the statewide and regional levels.	
Diabetes Care: Dilated Eye Examination Rate	The percentage of beneficiaries aged 18-75 with diabetes who received a dilated eye examination during the measurement period. This metric will also be calculated by gender, race, and region.	Number of HMW beneficiaries aged 18-75 with diabetes who received a dilated eye examination during the measurement demonstration year (excluding beneficiaries receiving hospice care)/Total number of HMW beneficiaries with diabetes during the measurement demonstration year (excluding beneficiaries receiving hospice care) For each gender and racial subgroup, the percentage will be calculated using the same formula, with both the numerator and denominator adjusted to reflect the respective subgroup.
Change in Dilated Eye Examination Rate Over Two Demonstration Years	The difference in the percentage of beneficiaries aged 18-75 with diabetes who received a dilated eye examination between the measurement demonstration year and the preceding demonstration year, among those enrolled in HMW during both years. This metric will be calculated at both the statewide and regional levels.	Dilated eye examination rate in measurement demonstration year − Dilated eye examination rate in preceding demonstration year
Service Expenditures Per Beneficiary Per Month	The average monthly service expenditures for each HMW beneficiary during the measurement demonstration year	Total expenditures in the measurement demonstration year / Total member months in the measurement demonstration year
Beneficiary Satisfaction Rate	The percentage of beneficiaries who reported satisfaction with the demonstration services among those who completed the telephone survey.	Number of HMW beneficiaries who reported being satisfied or very satisfied with the demonstration services during the telephone survey/ Total number of HMW beneficiaries who completed the telephone survey
Average Satisfaction Score	The average satisfaction rating reported by beneficiaries who completed the telephone survey	Sum of the satisfaction ratings reported by all HMW beneficiaries who completed the telephone survey/ Total number of HMW beneficiaries who completed the telephone survey

Data Sources

HMW Enrollment Data and Medicaid Fee for Services Claim Data

The primary data sources for the quantitative evaluation include HMW enrollment data and Medicaid Fee-for-Service (FFS) claims data. HMW enrollment data will be used to identify eligible beneficiaries, capture their demographic information, and track their enrollment histories. Medicaid FFS claims data will provide detailed information on healthcare utilization metrics and service expenditures. These datasets are maintained in the Medicaid Management Information System (MMIS) and the Decision Support System (DSS) and will be provided by the DOM. DOM will review, process, and validate claims and enrollment data throughout the demonstration period to ensure accuracy and completeness for reporting and analytic purposes.

Beneficiary Satisfaction Telephone Survey

In addition to analyzing claims and enrollment data, a structured telephone survey will be conducted to assess HMW beneficiaries' satisfaction with demonstration services, as well as to identify perceived barriers to access care and potential program improvements. Survey responses will provide both quantitative and qualitative insights that inform Evaluation Questions 7 through 11.

The survey will be administered via telephone interviews using Voxco, a professional telephone survey system designed to support large-scale telephone-based research. Structured questionnaires will be carefully developed to accommodate individuals with a reading level no higher than the recommended 6th-grade level, ensuring clarity, accessibility, and consistency in data collection (See Attachment V). Additionally, all interviewers will be trained to maintain a neutral and unbiased approach throughout the survey administration. To accommodate non-English-speaking beneficiaries, bilingual interviewers will be available as needed.

The survey sample will be selected through a rigorous methodology to ensure that responses are representative of the HMW beneficiary population. Participants will be drawn from a survey pool consisting of HMW beneficiaries who were enrolled for at least 12 consecutive months prior to survey administration and were not incarcerated.

A minimum response rate of 10% will be required to ensure statistical reliability. To improve response rates, follow-up attempts will be made for beneficiaries who do not respond to the initial outreach. Additionally, newly enrolled beneficiaries will be notified about the telephone survey in the welcome mail package sent by Medicaid. Once data collection is complete, survey responses will be converted into structured datasets and then be analyzed alongside quantitative claims data.

To enhance the credibility and reliability of survey findings, several methodological safeguards will be implemented. Full selection or randomized selection of survey participants will minimize selection bias, and validated survey instruments will be used to align with industry-standard methodologies such as Medicaid's Consumer Assessment of Healthcare Providers and Systems

(CAHPS). Prior to full-scale implementation, the survey will undergo pilot testing to refine the wording of questions and ensure clarity.

Ethical considerations will be strictly followed throughout the survey process. All participants will provide informed consent, ensuring that they fully understand the purpose of the survey and their right to withdraw at any time. Confidentiality will be maintained by anonymizing all responses, protecting participant privacy, and ensuring compliance with data protection regulations.

