State of New Hampshire
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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JEFFREY A. MEYERS
COMMISSIONER

December 28, 2018

Governor Christopher T. Sununu
State House, Room 208
107 North Main Street
Concord, New Hampshire 03301

Senate President Donna M. Soucy
State House, Room 302
107 North Main Street
Concord, New Hampshire 03301

Speaker of the House Steven Shurtleff
State House, Room 311
107 North Main Street
Concord, New Hampshire 03301

Re: Federal Approval of Granite Advantage Health Care Program Waiver

Dear Governor Sununu, President Soucy and Speaker Shurtleff:

In accordance with the provisions of 2018 Laws Chap. 342:1 (codified at RSA 126-AA:2, IV), I am writing to report on the differences between the terms of Senate Bill 313 and the waiver approved by the Centers for Medicare and Medicaid Services (CMS) on November 30, 2018 for the Granite Advantage Health Care Program (Waiver No. 11-W-00298/1).

The differences in language from the provisions of Senate Bill 313 that are highlighted below are not, in our judgment, attempts to vary from the legislative intent or to make the program more restrictive in any manner. Rather, the very few differences in language resulted from CMS's desire either to address issues that have been raised in litigation in other states, or to facilitate beneficiary compliance. I am most willing to meet with you and to appear before the legislature at your earliest convenience to address the waiver and to respond to your questions.

A copy of the approved waiver is enclosed for your convenience.

In approving the Granite Advantage Health Care Program, CMS waived three requirements of the Social Security Act of 1933, et seq., as follows:

1. Retroactive Eligibility — Section 1902(a)(10) and Section(a)(34)

To the extent necessary to enable the state not to provide medical coverage for any month prior to the month in which an affected beneficiary's Medicaid application is filed as specified in these STCs. The waiver of retroactive eligibility applies to beneficiaries described in STC 16 and does not apply to the following beneficiaries who would have been eligible in or after the third month before the month in which an application was made: pregnant women (including women during the 60-day period beginning on the last day of a pregnancy), infants under age 1 and children under age 19 (described in section 1902(l)(4) of the Act), parents and caretaker relatives, and individuals eligible in aged, blind, or disabled eligibility groups (including those who are applying for a long-term care determination). Coverage for affected beneficiaries will be effective as of the date of application.

2. Provision of Medical Assistance — Section 1902(a)(8) and Section 1902(a)(10)

To the extent necessary to enable New Hampshire to suspend or terminate eligibility for, and not make medical assistance available to, Granite Advantage beneficiaries who fail to comply with community engagement requirements, as described in these STCs, unless the beneficiary is exempted, or demonstrates good cause, as described in the STCs.

3. Eligibility — Section 1902(a)(10)

To the extent necessary to enable New Hampshire to require community engagement as a condition of continued eligibility as described in these STCs.

Although not specifically addressed in the Special Terms and Conditions (STCs) of the waiver approval, CMS declined to approve the provisions of RSA 126-AA:2, II(a)(1) and II(b) with respect to the reporting of assets in conjunction with determining eligibility, and also declined to approve the provisions of RSA 126-AA:2, V and VI, pertaining to, respectively, verification of citizenship by certain forms of identification and submission of information to the National Instant Criminal Background Check System. Thus, the waiver reflects federal law, which provides that beneficiaries must either be citizens of the United States or certain qualified non-citizens, such as lawful permanent residents.

Additionally, CMS made certain modifications to the provisions of the work and community engagement requirement as enacted in Senate Bill 313 and added a number of provisions related to state assurances, monitoring, reporting and further public oversight of the program that were not explicitly reflected in Senate Bill 313. All of these additions are intended to expand and not restrict a beneficiary's ability to comply, as well as to add new transparency and public input requirements.

Implementation Date and Further Public Review:

- STC 18 added the requirement that the state provide CMS with no less than 30 days prior notice before implanting the work requirement;
- STC 34 added a requirement that within 6 months of the implementation date, and annually thereafter, the state shall afford the public a meaningful opportunity to comment on the progress of the demonstration. This further public hearing and comment applies to every aspect of the waiver, including the work and community engagement requirement.

These changes will only ensure further public input and review of the implementation of the waiver.

Modification to Qualifying Activities:

- RSA 126-AA:2(III)(a)(2)(5) was amended to allow job skills training at any accredited college and university by deleting the limitation to New Hampshire specific institutions;
- RSA 126-AA:2(III)(a)(2)(6) was amended to delete the last sentence of that subparagraph, which allowed such activities to be credited on an hourly basis.
- RSA 126-AA:2(III)(a)(2)(9) was amended to delete the word "satisfactory" in order to permit any and all attendance at a secondary school;
- RSA 16-AA:2(III)(a)(2)(10) was amended to make clear that both community service and public service were qualifying activities, not one or the other; and
- Participation in a SNAP or TANF work activity was added as a qualifying activity consistent with RSA 126-AA(III)(d)(8), which provides that a person in compliance with a SNAP or TANF work requirement was exempt from the Granite Advantage Work and Community Engagement Requirement.

Each of these changes are intended to broaden the applicability of the qualifying activity and in important respects removes restrictions and limitations toward using the activity.

