

**Healthy Adult Opportunity (HAO)**

 **Section 1115 Demonstration Application Guidance & Template**

**Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application Guidance & Template**

This guidance and template provides a mechanism for states to apply to the Centers for Medicare & Medicaid Services (CMS) for a Healthy Adult Opportunity (HAO) demonstration under section 1115 of the Social Security Act (the Act),[[1]](#footnote-2) as further described in the January 30, 2020 release of State Medicaid Director Letter (SMDL) #20-001, entitled, “Healthy Adult Opportunity (HAO).” This application template may be used by states applying to use either an aggregate or a per capita cap financing model for certain populations, consistent with the SMDL guidance.

Submission of the information provided in this template and any attachments does not guarantee approval of a state’s demonstration request, and failure to complete or agree to all elements of this template and any attachments does not guarantee disapproval of a state’s demonstration request. CMS will work with states to identify any additional information necessary to consider demonstration requests. Use of this guidance and template is not required; it is a tool that states can use at their option. The guidance and template were designed to help states ensure the application contains the required elements for section 1115 demonstrations, as provided for under 42 CFR part 431 subpart G, and in particular the application procedures at 42 CFR 431.412(a), as well as to promote an efficient review process.

**Submission of Application**

When the state completes its application and fulfills its public transparency requirements, the state should submit its application electronically to 1115DemoRequests@cms.hhs.gov and to:

 Judith Cash, Director

 Centers for Medicare & Medicaid Services

 State Demonstration Group

 Mail Stop: S2-25-26

 7500 Security Boulevard

 Baltimore, MD 21244

# Structure and Content of Application

The framework for this application guidance and template is designed to facilitate the state’s application development by identifying the type of information, through a series of questions and checklists, CMS will consider for state application requests for a Healthy Adult Opportunity (HAO) demonstration. To facilitate CMS review of HAO demonstration applications, states using this application template should complete each section by providing the information requested in the text boxes as instructed in each section. The state may also provide additional information as attachments to the application template.

At the end of this application template, CMS provides in an informational appendix a list of general oversight, budget neutrality, monitoring and evaluation reporting requirements that would apply to demonstrations approved under this HAO demonstration initiative consistent with regulations at 42 CFR 431.420 and 431.428.

| **Section #** | **Content** |
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# Section I -- Demonstration Overview

1. **Project Description** – In the box below, describe the feature(s) of the states' current Medicaid program for which it is proposing to test an alternative approach or range of approaches in the administration and design of the program. Describe the core features and components of the flexibilities the state is proposing to test under this HAO demonstration to address the challenges with the state's current program administration and design that cannot be achieved or has been difficult to achieve through regular Medicaid state plan or other federal authorities. Include planned dates for implementing the demonstration, and the anticipated impact the demonstration will have on targeted beneficiaries, providers, contractors, and other stakeholders in the state.

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1. **Project Goals and Objectives** – In the box below, describe the state's program goals for this demonstration and how each of the proposed demonstration flexibilities outlined in section I.A above and the anticipated program outcomes have been designed to promote the objectives of the Medicaid program. Please note that in section X of this application guidance, the state is requested to detail the specific research hypotheses that the state is proposing to evaluate for each program component being tested under the demonstration.

If the state is proposing a range of policy options or approaches that it may elect to implement over the course of the approved demonstration period, it should also describe the range of proposed policy options or approaches below. For example, a state may want to include minimum and maximum premium and other cost sharing charges that may be imposed under the demonstration, as well as the initial premiums and cost sharing to be imposed; propose several EHB-benchmark plans it may adopt at a later date; or propose optional benefits it may eliminate upon implementation or at a later date. This would enable the state to titrate the amount of premiums or cost sharing charged, or benefits covered, over the course of the demonstration period more easily. The description should include how the range of policy options or approaches align with the state's intended program goals and objectives for this demonstration.

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1. **Modification to Medicaid State Plan** – In the box below, describe any other state plan program features that the demonstration would modify to permit the state to implement the demonstration flexibilities described in application section I.A. as well as any corresponding state plan amendments the state will need to effectuate these state plan program changes.

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1. **Modification to Existing Section 1115 Demonstration** – In the box below, identify by project name and number any existing section 1115 demonstration the state proposes to transition, in whole or in part, into the proposed HAO demonstration. Describe the existing section 1115 demonstration feature(s) that the proposed HAO demonstration would modify, including identifying the individuals who would be eligible for coverage under the proposed HAO demonstration who are already eligible for coverage under the existing demonstration(s). Describe whether and how the state proposes to modify or terminate current section 1115 demonstrations should this application for a HAO demonstration be approved.

The state may also include, as an attachment to this application, its proposed transition and orderly close-out plan for current section 1115 demonstrations, if applicable. If providing an attachment, the state should identify the attachment in the box below.

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# Section II -- Eligible Populations and Processes for Eligibility and Enrollment

This demonstration opportunity is available to all states as a mechanism to provide maximum flexibility for covering adults under age 65 who qualify for Medicaid on a basis other than disability or need for long term care services and supports and who are not covered under the Medicaid state plan, including covering all individuals described in the new adult group at section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119 (the new adult group). This demonstration opportunity can also be used to extend coverage to adult populations the state has previously covered in its Medicaid state plan or under other section 1115 demonstrations, but for whom the state has elected to end coverage.

1. **Targeted Population(s)** – The state should identify below the population(s) it intends to cover under this demonstration and any additional factors of eligibility it intends to apply under the proposed HAO demonstration:

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| [ ]  | State will cover all adults under age 65 who qualify for Medicaid on a basis other than disability or need for long-term care services and supports and who are not covered in the state plan, including individuals described in the new adult group at section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, and who have income at or below:[ ]  133 percent Federal Poverty Level (FPL)[ ] Other income standard: [*insert FPL level*] percent FPL |
| In the box below, describe in detail any additional factors of eligibility that would apply to the above population (e.g., premiums). If the state is proposing a range of options for implementing additional factors of eligibility over the course of the approved demonstration period, also describe the range of options in the box below. The description should identify the approach that the state proposes to elect at initial implementation of the HAO demonstration and then list the range of potential changes to implementation that the state may elect to impose under the demonstration at a later date.  |
|  |
| [ ]  | State will cover targeted subgroup of adults under age 65 who qualify for Medicaid on a basis other than disability or need for long-term care services and supports and who are not covered in the state plan, including individuals described in the new adult group at section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, and who have income at or below [*insert FPL level*] percent FPL. Describe subgroup below:  |
| Below, describe in detail any additional factors of eligibility that would apply to the above population. If the state is proposing a range of options for implementing additional factors of eligibility over the course of the approved demonstration period, also describe the range of options in the box below. The description should identify the approach that the state proposes to elect at initial implementation of the HAO demonstration and then list the range of potential changes to implementation that the state may elect to impose under the demonstration at a later date. |
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| [ ]  | State will cover a different population, as described here: |
| Below, describe in detail any additional factors of eligibility that would apply to the above population. If the state is proposing a range of options for implementing additional factors of eligibility over the course of the approved demonstration period, also describe the range of options in the box below. The description should identify the approach that the state proposes to elect at initial implementation of the HAO demonstration and then list the range of potential changes to implementation that the state may elect to impose under the demonstration at a later date. |
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1. **Enrollment Processes** – The state should identify below the approach it intends to take for processing beneficiary eligibility and enrollment under the HAO demonstration.

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| [ ]  | State will follow its Medicaid state plan processes for eligibility and enrollment for this demonstration. Demonstration eligibility and enrollment processes will align with all requirements of section 1943 of the Act (as implemented in regulation at 42 CFR part 435 subpart J).  |
| [ ]  | State will follow requirements of section 1943 of the Act (as implemented in regulation at 42 CFR part 435 subpart J) for this demonstration EXCEPT as described below with the intended purpose of improving administrative efficiency of the state's eligibility and enrollment processes: [*The state should insert here a description of the proposed demonstration specific eligibility and enrollment processes.]* |
| [ ]  | Other: [*The state should insert here a description of any other proposed demonstration-specific eligibility and enrollment processes it seeks to implement as well as describe how these alternative eligibility and enrollment processes are necessary for the state to meet its intended program goals and objectives for this demonstration.]* |

1. **Enrollment Projections for Targeted Populations** – For each category of beneficiary identified in application section II.A, the state should complete the below tables to provide an analysis of the expected impact of the proposed demonstration on total Medicaid enrollment; illustrating current trends in Medicaid enrollment without implementation of the proposed demonstration, projected demonstration enrollment, and an explanation and justification of the projected impacts of the HAO demonstration on total Medicaid enrollment.