Findings from the telephone survey will be triangulated with Medicaid claims and enrollment data to validate trends observed in the quantitative analysis. This integration will help determine whether lower utilization rates correlate with reported utilization and lower satisfaction, identify areas for program improvement, and provide insights that are not captured through claims-based analyses alone.

By incorporating multiple data sources—including HMW enrollment records, Medicaid claims, and qualitative beneficiary survey responses—this evaluation will provide a comprehensive and evidence-based assessment of the HMW demonstration's impact on healthcare utilization, preventive care, chronic disease management, and the place to improve.

The survey will be conducted twice during the current demonstration extension period. The first survey will be conducted within two months following the end of the first demonstration year, and the second within two months after the end of the third demonstration year. Survey results will be incorporated into the evaluation reports. The survey script and questions for the first survey in the current demonstration period were developed based on quantitative findings from the DY20 Annual Report (see Attachment V). The script and questions for the second survey will be refined using insights from the analysis of the first survey, as well as findings from the DY21 and DY22 annual monitoring reports for the current extension period.

Analytic Methods

Table 2 provides details on the quantitative research questions, hypotheses, measures, related populations, and data sources, as well as the specific analytic approaches.

Table 2: Summary of Quantitative Evaluation Hypotheses, Research Questions, Outcome Measures, Population, Data Sources, and Analytic Approaches

Research Question	Outcome Measure(s)	Population	Data Sources	Analytic Approach
Hypothesis 1: Beneficiaries who receive ambulatory and preventive care will have lower hospitalization rates than those who do not utilize these services. As HMW provides access to these services, hospitalizations among HMW beneficiaries are expected to decrease over time.				
• How does the hospitalization rate among HMW beneficiaries change over time? • Do hospitalizations decline as the duration of HMW enrollment increases? • Do beneficiaries who utilize ambulatory and preventive services experience fewer hospitalizations compared to those who do not?	• Hospitalization rate • Average hospitalization reduction rate over two demonstration year • Hospitalization rate among beneficiaries who accessed ambulatory and preventive services • Hospitalization rate among beneficiaries who did not access ambulatory and preventive services	• All beneficiaries in the measurement demonstration year • Beneficiaries enrolled in HMW during both the measurement demonstration year and the preceding year • Beneficiaries enrolled in HMW for at least six months who accessed ambulatory and preventive services at least once during the measurement demonstration year • Beneficiaries enrolled in HMW for at least six months who did not access ambulatory and preventive services during the measurement demonstration year	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	• Trend Analysis: 1. Calculate hospitalization rates for each demonstration year over the past four or six years[7]and assess overall trends using the Cochran–Armitage test. 2. Estimate individual-level logistic regression models with a continuous demonstration-year variable, controlling for demographic characteristics, to evaluate the direction and statistical significance of hospitalization trend. • Longitudinal Analysis: track hospitalization rates among beneficiaries enrolled for at least two consecutive demonstration years and analyze changes in hospitalization trends between the first and second enrollment years. • Subgroup Analysis: conduct subgroup analysis to compare hospitalization rates between beneficiaries who utilized ambulatory or preventive services at least once during the demonstration year and those who did not. T-tests or Chi-square tests will be used to assess differences in hospitalization rates and demographic characteristics between the two groups. Relevant summary statistics will also be provided to present the analysis results. • All the analyses mentioned above will be conducted at both the statewide and regional levels.

[7] The interim evaluation will include Demonstration Years (DY)20-DY23, and the summative evaluation will include DY20-DY25.