Verification of Compliance with Hours and Exemptions:

- Where Senate Bill 313 provides that enrollee status be verified initially "to the extent practicable" through the eligibility file and MCO reported information, STC 21 provided that beneficiaries, on a monthly basis:

(1) verify information regarding the beneficiary's compliance with or exemption from the community engagement requirements that the state has obtained from available data sources (see STC 24(c)); or (2) in cases where the state is unable to obtain compliance or exemption information from available data sources, self-attest to their compliance with or their qualification for an exemption from the community engagement requirements. Beneficiaries will be able to verify or document their compliance or exemption status using the options described in 42 CFR 435.907(a) for the submission of an application. Beneficiaries may also be required to provide appropriate supporting documentation when requested by the state, consistent with 42 CFR 435.952.

- Verification of compliance is also addressed in STC 24c. Similarly, to STC 21, the pertinent part of this paragraph states that "[i]n cases where the state cannot locate data through available systems and data sources, the state shall ensure that beneficiaries can attest to compliance with, or qualification for an exemption from, the community engagement requirements in STC 20 in a manner consistent with 42 CFR 435.945." The cited federal regulation is the long standing standard governing compliance with Medicaid eligibility. Thus, under the waiver, New Hampshire must allow beneficiaries to self-attest to their compliance with the work and community engagement requirement in the same manner they may attest to eligibility requirements.

The most significant impact of these changes is to establish that the state must accept self-attestation with respect to both qualifying activities and exemptions to the extent that the state does not have exiting sources from which to verify those activities and exemptions. In other words, self-attestation of employment must be honored.

Carry Over Hours and Opportunity to Cure:

- Senate Bill 313 contains no provision addressing the carry-over of surplus hours (more than 100 in any month) to another month. The CMS waivers issued to Kentucky and Indiana contain language prohibiting the carry-over of hours month to month that is nearly identical to the language in STC 21b in New Hampshire's waiver. The language contained in waivers issued to Wisconsin and Arkansas do not address the carry-over issue directly but contain other language providing that the required number of hours be accrued monthly.

- Senate Bill 313 contains a single reference to the opportunity to cure in what is now codified at RSA126-AA:2(III)(e)(4), namely that the rules adopted by the Department provide for "opportunity to cure and re-activation following non-compliance, including not being barred from re-enrollment. Opportunity to Cure is addressed in STC 22b and STC 22c. The language of STC 22b was the product of extensive discussion between the Department and CMS staff. This language permits a beneficiary to maintain

coverage in the program as long as the beneficiary, at a minimum, cures a deficiency from the prior month through any combination of qualifying activities and exemptions.

- The limitation on the repeated consecutive use of the opportunity to cure contained in STC 22c only limits the beneficiary from using this consecutive curing method to maintain coverage beginning in May 2020 and only if the beneficiary utilizes this method of curing for all 12 months of their coverage year (based upon their redetermination date).

Senate Bill 313 did not address the carry-over of surplus hours to a subsequent month. To our knowledge and review of other waivers, CMS has to date not authorized such a provision in any work and community engagement waiver.

Additional Provisions of the Special Terms and Conditions:

- STCs 24 through 48 of the waiver provide for numerous state assurances, monitoring and evaluation of the waiver and reporting requirements. These will have no negative impact on beneficiaries.

- The state assurances in STC 24, in particular, provide for extensive outreach and education of beneficiaries and impose numerous requirements on the state in order to facilitate compliance. These provisions expand transparency and accountability. Some of these provisions are highlighted below:

  - Ensure that there are processes and procedures in place to seek data regarding beneficiary participation in qualifying community engagement activities and data that indicate that the beneficiary may qualify for an exemption from the community engagement requirement from other sources, including but not limited to, SNAP and TANF, and ensure that the state uses available systems and data sources to verify that beneficiaries are meeting the community engagement requirements or are exempt from the requirement. In cases where the state cannot locate data through available systems and data sources, the state shall ensure that beneficiaries can attest to compliance with, or qualification for an exemption from, the community engagement requirements in STC 20 in a manner consistent with 42 CFR 435.945.

  - Ensure that specific activities that may be used to satisfy community engagement requirements and specific activities that would allow beneficiaries to cure an impending eligibility suspension (as described in STC 20) are available during a range of times and through a variety of means (e.g. online, in person) at no cost to the beneficiary.

- Conduct active outreach and education beyond standard noticing for Granite Advantage beneficiaries for successful compliance with community engagement requirement as beneficiaries move toward self-sufficiency and economic security.

- Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements.

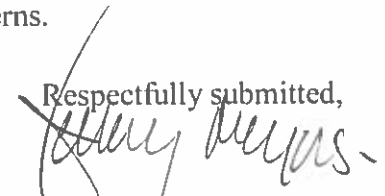
- Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be impossible or unreasonably burdensome for beneficiaries to meet.

- Assure that suspension, disenrollment, or termination of eligibility will only occur after an individual has been fairly screened and determined ineligible for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 42 CFR 435.916(f).

The Department will implement the work and community engagement requirement beginning on March1, 2019 consistent with all of the noticing requirements of the waiver. I will be separately submitting a report on the resources and components needed for an automated verification system to track the work and community engagement requirement.

To the extent that the Senate and the House have concerns about implementation based upon the provisions of the waiver and the Department's announced plan for implementation, then I welcome the opportunity to address those concerns.

Respectfully submitted,



Jeffrey A. Meyers
Commissioner

Enclosure
cc: Senator Dan Feltes
Senator Chuck Morse
Rep. Dick Hinch
Rep. Douglas Ley

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **11-W-00298/1**

TITLE: **New Hampshire Granite Advantage Health Care Program 1115 Demonstration**

AWARDEE: **New Hampshire Department of Health and Human Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived, shall apply to the demonstration project effective from January 1, 2018 through December 31, 2023. In addition, these waivers may only be implemented consistent with the approved special terms and conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs.