***All enrollment projections provided on tables 1 through 5 below should be reported in annual aggregate (i.e., total), unduplicated person counts.***

**C.1 – Total Medicaid Enrollment without the Proposed Demonstration**

| **Table 1 – Historical/Current Total Enrollment Data** – For each population that would be impacted by the proposed HAO demonstration, the state should report any applicable Medicaid enrollment data, or other relevant historical healthcare population data if there is insufficient historical Medicaid enrollment experience.  |
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| **Targeted Population(s)** | **Historical Year (HY) 01**[identify 12-month period] | **HY02**[identify 12-month period] | **HY03**[identify 12-month period] | **HY04**[identify 12-month period] | **Current Year**[identify 12-month period] |
|  |  |  |  |  |  |
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| In this box, please specify the data source(s), methodology, and supporting analysis used, including an explanation of the assumptions used and any limitations on the data, as applicable, to derive the enrollment counts.  |

| **Table 2 – Projected Total Medicaid Enrollment without the Proposed Demonstration** – For each population that would be impacted by the proposed HAO demonstration, the state should report projected Medicaid enrollment assuming no HAO demonstration for each of the five years that the state expects to implement the HAO demonstration.  |
| --- |
| **Targeted Population(s)** | **Y01**[identify 12-month period] | **Y02**[identify 12-month period] | **Y03**[identify 12-month period] | **Y04**[identify 12-month period] | **Y05**[identify 12-month period] |
|  |  |  |  |  |  |
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| In this box, please specify the data source(s), methodology, and supporting analysis used, including an explanation of the assumptions used and any limitations on the data, as applicable, to derive the enrollment counts.  |

**C.2 – Proposed Demonstration Program Enrollment**

| **Table 3 – Projected Demonstration Enrollment** – The state should report the projected number of individuals who are expected to be enrolled in the HAO demonstration. This enrollment projection should reflect the total unduplicated number of individuals who would be eligible for the demonstration and reported below by each targeted population identified in section II above. This projection should not include any expected impact on beneficiary coverage from the application of any additional condition(s) of eligibility that the state has identified as a demonstration flexibility in sections II or IV. |
| --- |
| **Targeted Population(s)** | **Demonstration Year (DY) 01** | **DY02** | **DY03** | **DY04** | **DY05** |
| **Example: Adults ≥ 133% FPL** | **20,000** |  |  |  |  |
|  |  |  |  |  |  |
| In this box, please specify the data source(s), methodology, and supporting analysis used to develop these projections.  |

| **Table 4A – Projected Number of Individuals Subject to Additional Condition(s) of Eligibility** (if applicable)– If the state has identified an additional condition of eligibility as a demonstration flexibility in sections II or IV, the state should report the projected total number of unduplicated individuals, by each targeted population identified in section II above, who would be subject to each identified additional condition of eligibility. This projection should not include any expected impact on beneficiary coverage from the application of the additional condition of eligibility.  |
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| **Targeted Population(s) Subject to Additional Condition(s) of Eligibility** | **DY01** | **DY02** | **DY03** | **DY04** | **DY05** |
| **Example: Adults ≥ 133% FPL – Community Engagement**  | **10,000** |  |  |  |  |
| **Example: Adults ≥ 133% FPL –** **Premiums ≥ 150% FPL** | **20,000** |  |  |  |  |
| **Table 4B – Projected Number of Individuals Subject to an Exemption from Additional Condition(s) of Eligibility** (if applicable) – If the state has completed Table 4A, also complete the below table with the projected number of individuals, by each targeted population identified in section II above, who would be exempt from each additional condition of eligibility listed in table 4A.  |
| **Targeted Population(s) Subject to Exemption from Additional Condition(s) of Eligibility** | **DY01** | **DY02** | **DY03** | **DY04** | **DY05** |
| **Example: Adults ≥ 133% FPL – Community Engagement** | **4,000** |  |  |  |  |
| **Example: Adults ≥ 150% FPL** **Premiums**  | **0** |  |  |  |  |
|  In this box, please specify the data source(s), methodology, and supporting analysis used to develop the projections in tables 4A and 4B:  |

**C.3 – Projected Total Medicaid Program Enrollment Assuming Impact of Proposed**

 **Demonstration**

| **Table 5 – Projected Impact of Demonstration on Total Medicaid Enrollment** – The state should report overall Medicaid enrollment expected to occur over the same period that the HAO demonstration policies will be implemented. Enrollment projections should be reported in annual aggregate (i.e., total), unduplicated person counts, separately for each population whose coverage is likely to be impacted by the proposed HAO demonstration.  |
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| **Targeted Population(s)** | **Y01** | **Y02** | **Y03** | **Y04** | **Y05** |
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| In the box below, the state should specify the data source(s), methodology, and supporting analysis used to develop these projections. The state's descriptive analysis should identify how the projected overall impacts of the proposed HAO demonstration (including, but not limited to, the impact on beneficiary coverage from the application of the demonstration flexibilities identified in sections II and IV) will affect total Medicaid enrollment. If the state’s analysis indicates that the net effect of the proposed HAO demonstration is a decline in total Medicaid enrollment, the state should include an explanation of why the proposed demonstration would nonetheless be likely to promote the objectives of the Medicaid program.  |
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1. **Eligibility and Enrollment Design Flexibilities –** The below table lists the general standard statutory and regulatory eligibility and enrollmentprovisions applicable under the Medicaid state plan. As part of this demonstration opportunity, the state may elect to not apply these provisions to the demonstration population(s) identified in section II.A of this application. The state should indicate below the provision(s) that it is requesting to not apply to the demonstration in order to permit the state to implement the program flexibilities made available under the HAO demonstration initiative through the use of section 1115(a)(2) authority.

| **Provisions Not Being Applied by the State for Eligibility and Enrollment Flexibilities** |
| --- |
| [ ]  | Section 1902(a)(10)(A)(i)(VIII); 42 CFR 435.119 | Flexibility to elect income standard best suited to state at, above or below 133 percent of the federal poverty level (FPL). (Income standard of at least 133 percent FPL is required for increased FMAP for adults with income at or below 133 percent FPL in accordance with sections 1905(y) and 1905(z) of the Act.) |
| [ ]  | Section 1902(a)(1); 42 CFR 431.50 and,Section 1902(a)(10)(A)(i)(VIII); 42 CFR 435.119 | Ability to limit eligibility to a defined subset of individuals described in the new adult group, based on geographic or other criteria. (Eligibility for all individuals described in the new adult group is required for increased FMAP in accordance with sections 1905(y) and 1905(z) of the Act.)  |
| [ ]  | Section 1903(i)(26) | Flexibility to receive FMAP for services rendered to the new adult group without having to provide such coverage through benchmark or benchmark-equivalent coverage. |
| [ ]  | Section 1902(a)(8); 42 CFR 435.911(c)(1) and,Section 1902(a)(10); 42 CFR 435.119 | Ability to impose additional eligibility requirements to further objectives of Medicaid program. |
| [ ]  | Section 1902(a)(8); 42 CFR 435.915(c)(1) | Flexibility to establish prospective enrollment for eligible applicants. |
| [ ]  | Section 1902(a)(10) and (34); 42 CFR 435.915 | Flexibility to eliminate retroactive eligibility. |
| [ ]  | Section 1902(a)(47)(B); 42 CFR 435.1110 | Flexibility to eliminatehospital presumptive eligibility. |
| [ ]  | Section 1902(e)(14)(C); 42 CFR 435.603(g)and,42 CFR 435.916(d) | Flexibility to provide continuous eligibility up to 12 months. |
| [ ]  | Section 1943; 42 CFR 435.916(a)(1) | Ability to renew eligibility of new beneficiaries prior to regular 12-month renewal in order to align Medicaid renewal cycle with Marketplace. |
| [ ]  | Other: [*specify section of statute/regulation requesting to not apply to demonstration*]  | [*Insert a description of the requirement(s) specified in the identified statutory/regulatory provision that the state is proposing to not apply to this demonstration.*] |

1. **Additional Information.** In the box below, provide any additional information the state believes is important for CMS to understand related to the proposed eligibility criteria and processes for eligibility and enrollment to be implemented under this HAO demonstration (optional).