Hypothesis 2: As HMW provides access to ambulatory and preventive healthcare services, their utilization among HMW beneficiaries is expected to increase over time. Additionally, utilization rates may differ across age groups.				
• How does the rate of ambulatory or preventive health visits change over time? • Does utilization of these services increase as the duration of HMW enrollment increases? • Does the utilization of ambulatory and preventive health visits vary across different age groups of beneficiaries?	• Ambulatory/preventive health visit rate • Average change rate in ambulatory/preventive health visits over two demonstration years • Average ambulatory/preventive health visits for different age groups (<18, 18-44, 45-64, 65-75, >75) of beneficiaries	• All beneficiaries in the measurement demonstration year • Beneficiaries enrolled HMW in both the measurement demonstration year and the preceding year • Beneficiaries in the measurement demonstration year categorized by age group (<18, 18-44, 45-64, 65-75, >75)	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	• Trend Analysis: 1. Calculate the rate of ambulatory and preventive health visits for each demonstration year over the past four or six years[8] and assess overall trends using the Cochran–Armitage test. 2. Estimate individual-level logistic regression models with a continuous demonstration-year variable, controlling for demographic characteristics, to evaluate the direction and statistical significance of the trend of ambulatory and preventive health visits. • Longitudinal Analysis: track the ambulatory or preventive health visits among beneficiaries enrolled for two consecutive demonstration years and analyze changes in visits between the first and second enrollment years. • Subgroup Analysis: compare the average number of ambulatory and preventive health visits across different age and region groups. The longitudinal analysis will be performed to subgroups.
Hypothesis 3: As HMW provides access to preventive screenings, the number of HMW beneficiaries receiving recommended preventive screenings will increase over time. Additionally, older HMW beneficiaries are more likely to receive preventive screenings compared to younger beneficiaries. Furthermore, beneficiaries are more likely to receive preventive screening as the duration of enrollment increase.				
• Does the number of HMW beneficiaries receiving age-appropriate preventive screenings (e.g., mammograms, cervical cancer screenings, and colorectal cancer	• Cervical cancer screening rate, calculated for all female beneficiaries aged 21-64 and separately for different age groups (21-29 and 30-64)	• Female beneficiaries aged 21-64 • Female beneficiaries aged 21-64 enrolled HMW in both the measurement demonstration year	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	• Trend Analysis: 1. Calculate the preventive screening rates for each demonstration year over the past four or six years[9] and assess overall trends using the Cochran–Armitage test. 2. Estimate individual-level logistic regression models with a continuous demonstration-year variable, controlling for demographic characteristics, to evaluate the

[8] The interim evaluation will include Demonstration Years (DY)20-DY23, and the summative evaluation will include DY20-DY25.
[9] The interim evaluation will include Demonstration Years (DY)20-DY23, and the summative evaluation will include DY20-DY25.

screenings) increase over time? • Does the proportion of HMW beneficiaries receiving preventive screenings increase as beneficiaries age? • Does this proportion increase as the duration of HMW enrollment increases?	• Change in cervical cancer screening rate over two demonstration years • Breast cancer screening rate, calculated for all female beneficiaries aged 50–74 and by specific age groups (50–64 and 65–74). • Change in breast cancer screening rate over two demonstration years • Colorectal cancer screening rate, calculated for all beneficiaries aged 45–75 and by specific age groups (45–64 and 65–74). • Change in Colorectal Cancer Screening Rate Over Two Demonstration Years	and the preceding demonstration year • Female beneficiaries aged 50-74 • Beneficiaries aged 45-75 • Beneficiaries aged 45-75 enrolled HMW in both the measurement demonstration year and the preceding demonstration year		direction and statistical significance of the preventive screening trend. • Longitudinal Analysis: track the preventive screenings among beneficiaries enrolled for two consecutive demonstration years and analyze changes in screening rates between the first and second enrollment years. • Subgroup Analysis: compare the preventive screening rates across different age and region groups. The longitudinal analysis will be performed to subgroups.
Hypothesis 4: As HMW provides access to HbA1c test, HMW beneficiaries with diabetes receiving an annual HbA1c test are expected to increase over time. Additionally, beneficiaries with diabetes are more likely to receive annual HbA1c test as the duration of enrollment increase. Furthermore, the utilization of annual HbA1c testing may differ across gender and race groups.				
• Does the proportion of HMW beneficiaries diagnosed with diabetes who receive an annual HbA1c test increase over time? • Does this proportion increase as the duration of HMW enrollment increases?	• Diabetes care: HbA1c testing rate, calculated for all beneficiaries aged 18-75 with diabetes and stratified by gender (male and female) and race (black, white, and other). • Change in HbA1c testing rate over two demonstration years	• All beneficiaries aged 18-75 with diabetes • Beneficiaries with diabetes who enrolled HMW in both the measurement demonstration year and the preceding demonstration year	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	• Trend Analysis:1. Calculate the HbA1c testing rate for each demonstration year over the past four or six years[10] and assess overall trends using the Cochran–Armitage test. 2. Estimate individual-level logistic regression models with a continuous demonstration-year variable, controlling for demographic characteristics, to evaluate the direction and statistical significance of the HbA1c testing trend.

[10] The interim evaluation will include Demonstration Years (DY)20-DY23, and the summative evaluation will include DY20-DY25.