1. Retroactive Eligibility — **Section 1902(a)(10) and Section 1902(a)(34)**

To the extent necessary to enable the state not to provide medical coverage for any month prior to the month in which an affected beneficiary's Medicaid application is filed as specified in these STCs. The waiver of retroactive eligibility applies to beneficiaries described in STC 16 and does not apply to the following beneficiaries who would have been eligible in or after the third month before the month in which an application was made: pregnant women (including women during the 60-day period beginning on the last day of a pregnancy), infants under age 1 and children under age 19 (described in section 1902(l)(4) of the Act), parents and caretaker relatives, and individuals eligible in aged, blind, or disabled eligibility groups (including those who are applying for a long-term care determination). Coverage for affected beneficiaries will be effective as of the date of application.

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

To the extent necessary to enable New Hampshire to suspend or terminate eligibility for, and not make medical assistance available to, Granite Advantage beneficiaries who fail to comply with community engagement requirements, as described in these STCs, unless the beneficiary is exempted, or demonstrates good cause, as described in the STCs.

3. Eligibility — **Section 1902(a)(10)**

To the extent necessary to enable New Hampshire to require community engagement as a condition of continued eligibility as described in these STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00298/1

TITLE: New Hampshire Granite Advantage Health Care Program

AWARDEE: New Hampshire Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the "New Hampshire Granite Advantage Health Care Program" (Granite Advantage) section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the State of New Hampshire (hereinafter state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act) which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. The New Hampshire Granite Advantage Health Care Program demonstration will be statewide and is approved for a 5-year period, from January 1, 2019 through December 31, 2023, with implementation of the community engagement requirements no sooner than January 1, 2019.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description And Objectives
III. General Program Requirements
IV. Eligibility
V. Community Engagement Requirements
VI. General Reporting Requirements
VII. Monitoring Calls and Discussions
VIII. General Financial Requirements
IX. Monitoring Budget Neutrality
X. Evaluation of the Demonstration

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Evaluation Report
Attachment C: Evaluation Design (reserved)
Attachment D: Implementation Plan (reserved)
Attachment E: Monitoring Protocol (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

The demonstration affects individuals in the new adult group covered under Title XIX of the Social Security Act, section 1902(a)(10)(A)(i)(VIII), who are adults from age 19 up to and including age 64 with incomes up to and including 133 percent of the federal poverty level (FPL), and who are not enrolled in (or eligible for) Medicare.

Through the demonstration, until December 31, 2018, the state used a premium assistance model to support the purchase of coverage by beneficiaries eligible under the new adult group provided by certain qualified health plans (QHPs) doing business in the individual market through the Health Insurance Exchange operating in the state. As of October 2018, the demonstration provided coverage to approximately 51,000 beneficiaries who, through this date, were enrolled in an Exchange QHP as authorized under the demonstration project. Beneficiaries received the state plan Alternative Benefit Plan (ABP) and had cost sharing obligations consistent with the state plan. The ABP was the same benchmark plan chosen by New Hampshire to establish Essential Health Benefits.

With this extension, beginning January 1, 2019, the state will eliminate its premium assistance program under the demonstration. Granite Advantage beneficiaries will transition to the state's Medicaid Care Management (MCM) delivery system, and non-exempt beneficiaries will be mandatorily enrolled into managed care organizations (MCOs), effective January 1, 2019, pursuant to authority in the state plan, and for relevant populations, the State approved 1915(b) waiver. In addition, the state has aligned its state plan benefit package with the Alternative Benefit Plan (ABP) for the new adult group. Since benefits are aligned between the ABP and the state plan, the state will no longer give medically frail beneficiaries in the new adult group the option of selecting between ABP and state plan benefits. The state will continue to identify medically frail individuals for purposes of exempting them from the community engagement requirements under this demonstration, consistent with these STCs.

Beginning January 1, 2019, the state is discontinuing the cost-sharing schedule for beneficiaries in the new adult group with incomes over 100 percent of the FPL. Instead, Granite Advantage will implement the state plan copayment schedule for all beneficiaries subject to cost sharing, which currently applies only to pharmaceuticals. American Indians/Alaska Natives receiving services through Indian Health Service, Tribal, or urban Indian organization (I/T/U) facilities will remain exempt from copayments.

Also beginning no sooner than January 1, 2019, the state will test an approach to promoting community engagement and work by instituting community engagement requirements as a condition of Granite Advantage eligibility. Once community engagement requirements are fully implemented, the state will ensure that beneficiaries have been adequately notified of the requirements. New Hampshire will also provide reasonable accommodations for beneficiaries with disabilities who need them. Granite Advantage beneficiaries in the new adult group must work or engage in other specified activities, including vocational educational training, job training, or job search activities, for at least 100 hours per month to maintain eligibility for coverage in the new adult group, unless they meet exemption criteria established by the state or demonstrate good cause for failing to meet the community engagement requirements, as described in these STCs. If Granite Advantage beneficiaries fail to meet these requirements for

two consecutive months, their Medicaid eligibility will be suspended. In addition, written notices will provide information on resources available to beneficiaries who may require assistance completing community engagement activities.

III. GENERAL PROGRAM REQUIREMENTS

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

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

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

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

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

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

in effect under federal law, whichever is sooner.