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# Section III – Benefit Package

For populations covered under this HAO demonstration initiative, benefits generally will be expected to align with coverage available through the individual health insurance market, such as qualified health plans (QHPs) offered through the Exchange in the state or in another state. States may also propose other benefit options for providing comprehensive coverage that meet larger health reform and Medicaid objectives. The state should complete the applicable sections below that correspond with the benefits package it proposes to provide under the HAO demonstration.

1. **Essential Health Benefits Package**

| **Essential Health Benefits Package Design –** The state should identify the benefit design that it intends to implement upon approval of this demonstration. If the state is proposing a range of options that it may elect to use over the course of the approved demonstration period, a description of the range of options should be provided in the designated box below.  |
| --- |
| [ ]  | State is aligning the benefit package for this demonstration population with the EHB-benchmark plan used by the State’s Department of Insurance for purposes of the individual market in the state by providing the coverage described in that EHB-benchmark plan, in a manner that complies with the EHB requirements for the individual insurance market under 45 CFR 156.100 through 156.125, including the regulation at 45 CFR 156.115(a)(3) applying the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as implemented at 45 CFR 146.136, and with the annual and lifetime dollar limit prohibition at 45 CFR 147.126. *If the state will substitute coverage of benefits for those covered by that EHB-benchmark plan, the state must also complete the benefits chart in subsection G to further describe the EHB benefits design it intends to provide under this demonstration.* |
| [ ]  | State is aligning the benefit package for this demonstration population with the EHB-benchmark plan used by another State’s Department of Insurance for the individual insurance market by providing the coverage described in that EHB-benchmark plan, in a manner that complies with the EHB requirements for the individual insurance market under 45 CFR 156.100 through 156.125, including the regulation at 45 CFR 156.115(a)(3) applying the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as implemented at 45 CFR 146.136, and with the annual and lifetime dollar limit prohibition at 45 CFR 147.126.Please identify the state: *If the state will substitute coverage of benefits for those covered by the EHB-benchmark plan, the state must also complete the benefits chart in subsection G to further describe the EHB benefits design it intends to provide under this demonstration.* |
| [ ]  | State is selecting one of the below options to design an EHB package that complies with the requirements for the individual insurance market under 45 CFR 156.100 through 156.125, including the regulation at 45 CFR 156.115(a)(3) applying the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as implemented at 45 CFR 147.160 and 146.136, and with the annual and lifetime dollar limit prohibition at 45 CFR 147.126. Actuarial analysis may be required. The state intends to:[ ]  Use the same EHB-benchmark plan currently operated in the state under an  Alternative Benefit Plan.[ ]  Replace coverage of any of the categories of EHB from their 2017 EHB-benchmark  plan with coverage of the same category from another state’s 2017-EHB  benchmark plan.[ ]  Select a set of benefits to become their new EHB-benchmark plan.*If choosing one of the above three options, the state must also complete the benefits chart in subsection G to further describe the EHB benefits design it intends to provide under this demonstration.* |
| **Range of Benefits (*if applicable*).** As indicated above, describe in the box below any range of benefit options the state may elect to implement over the course of the demonstration. The description should identify the approach that the state proposes to elect at initial implementation of the HAO demonstration and then list the range of potential changes that the state may elect to impose under the demonstration at a later date. |
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1. **Alternative Benefit Package –** If the state is not proposing a benefits package that aligns with the Essential Health Benefits options in section III.A above, describe in the box below the overall benefits proposal the state intends to implement under this demonstration. The description should include how this alternative benefit package aligns with larger health reform and Medicaid program objectives. If the state is proposing a range of options that it may elect to use over the course of the approved demonstration period, a description of the range of options should also be provided below. The description should identify the approach that the state proposes to elect at initial implementation of the HAO demonstration and then list the range of potential changes that the state may elect to impose under the demonstration at a later date.

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1. **Prescription Drug Coverage**

| **Prescription Drug Coverage** – The state should identify below the approach it intends to take for providing prescription drugs under this proposed HAO demonstration. |
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| [ ]  | State will provide a prescription drug benefit in accordance with section 1927 of the Act. |
| [ ]  | State will provide a limited prescription drug formulary in accordance with EHB requirements regarding prescription drug benefits, in addition to coverage of: (1) substantially all drugs for mental health (that is antipsychotics and antidepressants) consistent with Medicare Part D coverage; (2) substantially all antiretroviral drugs (including PrEP) consistent with Medicare Part D coverage, and (3) all forms, formulations, and delivery mechanisms for drugs approved by the FDA to treat opioid use disorders (OUDs) for which there are rebate agreements in place with the manufacturers. Section 1927(b) requirements pertaining to the obligation for a drug manufacturer with a drug rebate agreement to pay rebates will still apply pursuant to section 1115(a)(2) expenditure authority. If this option is selected, CMS will work with the state on additional information necessary for implementation .  |

1. **Institution for Mental Disease (IMD)**

| **IMD Coverage** – The state should identify below the approach it intends to take for providing IMD coverage under this proposed demonstration. |
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| [ ]  | The state will comply with the Institution for Mental Disease (IMD) Coverage Exclusion (Clause (B) following section 1905(a)(29) of the Act and 42 CFR 435.1009) as indicated below:  |
| [ ]  Exclusion applies.  |
| [ ]  State has approved state plan amendments for individuals 65 and over who are residing in an IMD consistent with 42 CFR 440.140. |
| [ ]  State has approved state plan amendment(s) for Inpatient psychiatric services for individuals under age 21 consistent with 42 CFR 440.160. |
| [ ]  State has an approved Substance Use Disorder demonstration authorizing  services for individuals residing in an IMD or is requesting section 1115(a)(2)  authority through this HAO demonstration to provide services to individuals  residing in an IMD, as described in section I of this application, in accordance with  CMS' November 1, 2017 State Medicaid Director Letter on "Strategies to Address  the Opioid Epidemic."  |
| [ ]  State has an approved Serious Mental Illness demonstration authorizing  services for individuals residing in an IMD or is requesting section 1115(a)(2)  authority through this HAO demonstration to provide services to individuals  residing in an IMD, as described in section I of this application, in accordance with  CMS' November 13, 2018 State Medicaid Director Letter on "Opportunities to  Design Innovative Service Delivery Systems for Adults with a Serious Mental  Illness or Children with a Serious Emotional Disturbance." |
|  | [ ]  State has approved Medicaid state plan amendment(s) for sections of the 2018  Support for Patients and Communities Act (SUPPORT Act) that include an IMD  exclusion.  [*Please identify the relevant Medicaid state plan amendments in this box or as an*  *attachment if necessary.*] |

1. **Federally Qualified Health Centers (FQHC)**

| **FQHC Services Coverage and Payment –** The state should identify below how it intends to administer the coverage of and payment for FQHC services under this proposed HAO demonstration.  |
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| **Coverage** |
| [ ]  | State is electing to cover FQHC services as defined in section 1905(a)(2)(C) of the Act.  |
| [ ]  | State is covering benefits otherwise covered under this HAO demonstration when provided by an FQHC, not subject to the definition of FQHC services in section 1905(a)(2)(C) of the Act, but similar to QHP coverage of services provided by FQHCs. |
| **Payment** |
| [ ]  | Payment will be made in accordance with section 1902(bb) of the Act. [ ]  Prospective Payment System, or [ ]  Alternative Payment Methodology.   |
| [ ]  | Payment will be based on a value-based payment (VBP) methodology consistent with regulations applicable to QHPs at 45 CFR 156.235(e).If VBP payment methodology is selected, please describe here or identify theattachment with the state’s plan for the proposed VBP strategy including reasonable, auditable performance targets and anticipated payment rates based on those targets. Please also include information about how the VBP strategy for FQHCs relates to other VBP arrangements or delivery system reform in the state. |
| [ ]  | Additional Information (optional): [*Please describe here.*] |