• Does the utilization of annual HbA1c testing vary by gender and race?				• Longitudinal Analysis: track HbA1c testing among beneficiaries enrolled for two consecutive demonstration years and analyze changes in HbA1c testing rates between the first and second enrollment years. • Subgroup Analysis: compare HbA1c testing rates across gender, race, and region groups. The longitudinal analysis will be performed to subgroups.
Hypothesis 5: As HMW provides access to HbA1c test, HMW beneficiaries with diabetes receiving an annual dilated eye examination will increase over time. Additionally, beneficiaries with diabetes are more likely to receive an annual dilated eye examination as the duration of enrollment increase. Furthermore, the utilization of annual dilated eye examinations may differ across gender and race groups.				
• Does the proportion of HMW beneficiaries diagnosed with diabetes who receive an annual dilated eye examination increase over time? • Does this proportion increase as the duration of HMW enrollment increases? • Does the utilization of annual dilated eye examinations vary by gender and race?	• Diabetes care: dilated eye examination rate, calculated for all beneficiaries aged 18-75 with diabetes and stratified by gender (male and female) and race (black, white, and other). • Change in dilated eye examination rate over two demonstration years	• All beneficiaries aged 18-75 with diabetes • Beneficiaries with diabetes who enrolled HMW in both the measurement demonstration year and the preceding demonstration year	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	• Trend Analysis: 1. Calculate the dilated eye examination rate for each demonstration year over the past four or six years[11] and assess overall trends using the Cochran–Armitage test. 2. Estimate individual-level logistic regression models with a continuous demonstration-year variable, controlling for demographic characteristics, to evaluate the direction and statistical significance of the dilated eye examination tends. • Longitudinal Analysis: track dilated eye examinations among beneficiaries enrolled for two consecutive demonstration years and analyze changes in the dilated eye examination rate between the first and second enrollment years. • Subgroup Analysis: compare dilated eye examination rates across gender, race and region groups. The longitudinal analysis will be performed to subgroups.

[11] The interim evaluation will include Demonstration Years (DY)20-DY23, and the summative evaluation will include DY20-DY25.

Hypothesis 6: With reduced more expensive hospitalization and increased relatively cheaper preventive healthcare, the service expenditure of beneficiaries will reduce				
• Do average service expenditures per beneficiary per month decrease over demonstration years?	• Service Expenditures Per Beneficiary Per Month	• All beneficiaries	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	The service expenditures per beneficiary per month for each measurement demonstration year will be calculated and compared to national or state Medicaid or Medicare service expenditures.
Hypothesis 7: HMW beneficiaries are more likely to report being satisfied than not with the benefits under the demonstration.				
• Are HMW beneficiaries satisfied with the demonstration services?	• Beneficiary Satisfaction Rate • Average Satisfaction Score	• Beneficiaries who were enrolled in HMW for at least 12 consecutive months during the measurement demonstration year at the time of survey administration	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data • Survey data, collected via telephone surveys conducted by the program evaluator during the measurement demonstration year	• Utilize HMW enrollment data and Medicaid FFS claims data to identify the survey pool, consisting of HMW beneficiaries who were enrolled for at least 12 consecutive months during the measurement demonstration year at the time of survey administration. • Fully select or randomly select beneficiaries from the survey pool of each region for participating in the survey. • Conduct telephone surveys using Voxco, a professional survey system. • Ensure that responses are collected from at least 10% of the survey pool to maintain statistical reliability. • Convert survey responses into structured data • Analyze survey results to assess beneficiary satisfaction with HMW services

IV. Methodological Limitations

While the evaluation is designed to be rigorous and methodologically sound, three limitations need to be acknowledged.

One limitation is the lack of pre-enrollment healthcare utilization data for HMW beneficiaries. Although a subset of HMW beneficiaries qualified for Medicaid through SSI prior to their enrollment in the HMW, Medicaid provides all healthcare services that HMW offers, making it difficult to determine whether access to care under HMW results in changes in healthcare utilization. For most HMW beneficiaries who were not eligible for Medicaid before enrolling in HMW, there is no available data on their healthcare utilization prior to enrollment. As a result, conducting a pre/post comparison for HMW beneficiaries will either lacking meaningful insights or unfeasible. To mitigate this issue, the evaluation will rely on historical trend analysis, comparing healthcare utilization across multiple demonstration years to assess patterns over time. Additionally, a longitudinal analysis will be conducted on beneficiaries enrolled in HMW for two consecutive demonstration years to track changes in healthcare utilization within the same individuals. The expectation is that utilization patterns will shift between the first year of enrollment, when beneficiaries are less familiar with the HMW benefits, and the second year, when they are more accustomed to the healthcare services provided.

Another limitation is the absence of a suitable comparison group. In theory, individuals who lack Medicaid benefits and are on the waiting list for HMW enrollment could serve as a comparable population due to their similar financial and health conditions. However, there is no existing data available for these individuals, making direct comparisons impossible.