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

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

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

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

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

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

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

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

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

   a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

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

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

   d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration

requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

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

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

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

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

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

b. Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a

different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider comments received during the 30-day period during its review of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) calendar days after CMS approval of the demonstration authority expiration plan.

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

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

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

13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request.

    The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved

Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

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

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

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

IV. ELIGIBILITY

16. **Populations Affected by the Demonstration.** The Granite Advantage Demonstration affects the coverage for adults aged 19 through 64 in the new adult group, eligible under the state plan consistent with section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR section 435.119. Eligibility and coverage for these individuals are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except to the extent expressly waived. Implementation of such waiver authority must be consistent with these STCs. Any Medicaid state plan amendments to this eligibility group will apply to this demonstration.

Medicaid State Plan Mandatory Groups	Federal Poverty Level	Funding Stream	Expenditure and Eligibility Group Reporting
Adults in Section 1902(a)(10)(A)(i)(VIII) Group	Adults at or below 133 percent FPL.	Title XIX	MEG – 1

17. **Retroactive Coverage.** The state will not provide medical coverage to adults under the demonstration for any month prior to the month in which a beneficiary's Medicaid application is filed, except for a pregnant woman (including during the 60-day period beginning on the last day of the pregnancy), an infant under age 1, a child under age 19, a parent or caretaker relative, or an individual eligible in aged, blind, or disabled eligibility

groups (including those who are applying for a long-term care determination). The state assures that it will provide outreach and education about how to apply for and receive Medicaid coverage and the importance of maintaining coverage when well and receiving regular preventative services. Outreach and education will be provided to the public and to Medicaid providers, particularly those who serve vulnerable populations that may be impacted by the retroactive eligibility waiver.

V. COMMUNITY ENGAGEMENT REQUIREMENTS

18. **Overview.** Subject to these STCs, the state will implement a community engagement requirements as a condition of eligibility for Granite Advantage beneficiaries, unless they are exempt as described in STC 19, or unless they demonstrate good cause as described in STC 22(a). To maintain Medicaid eligibility, non-exempt members will be required to participate in specified activities that may include employment, education, or community service, as specified in these STCs. The community engagement requirements will be implemented no sooner than January 1, 2019, and the state will provide CMS with notice 30 days prior to its implementation.

19. **Exempt Populations.** The following Granite Advantage beneficiaries are exempt from the community engagement requirements:
    - Beneficiaries who are temporarily unable to participate due to illness or incapacity as documented by a licensed provider;
    - Beneficiaries who are participating in a state-certified drug court program;
    - Beneficiaries who are a parent or caretaker where care of a dependent is considered necessary by a licensed provider;
    - Beneficiaries who are a custodial parent or caretaker of a dependent child under 6 years of age (only applies to one parent or caretaker in case of a 2-parent household);
    - Beneficiaries who are a parent or caretaker of a dependent child of any age with a disability (only applies to one parent or caretaker in the case of a 2-parent household);
    - Beneficiaries who are pregnant or 60 days or less post-partum;
    - Beneficiaries identified as medically frail;
    - Beneficiaries with a disability as defined by the ADA, Section 504, or Section 1557, who are unable to comply with the requirements due to disability-related reasons;
    - Beneficiaries residing with an immediate family member who has a disability as defined by the ADA, Section 504, or Section 1557, who are unable to meet the requirement for reasons related to the disability of that family member;
    - Beneficiaries who experience a hospitalization or serious illness;
    - Beneficiaries residing with an immediate family member who experiences a hospitalization or serious illness;
    - Beneficiaries who are exempt from Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements; or
    - Beneficiaries who are enrolled in New Hampshire's voluntary Health Insurance Premium Program (HIPP).

    Beneficiaries meeting one or more of the above listed exemptions will not be required to

complete community engagement qualifying activities to maintain eligibility.

20. **Qualifying Activities.** Beneficiaries without an exemption must document their participation in any one or a combination of qualifying activities by attesting to compliance with the community engagement requirements and reporting applicable changes in circumstances in accordance with 42 CFR 435.916(c). Granite Advantage beneficiaries may satisfy their community engagement requirements through a variety of activities, including but not limited to:
    - Unsubsidized employment (including by nonprofit organizations);
    - Subsidized private or public sector employment (including by nonprofit organizations);
    - Job skills training related to employment (including on-the-job training);
    - Enrollment at an accredited college or university (including a community college) that is counted on a credit hour basis;
    - Job search and readiness assistance, including but not limited to job training or job search activities that are required in order to receive unemployment benefits; and other job training related services, such as job training workshops and time spent with employment counselors, offered by the State of New Hampshire Employment Security Agency;
    - Vocational educational training not to exceed 12 months;
    - Education directly related to employment, in the case of a recipient who has not received a high school diploma or certificate of high school equivalency;
    - Attendance at a secondary school or in a course of study leading to a certificate of high school equivalency, in the case of a recipient who has not received a high school diploma or certificate of high school equivalency;
    - Participation in substance use disorder treatment;
    - Community service and public service;
    - Caregiving services for a non-dependent relative or other person with a disabling health, mental health, or developmental condition; or
    - Participation in and compliance with Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements.