1. **Optional Benefits or Provider Types**

| **Optional Benefits or Provider Types –** The state should identify below and in subsection G, if applicable, the optional services the stateintends to implement under this proposed demonstration. |
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| [ ]  | State is electing to cover Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) according to 1905(r) of the Act. |
| [ ]  | State is electing to assure Non-Emergency Medical Transportation according to 42 CFR 431.53.  |
| [ ]  | State is electing to cover additional benefits according to sections 1905(a), 1915(c), 1915(i), 1915(j), 1915(k), and/or 1945 of the Act that will be considered benefits in addition to EHB. Please list and describe in the "Additional Benefits" section of the table listed in subsection G below.  |

1. **Description of Benefits** – If the state selected an option above that indicated a description of benefits is needed, the state will complete the below chart to include the following information: service name, limitations on the service (if applicable), and provider qualifications. More than one service can be placed in the EHB-Benchmark Plan Services row to define EHB.

| **Essential Health Benefit** | **EHB-Benchmark Plan Service(s), Limitations, and Provider Qualifications** |
| --- | --- |
| Ambulatory Patient Services |  |
| Emergency Services |  |
| Hospitalization |  |
| Maternity and Newborn Care |  |
| Mental Health and Substance Use Disorder Services, Including Behavioral Health Services |  |
| Prescription Drugs |  |
| Rehabilitative and Habilitative Services and Devices |  |
| Laboratory Services |  |
| Preventive and Wellness Services and Chronic Disease Management |  |
| Pediatric Services Including Oral and Vision Care (generally not applicable in this demonstration) |  |
| **Additional Benefits** |
| **Name** **of Benefit** |  **Service Description, Limitations, and Provider Qualifications**  |
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1. **Additional Information** – In the box below, provide any additional information the state believes is important for CMS to understand the state’s intended design for the benefits component of this HAO demonstration. If the state is proposing flexibilities to vary the range or scope of the proposed benefits (as identified above) to individuals targeted under this HAO demonstration, describe those benefit flexibilities here.

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1. **Applicable Federal Benefit Design Standards** – Pursuant to the expenditure authority offered under this demonstration initiative, the expenditures under the approved HAO demonstration will be regarded as expenditures under the Medicaid state plan. The below table lists common standard requirements pertaining to the provision of benefits that we expect would be applicable under the demonstration and that states would be expected to administer in a manner analogous to the processes utilized for the administration of the Medicaid state plan. If the state is proposing to implement a *demonstration-specific process* to comply with any of the below standard requirements, the state should check the applicable provision(s) below and in the designated text box describe how the proposed process for compliance will be administered under the demonstration *differently from the state plan*. The state's description should also include the rationale for how the targeted demonstration process is necessary for the state to meet the intended goals and objectives of the demonstration.

As each application proposal will be unique to each state, this is not intended to be a comprehensive list of benefit standards that could be applicable to this demonstration and additional benefit standards may be negotiated with the state for CMS approval in alignment with goals of this HAO demonstration. Thereby, the state should also describe in the text box below any administrative process related to providing benefits that it intends to operationalize under the approved HAO demonstration differently from the state plan.

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| **Standard Benefit Design Provisions Applicable to this** **Section 1115(a) Demonstration Opportunity**  |
| [ ]  | The state will have a process to ensure that the demonstration operates in alignment with the Inmate Coverage Exclusion outlined in section 1905(a)(29)(A) of the Act.  |
| [ ]  | The state will have a process to ensure that room and board will not be eligible for reimbursement except in hospitals (section 1905(a)(1) of the Act), nursing facilities (section 1905(a)(4) of the Act), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs)(section 1905(a)(15) of the Act) and psychiatric residential treatment facilities (PRTFs)(section 1905(a)(16) of the Act).  |
|  |
| [ ]  | **Changes to Benefits Post-approval** – If the state elects to suspend, eliminate, or modify benefits under the demonstration as approved by CMS, it will have a process for providing advance state public notice in accordance with 42 CFR part 431, subpart E that provides the following information: 1. The specific benefit(s) being changed (adding, removing, increasing, or decreasing the benefit) and, if applicable, whether or not it is an EHB;
2. If applicable, the benefits used for supplementation of EHB;
3. If applicable, an actuarial equivalence analysis if a benefit is not an EHB and is being added to the definition of EHB as a substitution for another EHB;
4. Explanation of whether the benefit change is adding, removing or modifying amount, duration or scope of the benefit;
5. The clinical justification of the benefit change in amount, duration or scope of the benefit for the population that it serves.
6. Description of how beneficiaries will access the benefit; and,
7. Description of the anticipated fiscal impact.
 |

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| --- |
| For the provision(s) checked above, the state is proposing the following demonstration-specific approach for compliance: |

# Section IV -- Premiums and Cost Sharing

1. **Beneficiary Protections** – States with approved demonstration programs under this demonstration opportunity may have broad flexibility to establish premiums and cost-sharing structures. We would expect states to adhere to the following overarching limitations:
* Aggregate out-of-pocket costs incurred by beneficiaries covered under the HAO demonstration would not exceed five percent of the beneficiary’s household income, measured on a monthly or quarterly basis.
* Premiums and cost sharing charges for individuals needing treatment for substance use disorder and individuals living with HIV as well as cost sharing charges for prescription drugs needed to treat mental health conditions would not exceed amounts permitted under the statute and implementing regulations. States similarly would not be permitted to suspend enrollment for such individuals for failure to pay premiums or cost sharing, even if authorized for other individuals under the demonstration.

The state should check one of the below options to confirm whether it intends to implement cost-sharing requirements (i.e., enrollment fees, premiums, cost-sharing or similar charges) for individuals targeted by this HAO demonstration initiative.

|  |  |
| --- | --- |
| [ ]  | **NO**, this demonstration will not have any beneficiary requirements for premiums or cost-sharing. If the state checks this box, it should proceed to section V of this application. |
| [ ]  | **YES**, this demonstration will have beneficiary requirements for premiums, deductibles, co-payments, and/or similar cost-sharing charges. If the state checks this box, it should also complete subsection B and C of this application section. |

1. **Beneficiary** **Cost-Sharing Structure** – The state should identify the premium and/or cost-sharing structure that it intends to implement during the course of the approved demonstration period. If the state is anticipating using a range of premium and/or cost-sharing options over the course of the approved demonstration period, the state should identify the range of options as indicated in the designated boxes below.

| **Premium/Cost-Sharing Design/Flexibilities.** In the boxes below, the state should describe the proposed premium and/or cost-sharing structure to be implemented under this HAO demonstration. |
| --- |
| [ ]  Premiums  | [*Identify here the premiums or range of premiums the state will impose on targeted beneficiaries. If the state is proposing a range of premium options, a description of the range of options should also be provided that identifies the approach that the state proposes to elect at initial implementation of the HAO demonstration and then lists the range of potential changes that the state may elect to impose under the demonstration at a later date. The state’s description should also address the extent to which this proposed approach varies from state plan requirements*.] |
| [ ]  Co-payments | [*Identify here the co-payments or range of co-payments the state will impose on targeted beneficiaries. If the state is proposing a range of co-payment options, a description of the range of options should also be provided that identifies the approach that the state proposes to elect at initial implementation of the HAO demonstration and then lists the range of potential changes that the state may elect to impose under the demonstration at a later date. The state’s description should also address the extent to which this proposed approach varies from state plan requirements*.] |
| [ ]  Deductibles | [*Identify here the deductible or range of deductibles the state will impose on targeted beneficiaries. If the state is proposing a range of deductible options, a description of the range of options should also be provided that identifies the approach that the state proposes to elect at initial implementation of the HAO demonstration and then lists the range of potential changes that the state may elect to impose under the demonstration at a later date. The state’s description should also address the extent to which this proposed approach varies from state plan requirements*.] |
| [ ]  Other  Charges | [*Define and describe here any other charges or cost structure the state will impose on targeted beneficiaries. If the state is proposing a range of options, a description of those options should also be provided that identifies the approach that the state proposes to elect at initial implementation of the HAO demonstration and then lists the range of potential changes that the state may elect to impose under the demonstration at a later date. The state’s description should also address the extent to which this proposed approach varies from state plan requirements.*] |