A third limitation is potential response bias in self-reported data collected through the beneficiary satisfaction survey. Respondents may be inclined to overstate satisfaction with services or underreport challenges due to social desirability bias. To enhance the validity of survey findings, the evaluation will implement several measures, including randomized selection of participants, the careful design of survey questions to ensure neutrality and avoid leading language, and maintaining respondent anonymity to encourage honest feedback. Additionally, interviewers will undergo professional training to ensure they adopt a neutral and unbiased approach during survey administration, further minimizing the risk of response bias.

V. Special Methodological Considerations

DOM would like CMS to take into consideration the limitations listed above when reviewing the evaluation draft for scientific and academic rigor. Due to these constrains, DOM will adopt non-experimental designs because of the following reasons:

- Lack of an external comparison group: There is no data available for the potential comparison group external to HMW program, preventing the use of matching techniques to compare HMW beneficiaries with non-HMW beneficiaries.
- Limited pre-enrollment healthcare utilization data: There is insufficient data on healthcare utilization before HMW enrollment, making a pre/post quasi-experimental analysis infeasible.

Despite these limitations, the evaluation will employ rigorous analytical methodologies and mitigation strategies to ensure the reliability and validity of the findings. The combination of trend analysis and longitudinal assessments, and subgroup comparisons will provide valuable insights into the impact of HMW on healthcare utilization, preventive care, and chronic disease management while acknowledging and accounting for the inherent challenges of evaluating the program's effectiveness.

Attachment I: Independent Evaluator

As a result of a recent request for quotes, the Division of Medicaid (DOM) has secured the services of an independent evaluator and executed a professional services contract on August 7,2024 with the National Strategic and Planning Analysis Center (NSPARC) at Mississippi State University.

NSPARC is a trusted and experienced independent evaluator with over 15 years of expertise in conducting rigorous evaluations for federal and state programs, particularly in health, education, and workforce development. With a proven track record in assessing program impact, NSPARC has partnered with agencies such as DOM and the Mississippi Department of Employment Security (MDES), earning a reputation for delivering data-driven insights that inform policy and enhance program effectiveness.

NSPARC specializes in comprehensive evaluations, including survey design and deployment, focus group facilitation, data collection and analysis, and professional reporting with actionable insights to support evidence-based decision-making. Leveraging expertise in administrative records, longitudinal data systems, and advanced analytical techniques, the NSPARC team applies cutting-edge methodologies, including machine learning, to extract meaningful insights from complex data. This capability enables NSPARC to address the critical challenges faced by policymakers, employers, economic developers, and state agencies.

NSPARC's expertise aligns with the requirements for the Section 1115 Demonstration evaluation, which requires a comprehensive assessment of the demonstration's goals, hypotheses, methodologies, and outcomes. The NSPARC team will design and implement the evaluation, overseeing all aspects of data collection, cleaning, analysis, and reporting. Their extensive experience in evaluating large-scale health programs ensures that the evaluation meets both federal requirements and the program's specific objectives.

To ensure an objective, impartial evaluation with no conflict of interest, DOM has established robust oversight measures. The contract and contract monitoring process serve as the primary mechanisms for maintaining compliance. DOM enforces accountability through contractual provisions that define benchmarks, reporting deadlines, and approved methodologies. These measures allow DOM to monitor the independent evaluator's progress while upholding a conflict-free evaluation process.

Attachment II: Evaluation Budget

We estimate the total cost of the evaluation at $100,800. The staffing, survey tool license fees, and administrative costs are listed in the accompanying table and described below:

Line Item	Components of Budget	Line Item Cost
1	Estimated Cost of Staff	$80,000
2	Estimated administrative and other costs (such as administrative costs and annual telephone survey system licensing fee, etc.)	$20,800
	Total Amount	$100,800

Staffing

Project Director

Dr. Grice, a research professor and the executive director of NSPARC, will have overall responsibility for the evaluation, including developing the evaluation design and data collection instruments, overseeing staff, analyzing claims and survey data, and preparing annual reports. With over 30 years of experience in research and data analysis, Dr. Grice specializes in using data modeling and analytics to drive business intelligence and improve policymaking. He has secured over $130 million in research funding, serves as the Director of Mississippi's SLDS, and is the lead scientist for Mississippi Business Intelligence Research. Dr. Grice holds a Ph.D. in Sociology from Mississippi State University.

Associate Project Director

Dr. Taquino, a research professor and the deputy executive director for research and data analytics at NSPARC, will guide the evaluation design and data collection instruments, assist with data analysis, and conceptualize results for the annual report. With over 25 years of experience in social and economic impact research, labor market analysis, and workforce program evaluation, Dr. Taquino leads NSPARC's team of research scientists and data activities. He holds a Ph.D. in Sociology from Mississippi State University.