21. **Hour Requirements.** Beneficiaries without an exemption must participate for at least 100 hours per calendar month in one or more qualifying activities. Beneficiaries will be required to do one of the following on a monthly basis: (1) verify information regarding the beneficiary's compliance with or exemption from the community engagement requirements that the state has obtained from available data sources (see STC 24(c)); or (2) in cases where the state is unable to obtain compliance or exemption information from available data sources, self-attest to their compliance with or their qualification for an exemption from the community engagement requirements. Beneficiaries will be able to verify or document their compliance or exemption status using the options described in 42 CFR 435.907(a) for the submission of an application. Beneficiaries may also be required to provide appropriate supporting documentation when requested by the state, consistent with 42 CFR 435.952.

    a. **Reasonable modifications for people with disabilities.** The state must provide reasonable modifications related to meeting community engagement requirements for

beneficiaries with disabilities protected by the ADA, Section 504, or Section 1557, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the program. The state must also provide reasonable modifications for program protections and procedures, including but not limited to: assistance with demonstrating eligibility for an exemption from community engagement requirements on the basis of disability; assistance with demonstrating good cause; appealing suspensions and disenrollments; documenting and reporting community engagement activities and other documentation requirements; understanding notices and program rules related to community engagement requirements; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable modifications. The reasonable modifications must include exemptions from participation where an individual is unable to participate for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the required number of hours, and provision of support services necessary to participate, where participation is possible with supports. In addition, the state must evaluate individuals' ability to participate and the types of reasonable modifications and supports needed.

b. **Extra Hours.** Beneficiaries will not be permitted to carry extra hours of participation accrued in one month forward to the next month to satisfy community engagement requirements for the later month.

22. **Non-Compliance.** Eligibility will be suspended, effective under the time frame described in this STC 22(b), for beneficiaries who fail to meet required community engagement hours or qualify for an exemption, unless the beneficiary demonstrates that they have good cause for failing to meet the requirement, or appeals the suspension, prior to its effective date.

a. **Good Cause.** The state will not suspend eligibility, if beneficiaries who failed to meet the required community engagement hours demonstrate good cause for the failure based on a circumstance that occurred in the month in which the beneficiary failed to meet their required community engagement hours. Good cause includes, but is not limited to, at a minimum, the following verified circumstances:

i) The beneficiary has a disability protected by the ADA, section 504, or section 1557, and was unable to meet the requirement for reasons related to that disability, but was not exempted from community engagement requirements;

ii) The beneficiary resides with an immediate family member who has a disability protected by the ADA, section 504, or section 1557, and was unable to meet the requirement for reasons related to the disability of that family member, but was not exempted from community engagement requirements;

iii) The beneficiary experiences a hospitalization or serious illness, but was not exempted from community engagement requirements;

iv) The beneficiary resides with an immediate family member who experienced a hospitalization or serious illness, but the beneficiary was not exempted from community engagement requirements;

v) The beneficiary experiences the birth, or death, of a family member residing with the beneficiary;

vi) The beneficiary experiences severe inclement weather (including natural disaster) and therefore was unable to meet the requirement;
vii) The beneficiary has a family emergency or other life-changing event (e.g., divorce or domestic violence);
viii) The beneficiary is a custodial parent or caretaker of a child 6 to 12 years of age who, as determined by the Commissioner of New Hampshire Department of Health and Human Services on a monthly basis, is unable to secure necessary child care to enable the beneficiary to participate in qualifying activities for the required number of hours because of inability to pay (including with the help of any available child care subsidies) or inability to locate a suitable child care provider due to provider capacity, distance, or another factor; or
ix) Other circumstances constituting good cause, as determined by the state.

b. **Opportunity to Cure and Suspension Effective Date.** If a beneficiary fails to comply with community engagement requirements for a month, the state will send a written notice no later than the tenth day of the next month informing the beneficiary that his or her eligibility will be suspended effective the first day of the month after the month in which the notice is sent, unless, before the suspension would take effect, the beneficiary:
i. Demonstrates good cause for the failure;
ii. Demonstrates that he or she qualifies for an exemption; or
iii. Satisfies community engagement requirements by making up the deficient hours for the month that resulted in noncompliance.

For example: if an individual was deficient 50 hours in January and thereby failed to comply with the community engagement requirements, the state would send a notice no later than February 10 documenting the noncompliance in January. This notice would explain the opportunity to cure process to the beneficiary (see STC 22(c)) and would identify the suspension effective date as March 1, if the beneficiary does not cure the noncompliance for January by demonstrating good cause for the noncompliance or that the beneficiary qualifies for an exemption, or by completing the deficient hours, during the month of February. The written notice sent in February must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213.

Continuing the above example, the beneficiary can cure their January noncompliance by making up the deficient 50 hours during the month of February. Only 50 hours are required to cure noncompliance in January, but the beneficiary must complete 100 hours to be compliant for February under the normally applicable requirements. If the beneficiary successfully cures the January noncompliance by completing 100 hours in February, 50 of these 100 hours will be counted to cure the deficient hours for January as well, and the beneficiary's eligibility will not be suspended effective March 1. If the beneficiary only completes 50 hours in February, these hours will be counted first to cure the January deficiency. The beneficiary's eligibility would not be suspended effective March 1 because the January deficiency would have been cured; however, the beneficiary would be noncompliant for failing to complete 100 hours, and would incur a deficiency

of 50 hours for February. In this case, the beneficiary would be sent a notice no later than March 10 identifying the February deficiency and explaining the opportunity to cure so that coverage will not be suspended effective April 1. Note, as provided in STC 22(c), the repeated consecutive use of the opportunity to cure to make up deficient hours for an entire one-year eligibility period is prohibited.