1. **Beneficiary Consequences for Non-payment** – In the box below, describe any consequences for beneficiary non-payment of premiums and/or cost-sharing charges.

|  |
| --- |
|  |

1. **Calculating** **Beneficiary** **Cost-Sharing –** In the box below, describe the state's process for calculating the five percent limit on a monthly or quarterly basis and ensuring that beneficiaries do not incur cost-sharing that exceeds five percent of the beneficiary’ household income. Premiums and cost-sharing incurred by the beneficiary, spouse, children and other members of the beneficiary’s household, as defined in 42 CFR 435.603(f), will be counted toward the five percent limit.

|  |
| --- |
|  |

1. **Applicable Federal Premium/Cost-sharing Design Standards** – Pursuant to the expenditure authority offered under this demonstration initiative, the expenditures under the approved HAO demonstration will be regarded as expenditures under the Medicaid state plan. The below table lists common standard requirements pertaining to cost-sharing that we expect would be applicable under the demonstration and that states would be expected to administer in a manner analogous to the processes utilized for the administration of the Medicaid state plan. If the state is proposing to implement a separate *demonstration-specific process* to comply with any of the below standard requirements, the state should check the applicable provision(s) below and in the designated text box describe how the proposed process for compliance will be administered under the demonstration *differently from the state plan*. The state's description should also include the rationale for how the targeted demonstration process is necessary for the state to meet the intended goals and objectives of the demonstration.

As each application proposal will be unique to each state, this is not intended to be a comprehensive list of cost-sharing standards that could be applicable to this demonstration and additional cost-sharing standards may be negotiated with the state for CMS approval in alignment with goals of this HAO demonstration. Thereby, the state should also describe in the text box below any administrative process related to providing benefits that it intends to operationalize under the approved HAO demonstration differently from the state plan.

| **Standard Premium/Cost-sharing Design Provisions Applicable to this****Section 1115(a) Demonstration Opportunity** |
| --- |
| [ ]  | The state will have safeguards to ensure that its process as described in section IV.D above is properly calculating and ensuring adherence to the requirement that beneficiaries do not incur cost-sharing that exceeds the five percent limit on a monthly or quarterly basis.  |
| [ ]  | The state will have a process for providing beneficiary and public notice of premiums, cost-sharing and similar charges under the demonstration consistent with the notice requirements described in 42 CFR 447.57. |

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| --- |
| For the provision(s) checked above, the state is proposing the following demonstration-specific approach for compliance as follows: |

# Section V – Delivery System and Payment Models

1. **Delivery System Type** – The state should check which delivery system(s) it intends to use for this demonstration:

| **Delivery System** |
| --- |
| [ ]  | **Managed Care**[ ]  Managed Care Organization (MCO)[ ]  Prepaid Inpatient Health Plan (PIHP)[ ]  Prepaid Ambulatory Health Plan (PAHP)[ ]  Primary Care Case Management (PCCM)/PCCM-Entities |
| [ ]  | **Fee-for-Service (FFS)**[ ]  Section 1902(a)(23) and implementing regulations at 42 CFR 431.51, which  allows a beneficiary to obtain services from any institution, agency,  community pharmacy, or person qualified to perform the services and who  undertakes to provide such services. [ ]  Restrict a beneficiary (except in emergency circumstances) to obtaining services from any provider or practitioner who provides services in compliance with the state’s written standards for reimbursement, quality, and utilization of covered services, provided that the state’s standards are consistent with accessible, high-quality delivery, and efficient and economic provision of covered services. *Please describe here the services that are subject to this approach:* |
| [ ]  | **Premium Assistance** |
| [ ]  | **Other:** [*Describe*] |

1. **Enrollment Strategies** – For a state using managed care or premium assistance delivery system(s), it should describe below how the eligibility groups will be enrolled in managed care.

| **Eligibility Group** | **Mandatory, Voluntary, Excluded** | **Geographic Area** | **Other Criteria (such as FPL range or type of premium assistance)** | **Notes** |
| --- | --- | --- | --- | --- |
| **Example: 1902(a)(10)(A)(i)(VIII)** | **Mandatory****Managed Care** | **Statewide** | **Mandatory ESI Premium Assistance** | **Medically frail individuals will be voluntary** |
|  |  |  |  |  |
|  |  |  |  |  |

1. **Exceptions to Managed Care and Premium Assistance Enrollment** – The state should describe below any demonstration populations that are excluded from the enrollment strategies in subsection B.

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1. **Services Included in Each Delivery System** – The state should list the services/benefits included in the demonstration's delivery system and note any differences by eligibility category. For services where section 1902(a)(23) of the Act does not apply and the state chooses to add providers using Essential Community Provider (ECP) rules at 45 CFR 156.235, please describe how ECPs will be incorporated into the demonstration.

|  **Type** | **Population(s) Covered**  | **Services Included**  |
| --- | --- | --- |
| MCO |  |  |
| PIHP |  |  |
| PAHP |  |  |
| PCCM/ PCCM-E |  |  |
| FFS |  |  |
| Premium Assistance |  |  |
| Other |  |  |

1. **Managed Care Delivery System Flexibilities**

| **Managed Care Flexibilities –** The state should identify which of the following options the state intends to apply to the managed care delivery system to be implemented under the demonstration by checking applicable boxes below. |
| --- |
|  **Access to Care -** States will need to ensure, and will be expected to regularly report, that services covered under a HAO demonstration are available and accessible to beneficiaries in a timely manner.  |
| [ ]  | The state will document compliance with the requirements of 42 CFR 438.68, 438.206, and 438.207 to establish and monitor the adequacy and capacity of MCOs, PIHPs and PAHPs to deliver all covered services within the delivery system. |
| [ ]  | The state will follow an alternative approach by providing reasonable evidence of enrollee access to care and satisfaction, including direct measures of access evidencing that the state-established standards are met. *[Describe here the alternative approach and how it will meet the statutory requirement for access described in section 1932(b)(5) of the Act to establish and monitor the adequacy and capacity of MCOs, PIHPs and PAHPs to deliver all covered services within the delivery system.]*  |
| **Managed Care Capitation Rates –**The state will be expected to establish a process to assure managed care capitation rates under the demonstration are actuarially sound. The state should identify in the box below which approach it intends to implement under the demonstration. |