Statistical Analyst

Dr. Tang, associate director of research and applied science, and Dr. Wang, research project manager, will manage data cleaning and analysis for enrollment, claims, and survey data. Dr. Tang has extensive expertise in data-driven decision-making, predictive modeling, and machine learning, with advanced degrees in Statistics, Accounting, and Geography. Dr. Wang, holding a Ph.D. in Economic Analysis and Policy from Tulane University, specializes in program evaluation using

advanced analytical methodologies. Both bring over a decade of experience in statistical analysis and data management.

Dissemination/Special Project Coordinator

Dr. Wang will coordinate survey administration, prepare protocols for review, and assist in preparing annual reports. With a successful track record of evaluation projects for organizations like MDES and Mississippi DOM, she brings expertise in survey administration, data analysis, and report preparation, supported by five years of project coordination experience.

Telephone Survey Implementation Staff

The independent evaluation team is composed of highly experienced professionals with expertise in designing, developing, testing, and conducting telephone surveys. The team will utilize Voxco, a professional telephone survey platform, which will be operated under a one-time paid license to ensure seamless survey administration. Adhering to industry best practices, the team will uphold data integrity, reliability, and respondent confidentiality throughout the survey process.

Once data collection is complete, data analysts will systematically process survey responses, converting them into structured datasets for analysis. The responses will be evaluated alongside quantitative findings, and the results will be synthesized into a written report that provide a comprehensive evaluation of the effectiveness of the HMW program.

Attachment III: Timeline and Major Milestones

Deliverable	Timeline	Projection Submission Date
Annual Monitoring Report	Within 180 days following the end of each demonstration year since DY21	March 29, 2025-2028
Draft Evaluation Design Plan	Within 180 calendar days after demonstration approval	March 23, 2025
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	Pending CMS Comment Period
Draft Interim Evaluation Report	Within one year prior to the end of the demonstration or with submission of a demonstration extension request	September 30, 2028
Revised Interim Evaluation Report	Within 60 calendar days following receipt of CMS comments on the Draft Interim Evaluation Report	Pending CMS Comment Period
Summative Evaluation Report	Within 18 months following the end of the demonstration approval period identified in these STCs	March 31, 2031
Revised Summative Evaluation Report	Within 60 calendar days after receipt of CMS comments on the Draft Summative Evaluation Report	Pending CMS Comment Period

Attachment IV: Survey Script for the First Survey

[Introductory Script]

Hello, may I speak with **(Beneficiary Name)?**

(If available, proceed. If not, ask:)

Is there a better time that I can call back to get in touch with **(Beneficiary Name)**?

My name is **(Interviewer First Name).** We are conducting a short survey on behalf of Mississippi Medicaid about services received through the Healthier Mississippi Waiver.

Our records show you enrolled in the Healthier Mississippi Waiver program within the past year. Is this correct?

(If Yes, Proceed. If No, Thank you for your time.)

I would like to ask you some questions about the services you received. This survey is voluntary, will only take about 5 minutes, and your responses are confidential. Would you be willing to take this survey?

(If Yes, Proceed to the First Question. If No, Thank you for your time.)

[Survey Questions]

- For first question, I would like you to rank your satisfaction with the services received on a scale of 1 to 5, with 1 being very dissatisfied and 5 being very satisfied.

  Overall, how satisfied are you with the healthcare services covered by the Healthier Mississippi Waiver program?

- For the next question, I would like you to answer either better, worse, or the same.

  Do you think having access to Medicaid made your health:

  (a)better,
  (b)worse, or
  (c)the same?

- For next questions, please answer Yes or No.

  Have you seen a doctor in the past 12 months?

Have you had any problems seeing a doctor or other health care provider through the Healthier Mississippi Waiver program?

(If No, Proceed to the Next Question. If Yes, ask:)

Have you faced any challenges related to

- **Transportation?**
- **Trouble scheduling an appointment?**
- **Other?**

(If Other, ask:)

please specify.

- For the next question, please answer Yes or No if you have had any of the following screenings or tests in the last 12 month:
  - **Mammogram (Yes/No)**
  - **Colon cancer screening (Yes/No)**
  - **Cervical cancer screening (Yes/No)**
  - **Diabetes screenings (HbA1c test, dilated eye exam) (Yes/No)**

(If No for any of them, ask:)

For the preceding screenings or tests that you did not have, was the main reason related to:

- **Transportation?**
- **Not knowing it was needed?**
- **Not knowing it was covered?**
- **Trouble scheduling an appointment?**
- **Other?**

(If Other, ask:)

please specify.