c. **Limitation on the Opportunity to Cure.**
   i. Beginning May 1, 2020, the repeated consecutive use of the opportunity to cure to satisfy community engagement requirements by making up deficient hours for a month during the following month, for an entire one-year eligibility period, is prohibited.
   ii. Beginning May 1, 2020, a beneficiary who engages in the repeated consecutive use of the opportunity to cure for an entire one-year eligibility period will be suspended at redetermination.
   iii. A beneficiary whose eligibility is suspended pursuant to this STC 22(e) may reactivate eligibility pursuant to STC 22(d).

d. **Reactivating Eligibility after Suspension**. The suspension will remain in effect until the beneficiary reactivates eligibility by (1) satisfying the deficiency in community engagement hours for the month that resulted in non-compliance, or in the case of a beneficiary whose coverage is suspended pursuant to STC 22(b), completing at least 100 hours of qualifying community engagement activities, within a single calendar month; (2) meeting the qualifications for an exemption listed at STC 19; (3) demonstrating good cause for the earlier non-compliance as described in subsection (a) (does not apply in the case of a beneficiary whose coverage is suspended pursuant to STC 22(c)); or (4) becoming eligible for Medicaid under an eligibility category that is not subject to the community engagement requirement. Beneficiaries can reactivate eligibility prior to their redetermination date without having to complete a new application, provided that at least one of the above-listed criteria for reactivation is met. Eligibility will be reactivated effective the same day that the state receives information that a beneficiary's has met at least one of the above-listed criteria for reactivation.

e. **Redetermination.** The state will send beneficiaries whose eligibility has been suspended due to failure to meet the community engagement requirements a notice informing them of their upcoming redetermination period and of the consequences of failing to come into compliance with the community engagement requirements during their redetermination period. During redetermination, the state will terminate eligibility for beneficiaries who are not in compliance with the community engagement requirements. Beneficiaries whose eligibility is terminated at redetermination for failure to meet the community engagement requirements can reapply at any time for Medicaid. When a person whose enrollment was terminated at redetermination reapplies, his or her prior noncompliance with the community engagement requirements will not be factored into the state's new eligibility determination.

23. **Notice Period.** All currently enrolled beneficiaries will have 75 calendar days after the start date of the community engagement requirements (no earlier than January 1, 2019) before they must begin to meet the community engagement hours requirement or qualify for an exemption. The state must send a written notice explaining the community engagement requirements, including relevant content as described in Section V of these STCs, to currently enrolled beneficiaries no later than 10 calendar days after the start date of the community engagement requirements. Beneficiaries who are determined eligible after the start date of the community engagement requirements will also have 75 calendar days beginning with the date of their eligibility determination before they must begin to meet the community engagement requirements or qualify for an exemption. The state must send a written notice explaining the community engagement requirements, including relevant content as described in Section V of these STCs to beneficiaries who are determined eligible after the start date of the community engagement requirements within 10 calendar days of the beneficiary's eligibility determination date, and such notice may be included with, or as part of, the beneficiary's eligibility determination notice. Beneficiaries who reapply after their eligibility was terminated at redetermination for failure to meet community engagement requirements will also have 75 calendar days beginning with the date of their eligibility determination before they must begin to meet the community engagement requirements or qualify for an exemption, provided that they have been disenrolled for at least six (6) months. Beneficiaries must begin to meet the community engagement hours requirement or qualify for an exemption beginning with the first full month following any applicable 75-day notice period or, in the case of a beneficiary whose eligibility was terminated at redetermination for failure to meet the community engagement requirements but who has been disenrolled for less than six (6) months, beginning with the first full month following re-enrollment. The state will comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213.

24. **State Assurances.** Prior to implementation of the community engagement requirements as a condition of eligibility, the state shall:

    a. Maintain system capabilities to operationalize the suspension and/or termination of eligibility and the lifting of suspensions of eligibility once community engagement requirements are met.

    b. Maintain mechanisms to stop payments to a managed care organization (MCO) when a beneficiary's eligibility is suspended for failure to comply with the community engagement requirements, and to trigger payment once the suspension is lifted.

    c. Ensure that there are processes and procedures in place to seek data regarding beneficiary participation in qualifying community engagement activities and data that indicate that the beneficiary may qualify for an exemption from the community engagement requirement from other sources, including but not limited to, SNAP and TANF, and ensure that the state uses available systems and data sources to verify that beneficiaries are meeting the community engagement requirements or are exempt from the requirement. In cases where the state cannot locate data through available systems and

data sources, the state shall ensure that beneficiaries can attest to compliance with, or qualification for an exemption from, the community engagement requirements in STC 20 in a manner consistent with 42 CFR 435.945.

d. To the extent that participation in community engagement activities is required by SNAP or TANF, beneficiaries who participate in SNAP and/or TANF and Granite Advantage will have the option of reporting community engagement activities through any of these programs in which the beneficiary is participating. If a beneficiary reports activities through SNAP or TANF, New Hampshire will transfer relevant information from the individual's file to Granite Advantage to satisfy reporting for each applicable program. In accordance with all applicable federal and state reporting requirement for the applicable programs, beneficiaries enrolled in and compliant with, or exempt from, a SNAP or TANF work requirement will be considered to be complying with the Granite Advantage community engagement requirement without further need to report.