|  |  |
| --- | --- |
| [ ]  | *Federal Actuarial Review* – The state will develop capitation rates consistent with the requirements of 42 CFR part 438 and CMS’ Managed Care Capitation Rate Development Guide. The state will submit to CMS a final set of managed care capitation rates supported by a rate certification at least 30 days prior to the start of a rating period, and make all modifications to such rates on a prospective basis. |
| [ ]  | *Fiscal Integrity through Transparency, Medical Loss Ratios, and Audits* – The state will develop an alternative option as described below that exempts them from the requirements of 42 CFR 438.7(a) and eliminates the prospective federal review, but relies on the following requirements to assure capitation rates are actuarially sound: 1. *Capitation rate transparency*. Capitation rates will be developed annually consistent with the requirements of 42 CFR part 438 and an enhanced CMS Managed Care Capitation Rate Development Guide that establishes a specific outline for the rate certification and required tables to document assumptions and data used for the capitation rate development. Additionally, the rate certification will be publicly posted on the state’s website 60 days in advance of the annual rating period; and changes are identified in a rate amendment certification provided to CMS and posted on the state’s website 30 days prior to making the change in rates.
2. *Components of the rate development*. The state’s managed care capitation rates are based only upon approved Medicaid services covered under the Medicaid state plan, a section 1115 demonstration, a section 1915 waiver, and additional services deemed by the state to be necessary to comply with the requirements of MHPAEA, as implemented in 42 CFR part 438, subpart K, 42 CFR 440.395, and 45 CFR 147.160 and 146.136, as applicable. Further, the state’s managed care capitation rates are based only upon the expected utilization and delivery of services for the time period and the population covered under the terms of the state’s contract with the managed care plans. Finally, the state’s managed care capitation rates may not include any pass-through payments or supplemental provider payments. *To the extent that the state intends to make pass-through payments or supplemental payments to providers, CMS would expect that the payments would be explicitly authorized in the state’s section 1115 demonstration and paid to providers outside of the managed care capitation rates. The state should also complete section VI, subsection G of this application.*
3. *Use of medical loss ratios (MLRs) with remittance*. The state’s contract with each managed care plan will require remittance based on a corridor around the MLR defined in 42 CFR 438.8. The state will calculate and reconcile each managed care plan’s MLR and report calculations to CMS within 12 months of the rating period. *Further, remittances will be required of plans if the MLR falls below 85 percent level, and states will be required to submit remittances to plans if the MLR is above 95 percent. Remittances required to be paid by the state in excess of the annual cap will not be eligible for FFP*.

 1. *Use of audits*. The state will meet enhanced requirements by requiring plans to submit independent financial audits in order to assure that the managed care capitation rates are actuarially sound. In addition to requirements at 42 CFR 438.3(m), states and managed care plans will need to ensure that the financial audit is conducted by an independent entity in accordance with generally accepted accounting principles and auditing standards, and be of sufficient detail that the state and managed care plan can reconcile the data used for the MLR calculations to the information reported in the independent financial audit. The state will submit the audited financial reports, as well as documentation reconciling the data used for the MLR, to CMS within 12 months of the end of the rating period.
 |

| **Managed Care Contracts Review -** The state will submit its initial managed care contracts to CMS for review and approval. However, the state should identify flexibility in the administration of their managed care plan contract amendments.  |
| --- |
| [ ]  | The state will seek formal CMS approval of contract amendments in advance of the amendment taking effect. States will incorporate the potential impact of substantive contract amendments into the capitation rates paid to managed care plans. |
| [ ]  | The state will not seek prior CMS approval of contract amendments, but will submit amendments to CMS. States will incorporate the potential impact of substantive contract amendments into the capitation rates paid to managed care plans. |
| **State Directed Payments –** The state should identify how they will direct managed care plans’ expenditures with regards to State Directed Payments at 42 CFR 438.6(c), if applicable.  |
| [ ]  | The state will seek formal CMS approval of State Directed Payments pursuant to 42 CFR 438.6(c) in advance of the payment(s) taking effect. |
| [ ]  | The state will not seek prior approval of State Directed Payments, but will comply with all other requirements under 42 CFR 438.6(c). The state will maintain documentation of compliance with 42 CFR 438.6(c), including that any direction of managed care plans’ expenditures is based only on delivery and utilization of services to Medicaid beneficiaries covered under the contract, or outcomes and quality of the delivered services during the rating period associated with the directed payment.  |

| **Other: List other managed care related regulatory flexibilities requested** |
| --- |
| [ ]  | The state will meet all other statutory requirements for managed care outside of those directly addressed in this application. |
| [ ]  | The state will implement other, alternative approaches to meeting the statutory requirements for managed care beyond those specifically identified in this application, and that are not consistent with the regulations in 42 CFR part 438. The state will include the alternative approach(es) in their demonstration application, including provide reasonable evidence that the alternative approach meets the statutory requirements of 42 CFR part 438. Absent inclusion of an alternative approach in the approved STCs, the regulatory provisions in 42 CFR part 438 will apply to HAO demonstrations. Please describe here the flexibilities requested. |

1. **Delivery System Reform and Payment Model Integration** – States may also propose an alternative approach to their delivery system that leverages the private insurance market or coverage programs designed under an applicable complementary waiver under section 1332 of the Patient Protection and Affordable Care Act. If the state is seeking such an alternative approach, please describe in the box below or as an attachment the proposed approach(es) to measuring and ensuring sufficient access to care under the demonstration. If providing an attachment, the state should identify the attachment in the box below.

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|  |

1. **Delivery System Reform through Choice and Competition –** In the box below, the state should explain whether any of its proposed payment models or delivery system approaches described above are being initiated to support state efforts to influence state laws, regulations, guidance, and polices on choice and competition in health care workforce, provider, and insurance markets based on the 2018 *Reforming America’s Healthcare System through Choice and Competition* report issued by the Departments of Health and Human Services, Labor, and the Treasury. Also identify actions that the state will be implementing that will drive greater efficiency and improved outcomes from other providers in order to achieve increased state flexibility and improved outcomes.

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1. **Additional Information** – In the box below, provide any other information that the state believes is important for CMS to understand about the state’s proposed delivery system and/or payment model for this demonstration. (optional)

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# Section VI – Financing and Cost Projections

1. **Non-Federal Share Source(s).**

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| **Non-Federal Share Source(s).** All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. The state shouldidentify below, the source of non-federal share for each type of payment to be mad e under the demonstration, including specifying whether each source is a state general fund appropriation from the legislature to the Medicaid agency, intergovernmental transfers (IGTs), certified public expenditures (CPEs), health care-related taxes, or another mechanism. Include a full description of the financing arrangement(s) to be used. |
|  |

1. **Expenditure History for Relevant Population(s) and Services –** In the table below, the state shouldidentify the total computable net expenditures from the Medicaid Budget and Expenditure System (MBES), Form CMS-64 for the most recent eight consecutive quarters after December 31, 2016 for which CMS has issued a finalized grant award to the state. This should be delineated for each population covered by the demonstration. Expenditures apply to a quarter based on the date the original payment is made, consistent with 45 CFR 95.13(b). Prior period adjustments and collections/offsets should be attributed to the quarter in which the original expenditure was made. Net expenditures include current quarter expenditures, prior period adjustments, and collections and offsets. Note, expenditures for VIII group enrollees should be separately identified.

*If the state has not separately reported expenditures on the CMS-64 for the targeted demonstration population(s), please also complete subsection C of this application section for identification of the data source(s) the state used to complete the below table.*

Base period expenditures provided below should exclude Medicaid Disproportionate Share Hospital payments, state administrative expenditures, expenditures for public health emergencies, and time-limited supplemental or pool payments being made under section 1115 authority such as, but not limited to: Designated State Health Program (DSHP) payments, Delivery System Reform Incentive Payments (DSRIP), and Uncompensated Care Cost (UCC) Payments.

| **Targeted Populations** | **[*Identify Population*]**  | **[*Identify Population*]** | **[*Identify Population*]** | **Total Sum** (across all populations) |
| --- | --- | --- | --- | --- |
| **Q01 20\_\_** |  |  |  |  |
| **Q02 20\_\_** |  |  |  |  |
| **Q03 20\_\_** |  |  |  |  |
| **Q04 20\_\_** |  |  |  |  |
| **Q01 20\_\_** |  |  |  |  |
| **Q02 20\_\_** |  |  |  |  |
| **Q03 20\_\_** |  |  |  |  |
| **Q04 20\_\_** |  |  |  |  |
| **Total Sum**(by Population)  |  |  |  |  |
|  |
| In the box below, the state should specify the source of the data provided above from the CMS-64 (by form name, line number, and quarter). |
|  |

1. **Non-CMS 64 Based Expenditure History for Relevant Population(s) and Services –** If the state has not separately reported expenditures on the CMS-64 for the targeted demonstration population(s), please indicate below the type of information the state is providing as an attachment to this application to support the expenditure information reported in subsection B of this application section:

|  |  |
| --- | --- |
| [ ]  | The state is providing at least two years of auditable expenditure data for the relevant population and services that ties directly to expenditures reported on the Form CMS-64. These expenditures are net of collections and include prior period adjustments as described in subsection A of this application section. This information is in attachment \_\_\_ of this application. |
| [ ]  | The state is providing an audit report from an external independent auditor validating the expenditure data and demonstrating how the data ties directly to the state’s expenditures reported on the CMS-64 for the base period. This information is in attachment \_\_\_ of this application. |
| [ ]  | Other, including data or information for newly covered populations: [*describe documentation here*]. This information is in attachment \_\_\_ of this application. |