- For the last question**,** please answer Yes or No if you think any of them following would make this program more helpful for you:
  - **Easier way to schedule appointments**
  - **Easier access to specialists**
  - **Help with transportation to appointments**
  - **Telehealth visits**
  - **A simpler, easier way to use website**
  - **Better Communication or clearer information (transparency)**

[Closing Statement]

Thank you so much for your time and valuable feedback. Have a great day!

Attachment V: Estimated Timeline for Conducting a Telephone Survey

Activity	Month 1	Month 2	Month 3	Month 4	Month 5
Plan and Preparation					
Design and develop survey information to be included in the welcome mail package for new enrollees.					
Begin distributing welcome mail packages containing survey details.					
Finalize survey questions and script to ensure clarity					
Prepare enrollment and claims data to identify the survey population.					
Process and analyze data to determine eligible survey participants (HMW beneficiaries enrolled for at least 12 months at the time of data processing).					
Compile contact phone numbers for identified survey populations.					
Randomly select survey participants from the identified survey population within each region					
Survey Implementation					
Obtain access to Voxco, a professional telephone survey tool					
Integrate survey questions into the Voxco Telephone Survey Tool					
Conduct test deployment to ensure survey functionality and reliability.					
Train survey interviewers on proper survey administration techniques, including maintaining neutrality and ensuring data integrity					
Launch the telephone survey and monitor progress					
Conduct follow-up outreach to maximize response rates					
Survey Response Processing and Analysis					
Convert survey responses into structured datasets					
Process and analyze survey responses					
Reporting and Integration					
Create a written report that synthesize findings and analyzes the results of the survey					
Integrate survey findings into the annual evaluation report					

Attachment VI: Baselines of Healthier Mississippi Waiver

Table VI-1: Hospitalization Rates of All HMW Beneficiaries in DY20

	# of Beneficiaries	# of Beneficiaries with Hospitalizations	Hospitalization Rate
Statewide	9,784	837	8.6%
By Region			
Central	2,984	280	9.4%
Delta	1,045	52	5.0%
North	2,435	178	7.3%
South	3,320	327	9.8%

Data Sources: HMW Membership data, extracted in November 2024; Hospitalization data, extracted in November 2025.

Table VI-2: Ambulatory/Preventive Health Visit Rates of All HMW Beneficiaries in DY20

	# of Beneficiaries	# of Beneficiaries with Ambulatory/Preventive Health Visits	Ambulatory/Preventive Health Visit Rate
Statewide	9,784	6,089	62.3%
By Region			
Central	2,984	1,746	58.5%
Delta	1,045	610	58.4%
North	2,435	1,610	66.1%
South	3,320	2,123	63.9%

Data Sources: HMW Membership data, extracted in November 2024; Ambulatory/preventive health visit data, extracted in November 2025.

Table VI-3: Average Ambulatory/Preventive Health Visits Per HMW Beneficiaries in DY20

	# of Beneficiaries	Total Ambulatory/Preventive Health Visit	Average Ambulatory/Preventive Health Visit
Statewide	9,784	31,577	3
By Age			
<18	62	142	2
18-44	1,761	5,093	3
45-64	6,388	24,308	4
65-75	1,534	1,969	1
>75	39	65	2
By Region			
Central	2,984	8,681	3
Delta	1,045	2,698	3
North	2,435	8,289	3
South	3,320	11,909	4

Data Sources: HMW Membership data, extracted in November 2024; Ambulatory/preventive health visits data, extracted in November 2025.

Table VI-4: Cervical Cancer Screening Rate among HMW Beneficiaries Aged 21-64 in DY20

	# of Beneficiaries	# of Beneficiaries with Cervical Cancer Screenings	Cervical Cancer Screening Rate
Statewide	4,303	182	4.2%
By Age			
21-29	174	8	4.6%
30-64	4,129	174	4.2%
By Region			
Central	1,237	55	4.4%
Delta	492	24	4.9%
North	1,125	40	3.6%
South	1,449	63	4.3%

Note: Beneficiaries receiving hospice care are excluded.
Data Sources: HMW Membership data, extracted in November 2024; Cervical cancer screening data, extracted in November 2025.

Table VI-5: Breast Cancer Screening Rates among HMW Beneficiaries Aged 50-74 in DY20

	# of Beneficiaries	# of Beneficiaries with Breast Cancer Screenings	Breast Cancer Screening Rate
Statewide	3,846	663	17.2%
By Age			
50-64	3,498	659	18.8%
65-74	348	4	1.1%
By Region			
Central	1,073	182	17.0%
Delta	474	85	17.9%
North	961	151	15.7%
South	1,338	245	18.3%

Data Sources: HMW Membership data, extracted in November 2024; Breast cancer screening data, extracted in November 2025.