e. Ensure that there are timely and adequate beneficiary notices provided in writing, including but not limited to:

   i. When community engagement requirements will commence for that specific beneficiary;

   ii. Whether the beneficiary has already been determined to be exempt from the community engagement requirements, how the beneficiary may apply for and document that he or she meets the requirements for an exemption, and under what conditions an approved the exemption would end;

   iii. The specific number of community engagement hours per month that a beneficiary is required to complete to meet the requirement, and when and how the beneficiary must report participation or qualification for an exemption or demonstrate good cause;

   iv. A list of the specific activities that may be used to satisfy the community engagement requirements and a list of the specific activities that beneficiaries can engage in to cure an impending suspension or termination of eligibility, as described in STC 20;

   v. Information about resources that help connect beneficiaries to opportunities for activities that would meet the community engagement requirements, and information about the community supports that are available to assist beneficiaries in meeting the community engagement requirements;

   vi. Information about how community engagement hours will be counted and documented;

   vii. What circumstances give rise to suspension or disenrollment under this demonstration, including failure to comply with the community engagement requirements; what suspension or disenrollment would mean for the beneficiary,

including how it could affect redetermination; how to avoid suspension or disenrollment, including how to demonstrate good cause for failure to meet the requirement and what kinds of circumstances might give rise to good cause; how to request an exemption; and how to request an eligibility review if the beneficiary believes he or she may qualify for Medicaid in another eligibility group that is not subject to the community engagement requirements;

viii. If a beneficiary is not in compliance for a particular month, that the beneficiary is out of compliance, and how the beneficiary can resume compliance in the month immediately following the month of non-compliance and cure the non-compliance for the applicable month to avoid a suspension of coverage. Such content must include an explanation of the limitation on repeated consecutive use of the opportunity-to-cure period to make up deficient hours for an entire one-year eligibility period, as provided under STC 22(c);

ix. If a beneficiary has eligibility terminated or the beneficiary is disenrolled or has coverage suspended due to failure to meet the community engagement requirements, how to appeal, how to have suspension lifted (if applicable), including the number of community engagement hours that must be performed by the specific beneficiary within a calendar month (if the beneficiary's coverage has been suspended and he or she is not seeking a good cause exception or an exemption), and how to access primary and preventive care while coverage is suspended or terminated;

x. If a beneficiary has sought to demonstrate good cause, whether good cause has been approved or denied, with an explanation of the basis for the decision, applicable appeal rights, and how to appeal a denial.

xi. Any differences in the program requirement that individuals will need to meet in the event they transition off of SNAP or TANF but remain subject to the community engagement requirements of this demonstration.

f. Ensure that specific activities that may be used to satisfy community engagement requirements and specific activities that would allow beneficiaries to cure an impending eligibility suspension (as described in STC 20) are available during a range of times and through a variety of means (e.g. online, in person) at no cost to the beneficiary.

g. Conduct active outreach and education beyond standard noticing for Granite Advantage beneficiaries for successful compliance with community engagement requirement as beneficiaries move toward self-sufficiency and economic security.

h. Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements.

i. Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be impossible or unreasonably burdensome for beneficiaries to meet.

j. Ensure that the state will monitor the application of exemptions to ensure that there is not an impermissibly discriminatory impact.

k. Develop and maintain an ongoing partnership with the New Hampshire Department of Employment Security to assist Granite Advantage beneficiaries with complying with community engagement requirements and moving toward self-sufficiency.

l. Provide full appeal rights, as required under 42 CFR part 431 subpart E, prior to suspension and/or disenrollment and observe all requirements for due process for beneficiaries whose eligibility would be suspended or terminated for failing to meet the community engagement requirements, including allowing beneficiaries the opportunity to raise additional issues in a hearing, in addition to whether the beneficiary should be subject to suspension or termination or provide additional documentation through the appeals process.

m. Maintain timely processing of applications to avoid further delays in accessing benefits once the disenrollment period is over.

n. Assure that suspension, disenrollment, or termination of eligibility will only occur after an individual has been screened and determined ineligible for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 42 CFR 435.916(f).

o. Establish beneficiary protections, including assuring that Granite Advantage beneficiaries do not have to duplicate requirements to maintain access to all public assistance programs that require community engagement and/or employment.

p. With the assistance of other state agencies including the New Hampshire Department of Employment Security and other public and private partners, DHHS will make good faith efforts to screen, identify, and connect Granite Advantage beneficiaries to existing community supports that are available to assist beneficiaries in meeting community engagement requirement, including available non-Medicaid assistance with transportation, child care, language access services and other supports; and make good faith efforts to connect beneficiaries with disabilities protected under the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act with services and supports necessary to enable them to meet community engagement requirements, including any applicable reporting requirements.

q. Comply with protections for beneficiaries with disabilities under ADA, Section 504, or Section 1557.

r. Assess whether people with disabilities have limited job or other opportunities for reasons related to their disabilities, and if such barriers exist for people with disabilities, address these barriers.

s. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications related to meeting community engagement requirements.

t. Maintain a system for providing reasonable modifications related to meeting the community engagement requirement to beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act.

u. Provide each beneficiary who has been disenrolled from Granite Advantage or whose coverage has been suspended with information on how to access primary care and preventative care services at low or no cost to the individual. This material will include information about free health clinics and community health centers including clinics that provide behavioral health and substance use disorder services. New Hampshire shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries whose eligibility has been suspended or terminated.

v. Submit an Implementation Plan that adheres to the provisions of STC 28 no later than 90 calendar days after approval of the demonstration. CMS will work with the state if we determine changes are necessary to the state's submission, or if issues are identified as part of the review. Once approved, the Implementation Plan will be incorporated into the STCs as Attachment D. The state will provide status updates on the implementation of the Implementation Plan in the quarterly reports. Should the state wish to make changes to the Community Engagement Implementation Plan, the state must submit a revised plan to CMS for review and approval.