1. **Population Adjustments**

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| --- |
| In the box below, please indicate any proposed adjustments relating to the covered population(s) that would improve the accuracy of the base period expenditures the state reported above in subsection B of this application section. For each adjustment, please: * 1. Identify the amount,
	2. Explain why it is necessary, and
	3. Explain how the state calculated the adjustment amount.
 |
|  |

1. **Adjustments for Covered Services**

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| --- |
| In the box below, please indicate any proposed adjustments relating to the covered services that would improve the accuracy of the base period expenditures the state reported above in subsection B of this application section. For each adjustment, please: * 1. Identify the amount,
	2. Explain why it is necessary, and
	3. Explain how the state calculated the adjustment amount.
 |
|  |

1. **Expenditure Projections for Targeted Demonstration Population(s) –** In the table below, the state should provide its total cost projections for coverage of the targeted demonstration population(s) in annual aggregate totals for each demonstration year (DY) of this proposed demonstration; as supported by the historical expenditure data the state reported above in subsection B of this application section.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Targeted Population** | **DY01** | **DY02** | **DY03** | **DY04** | **DY05** |
| **[*Identify Population*]** |  |  |  |  |  |
| **[*Identify Population*]** |  |  |  |  |  |
| **Total Sum** |  |  |  |  |  |
|  |
| In the box below, the state should describe the analysis used to derive the above cost projections for each targeted demonstration population.  |
|  |

1. **Supplemental and Managed Care Pass-Through Payment Adjustments**

|  |
| --- |
| In the box below, for the applicable base period, please list all Medicaid supplemental payments and managed care pass-through payments made to providers for services and individuals covered under this HAO demonstration. |
|  |
| For qualifying supplemental payments and managed care pass-through payments included in the baseline, the state must allocate supplemental payment and managed care pass-through expenditures to the HAO demonstration population based on the percentage of base Medicaid payments, on a service-specific basis, made for these populations during the corresponding base period. In the box below, for each applicable supplemental payment or managed care pass-through payment please: 1. Identify the service,
2. Identify the total amount of the supplemental or pass-through payment,
3. Identify the amount allocated to the HAO demonstration population,
4. Identify the source data (e.g., MMIS for paid base claims),
5. Explain the allocation methodology, and,
6. Indicate if the payment authority is time-limited.
 |
|  |
| Please "check" each box below to confirm the state has excluded the following supplemental payments:  [ ] Designated State Health Program (DSHP) payments,  [ ] Delivery System Reform Incentive Payments (DSRIP),  [ ] Uncompensated Care Cost (UCC) Payments, and,  [ ] Other similar pool payments made under section 1115 authority:  [*Please* *describe here*] |

1. **Other Adjustments (optional)**

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| --- |
| If the state proposes to make additional adjustments to improve the accuracy of base period expenditures (e.g., anticipated collections, anticipated increasing prior period adjustments, etc.), in the box below, please: 1. Identify each proposed adjustment amount,
2. Explain why the adjustment is necessary, and,
3. Explain how the state calculated the adjustment amount.
 |
|  |

1. **FOR PER CAPITA CAP APPLICATIONS ONLY - Member Month Enrollment Data –** This subsection should only be completed by states requesting "per capita cap" financing for this demonstration. In the table below, the state should identify the total number of enrollee member months for the targeted demonstration population(s) that correspond to the base period expenditures reported by the state in subsection B of this application section.

|  |
| --- |
| **A. Member Month Enrollment Projection for Targeted Demonstration Population(s)** |
| In the table below, the state should provide its total enrollee member month projection for the targeted demonstration population(s) for each demonstration year (DY) of this proposed demonstration. These projections should correspond with the unduplicated person count projections provided in section II of this application. |
| **Targeted Population** | **DY01** | **DY02** | **DY03** | **DY04** | **DY05** |
| **[*Identify Population*]** |  |  |  |  |  |
| **[*Identify Population*]** |  |  |  |  |  |
| **Total Sum** |  |  |  |  |  |

|  |
| --- |
| **B. Member Month Enrollment History for Targeted/Relevant Population(s)** |
| In the table below, the state should provide historical total enrollee member month data used to derive the member month projections in table A above. |
| **Targeted Populations** | **[*Identify Population*]**  | **[*Identify Population*]** | **[*Identify Population*]** | **Total Sum** (across all populations) |
| **Q01 20\_\_** |  |  |  |  |
| **Q02 20\_\_** |  |  |  |  |
| **Q03 20\_\_** |  |  |  |  |
| **Q04 20\_\_** |  |  |  |  |
| **Q01 20\_\_** |  |  |  |  |
| **Q02 20\_\_** |  |  |  |  |
| **Q03 20\_\_** |  |  |  |  |
| **Q04 20\_\_** |  |  |  |  |
| **Total Sum**(by Population)  |  |  |  |  |
|  |
| In the box below, the state should specify the source of the data provided above and describe the analysis used to derive the baseline enrollee member month counts and associated enrollee member month projections for each targeted demonstration population; including how this analysis corresponds with the states' analysis described in section II above for estimating unduplicated person counts.If the state is basing its member month data from enrollment data reported in the MBES, please also specify data by form name, line number, and quarter.  |
|  |
| If the state proposes to make additional adjustments to improve the accuracy of base period total enrollee member months, in the box below: * 1. Identify each proposed adjustment amount,
	2. Explain why the adjustment is necessary, and,
	3. Explain how the state calculated the adjustment amount.
 |
|  |

# Section VII – Section 1115 Authorities

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| --- |
| The Medicaid program flexibilities requested by the state in this HAO demonstration application are designed to be provided specifically pursuant to expenditure authority under section 1115(a)(2) of the Act, without the need for section 1115(a)(1) waiver authorities. The state should describe in the box below any component of the proposed policy options or approaches to program administration and design identified in this application template that the state believes additional authorities may be necessary to authorize the HAO demonstration. |
|  |

# Section VIII -- Fair Hearing Rights

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| --- |
| **The state should choose one of the following options for providing fair hearing rights under this proposed HAO demonstration.**  |
| [ ]  | The state will comply with all notice and fair hearing provisions in 42 CFR part 431 subpart E. |
| [ ]  | As described below, the state is proposing the following fair hearing process, as an alternative to 42 CFR part 431 subpart E requirements, with the purpose of improving upon the fair hearing process outlined in these regulatory provisions. The state's description should include an explanation of how the state believes this alternative approach will improve upon the state’s fair hearing process and will still afford to individuals applying for or receiving coverage in the HAO demonstration constitutional and statutory protections that include, but are not limited to, such basic elements as the right to advance notice of a termination or other adverse action; clearly explaining the reason for the action; a timely fair hearing before an impartial arbiter; the opportunity to be represented by counsel at the hearing and to present evidence, including the right to call witnesses; the right to know opposing evidence and cross examine witnesses; and a requirement that the tribunal hearing the case prepare a record of the evidence presented, make a decision based solely upon the evidence presented at the hearing, and produce written findings of fact and reasons for its decision).Other requirements rooted in laws other than the Medicaid statute, such as accessibility requirements for individuals living with disabilities or individuals with limited English proficiency also would apply to a HAO demonstration under section 1115(a)(2) authority. |
| [*DESCRIBE PROPOSED ALTERNATIVE PROCESS HERE*].  |
| **Additional Information.** In the box below, provide any additional information the state believes is important for CMS to understand its intended approach for providing fair hearing rights under this HAO demonstration. |
|  |