Table VI-6: Colorectal Cancer Screening Rate among HMW Beneficiaries Aged 45-75 in DY20

	# of Beneficiaries	# of Beneficiaries with Colorectal Cancer Screenings	Colorectal Cancer Screening Rate
Statewide	7,747	298	3.9%
By Age			
45-64	6,629	298	4.5%
65-75	1,118	0	0.0%
By Region			
Central	2,292	92	4.0%
Delta	887	26	2.9%
North	1,914	77	4.0%
South	2,654	103	3.9%

Note: Beneficiaries receiving hospice care are excluded.
Data Sources: HMW Membership data, extracted in November 2024; Colorectal cancer screening data, extracted in November 2025.

Table VI-7: HMW Beneficiaries Aged 18 to 75 with Diabetes Receiving Hemoglobin A1c (HbA1c) Tests in DY20

	# of Beneficiaries	# of Beneficiaries Receiving HbA1c Tests	% of Beneficiaries Receiving HbA1c Tests
Statewide	3,272	1,193	36.5%
By Gender			
Female	1,966	761	38.7%
Male	1,306	432	33.1%
By Race			
Black	1,910	638	33.4%
White	1,180	487	41.3%
Others	182	68	37.4%
By Region			
Central	961	343	35.7%
Delta	394	127	32.2%
North	836	327	39.1%
South	1,081	396	36.6%

Note: Beneficiaries receiving hospice care are excluded.
Data Sources: HMW Membership data and HbA1c test data, extracted in November 2024.

Table VI-8: HMW Beneficiaries Aged 18 to 75 with Diabetes Receiving Eye Examinations in DY20

	# of Beneficiaries	# of Beneficiaries Receiving Eye Exams	% of Beneficiaries Receiving Eye Exams
Statewide	3,272	444	13.6%
By Gender			
Female	1,966	293	14.9%
Male	1,306	151	11.6%
By Race			
Black	1,910	276	14.5%
White	1,180	138	11.7%
Others	182	30	16.5%
By Region			
Central	961	130	13.5%
Delta	394	49	12.4%
North	836	131	15.7%
South	1,081	134	12.4%

Note: Beneficiaries receiving hospice care are excluded.
Data Sources: HMW Membership data and eye examination data, extracted in November 2024.

Table VI-9: Hospitalization Rate and Ambulatory/Preventive Healthcare Visit Rate Among HMW Beneficiaries Who Enrolled in Two Demonstration Years (DY19-DY20)

	Average Per Year in DY19	Average Per Year in DY20	% Change from DY19 to DY20
# of Hospitalizations	0.4	0.5	-63.7%
# of Ambulatory/Preventive Healthcare Visits	1,966	293	14.9%

Note: The average per year value is calculated by multiplying the average per month value by 12.
Data Sources: HMW Membership data, extracted in November 2024; Hospitalization and ambulatory/preventive healthcare visit data, extracted in November 2025.

Table VI-10. Preventive Cancer Screening Rates and Diabetic Testing Rates Among HMW Beneficiaries Enrolled in Two Demonstration Years (DY19–DY20)

	Rates in DY19	Rates in DY20	Changes in Rate from DY19 to DY20
Cervical Cancer Screening	5.6%	7.6%	2%
Colorectal Cancer Screening	5.1%	9.1%	4%
A1c (HbA1c) Test	39.9%	60.7%	20.8%
Eye Examination	18.1%	25.6%	7.5%

Data Sources: HMW Membership data, extracted in November 2024; Preventive cancer screening and diabetic test data, extracted in November 2025.

Table VI-11. Hospitalization Rates with and without Prior Ambulatory/Preventive Healthcare Visits Among HMW Beneficiaries Enrolled in DY20 for at Least Six Months

	Number of Beneficiaries	Number of Beneficiaries with Hospitalizations	Hospitalization Rate
Total Beneficiaries Enrolled for at Least 6 Months	5,064	7.6%	11.9%
With Prior Ambulatory/Preventive Healthcare Visit	3,564	468	13.1%
Without Prior Ambulatory/Preventive Healthcare Visit	1,500	133	8.9%

Data Sources: HMW Membership data, extracted in November 2024; Hospitalization and ambulatory/preventive healthcare visit data, extracted in November 2025.

Table VI-12. FFS Expenditure Per Beneficiary Per Month (PBPM)

	Total FFS Expenditure	Total Enrolled Months	Average Expenditure (PBPM)
DY 20	$64,579,260	67,456	$957

Data Sources: HMW Membership data, extracted in November 2024; HMW FFS expenditure, provided by MDOM in November 2025.