VI. GENERAL REPORTING REQUIREMENTS

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

CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.
The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted because it was inconsistent with the requirements of this agreement with respect to the required contents of the deliverable:

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

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process will be provided. CMS may agree to accept 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 action plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of 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 with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

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

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

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

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

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

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

28. **Implementation Plan.** The state must submit an Implementation Plan to CMS no later than 90 calendar days after approval of the demonstration. The Implementation Plan must cover at least the key policies being tested under this demonstration, including community engagement, and the waiver of retroactive eligibility. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment D. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the Implementation Plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

29. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment E.

    At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 30(b) below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to community engagement and the waiver of retroactive eligibility. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates as described in STC 30(a) below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

30. **Monitoring Reports.** The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within

the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

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

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS' framework which includes the following key policies under this demonstration – community engagement and the waiver of retroactive eligibility. The performance metrics will also reflect all components of the state's demonstration. For example, these metrics will cover enrollment, disenrollment, or suspension by specific demographics and reason, participation in community engagement qualifying activities, access to care, and health outcomes.

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

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

c. Financial Reporting Requirement. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this

demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

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

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

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

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

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

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

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

e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 25.

VII. MONITORING CALLS AND POST-AWARD FORUM

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

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

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

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

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

VIII. GENERAL FINANCIAL REQUIREMENT

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

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

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

X. EVALUATION OF THE DEMONSTRATION

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

administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 25.

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

39. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after approval of the demonstration.

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

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

    a. All applicable Evaluation Design guidance, including guidance about community engagement and the waiver of retroactive eligibility. Community engagement hypotheses will include (but not be limited to): effects on enrollment and continuity of enrollment; and effects on employment levels, income, transition to commercial health insurance, health outcomes, and Medicaid program sustainability. Hypotheses for the waiver of retroactive eligibility will include (but not be limited to): the effects of the waiver on enrollment and eligibility continuity (including for different subgroups of individuals, such as individuals who are healthy, individuals with complex medical needs, prospective applicants, and existing beneficiaries in different care settings). Hypotheses applicable to the demonstration as a whole, and to all key policies referenced above, will include (but will not be limited to): the effects of the demonstration on health outcomes; the financial impact of the demonstration (for example, such as an assessment of medical debt and uncompensated care costs); and the effect of the demonstration on Medicaid program sustainability.

    b. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.

40. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon

CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval.

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

42. **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.

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

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

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

    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If

the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

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

44. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

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

    b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

45. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

46. **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.

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

48. **Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles),

by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

Attachment A
Developing the Evaluation Design

Introduction

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

Expectations for Evaluation Designs

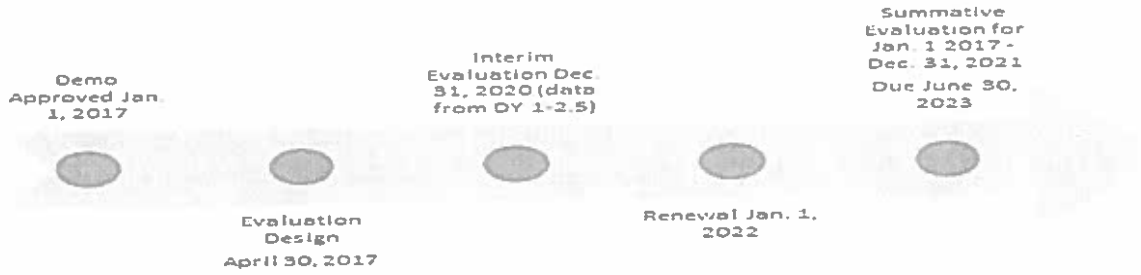
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses,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

The format for the Evaluation Design is as follows:

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

Submission Timelines

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



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

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

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

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

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

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

5) Describe the population groups impacted by the demonstration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1) 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 a "No Conflict of Interest" statement signed by the independent evaluator.

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

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

Attachment B
Preparing the Evaluation Report

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 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.

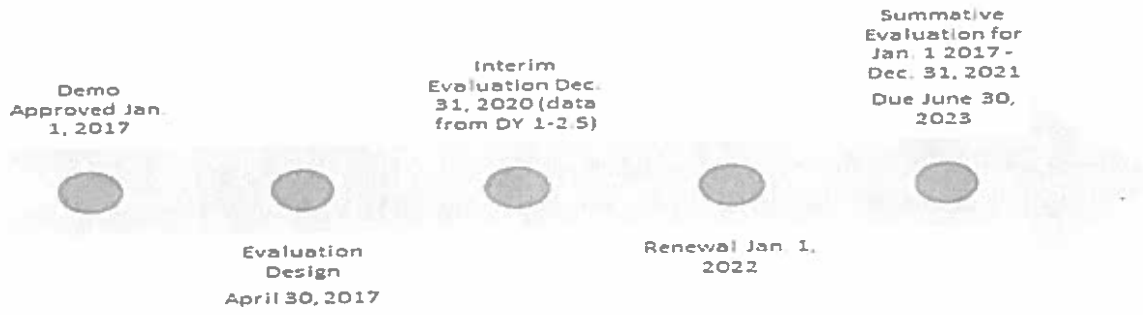
The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;

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

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). 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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

J. Attachment

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

Attachment C
Evaluation Design (Reserved)

Attachment D
Community Engagement Implementation Plan (Reserved)

Attachment E
Monitoring Protocol (Reserved)