# Section IX – Performance Baseline Data

**Baseline Data** – The state should indicate below the documentation it is providing to describe its baseline performance data and any additional data the state plans to use as part of this proposed HAO demonstration. This includes baseline performance data on CMS’ mandatory subset of the Medicaid Adult Core Set quality measures as well as baseline data on CMS’ set of continuous performance indicators as described in the HAO demonstration SMDL guidance. The specific baseline data submission requirements will vary depending on whether the state is proposing coverage of individuals that will be newly eligible under this demonstration, individuals already eligible for coverage, or a combination.

|  |  |  |
| --- | --- | --- |
| If the state is including in this demonstration individuals **already eligible** **for coverage**, for whom baseline data should be available, check the box(es) below to indicate the information that the state is providing as an attachment to this application. |  | If the state is proposing coverage of individuals under this demonstration that will be **newly eligible**, check the box(es) below to indicate the information that the state is providing as an attachment to this application.  |
| [ ]  | The state is providing as attachment \_\_\_ the baseline performance data for the mandatory subset of the Medicaid Adult Core Set quality measures described in Appendix D of the HAO demonstration SMDL guidance.  |  | [ ]  | The state is providing as attachment \_\_\_ its plan and timeline for how it will collect the baseline performance data for the mandatory subset of the Medicaid Adult Core Set quality measures described in Appendix D of the HAO demonstration SMDL guidance.  |
| [ ]  | The state is providing as attachment \_\_\_ the baseline performance data on the continuous performance indicators that it intends to use for timely indicators of potential issues impacting beneficiary access to coverage or care as described in Appendix H of the HAO demonstration SMDL guidance.  |  | [ ]  | The state is providing as attachment \_\_\_ its plan and timeline for how it will collect the baseline performance data on the continuous performance indicators that it intends to use for timely indicators of potential issues impacting beneficiary access to coverage or care as described in Appendix H of the HAO demonstration SMDL guidance.  |

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| **Additional Information.** In the box below, provide any additional information the state believes is important for CMS to understand its intended approach for performance measurement and the data it will use to establish baseline performance. |
|  |

# Section X – Evaluation

**Evaluation Design** – In the table below, the state should provide research hypotheses and proposed evaluation parameters for testing the outcomes of the HAO demonstration associated with the proposed goals and objectives listed in section I.B of this application. To assist the state in completing this section, the state may refer to CMS' published guidance on how to develop evaluations that align with CMS' expectations for rigorous evaluation by clicking the following link: <https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/developing-the-evaluation-design.pdf>.

| **Objective/Goal** | **Hypothesis** | **Evaluation Parameters/Methodology** |
| --- | --- | --- |
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# Section XI – Adequacy of Infrastructure

1. **Information Technology (IT) Infrastructure –** States will be expected to ensure the availability of adequate resources for implementation and monitoring of this demonstration including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with any applicable cost sharing requirements; and reporting on financial and other demonstration components. In the box below or as an attachment to the application, the state should describe how it has developed, or plans to develop, the information technology (IT) systems capability needed to support this demonstration and meet the reporting requirements.

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1. **Transition Planning –** States will be expected to have a plan for transition and orderly close-out if the HAO demonstration, in whole or in part, is being suspended or terminated prior to the date of expiration, or not being extended beyond the date of expiration. In the box below or as an attachment to the application, the state should describe how it has developed, or plans to develop, a transition plan that aligns with each of the listed minimum requirements:

| **Transition Plan Requirement** | **State Process** |
| --- | --- |
| Description of how the state will comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213.  |  |
| Description of how the state will notify affected beneficiaries, including leveraging community outreach activities or community resources that are available. Including providing notice that enrollment of new individuals into the demonstration will be suspended during the last six months of the demonstration. |  |
| Description of the proposed content of beneficiary notices or sample notices that will be sent to affected beneficiaries. |  |
| Description of how the state will assure all appeal and hearing rights are afforded to demonstration participants as outlined in 42 CFR 431.220 and 431.221; including maintaining benefits as required by 42 CFR 431.230 if a demonstration participant requests a hearing before the date of action.  |  |
| Description of the state's process for conducting renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category (42 CFR 435.916). |  |
| If suspension or early termination is being initiated by the state, description of how the state will notify CMS in writing of the effective date and reason(s) for any suspension or early termination initiated by the state at least 120 days before the effective date of the demonstration’s suspension or termination. |  |
| Description of how the state will track and ensure that demonstration expenditures claimed for FFP are limited to normal closeout costs associated with suspension or terminating the demonstration such as administrative costs of disenrolling participants. |  |
| If the state is requesting exemption from public notice procedures pursuant to 42 CFR 431.416(g), description of the qualifying circumstances for which the state is requesting CMS to expedite or waive federal and/or state public notice requirements. |  |

**XII – Programmatic Changes**

**Program Options** **Not Subject to Prior CMS Approval:**

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| States may maximize its ability to make administrative and programmatic changes after the HAO demonstration is approved, without need for additional CMS approval, by describing in the box below a range of policy options or approaches to the design or operation of the demonstration that it may consider implementing over the course of the demonstration approval period. CMS will incorporate in the Special Terms and Conditions (STCs) the range of changes to the policy, design or operation of the HAO demonstration that is being authorized as part of the demonstration approval. States would be expected to provide notice to CMS, an opportunity for public notice and comment, and tribal consultation (if applicable) at least 60 days in advance of implementing a planned change. If the state intends to revise its planned programmatic change, within approved STC parameters, in response to public comments received, states are expected to provide CMS with written notification at least 30 days prior to implementation of such revised change(s). States do not need to repeat here any range of policy options it has already outlined in any of the above application sections. |
|  |

**Please note that any programmatic options not approved in the demonstration STCs will require a demonstration amendment, subject to the federal transparency requirements set forth in 42 CFR part 431 subpart G, and (if applicable) tribal consultation requirements as outlined in the state's approved Medicaid state plan or CMS' July 17, 2001 State Medicaid Director Letter (#01-024).**

**Section XIII – Documentation of State Public Notice and Transparency Efforts**

States are expected to comply with the federal transparency requirements set forth at 42 CFR part 431 subpart G prior to submission of this demonstration application to CMS. Consistent with 42 CFR 431.408(b) and the CMS Tribal Consultation Policy, states developing HAO demonstration applications will be expected to hold meaningful consultation on a government-to-government basis with federally recognized tribes located in their state, in order to develop the details of how a HAO demonstration would be implemented and apply to tribal beneficiaries.  In particular, under 42 CFR 431.408(b), states with federally recognized Indian tribes, Indian health programs, and/or urban Indian health organizations must consult with tribes and solicit advice from Indian health programs and urban Indian health organizations in the state, prior to submitting a demonstration application to CMS, if the demonstration would have a direct effect on Indians, tribes, Indian health programs, or urban Indian health organizations.

In the box below or as an attachment to this application, the state should describe how it complied with these requirements prior to submission to CMS. The description should include the following: 1) a description of all mechanisms used by the state to publish its public notice and the structured formats used to solicit input from interested parties; 2) documentation of the state's full public notice, abbreviated public notice, and tribal consultation notice (if applicable); 3) the active link(s) to the state's website where the public notice documents and public input procedures were made available to the public; and 4) a report of the issues raised during the state public comment period that includes the number of comments received, types of commenters (individual, professional organizations, etc.), common themes or trends of comments received, and the correlation to how these comments were addressed via changes to the state's proposed application or implementation of the demonstration.

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 **Section XIV – State Contact Information**

In the box below, the state should identify the state representative(s) that CMS can contact with any questions regarding this application submission.

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**Appendix A: Summary of Monitoring and Oversight Standards Applicable to Healthy Adult Opportunity (HAO) Demonstrations**

This appendix summarizes general oversight, budget neutrality, monitoring and evaluation reporting requirements that we expect to incorporate into the HAO demonstration STCs. Consistent with regulations at 42 CFR 431.420 and 431.428, the below list of standard provisions will assist CMS is understanding the outcomes and impacts of the state program flexibilities being demonstrated under the approved HAO demonstration. This is not intended to be a comprehensive list of standards that could be applicable to an approved HAO demonstration. CMS may consider additional requirements to be negotiated with the state for approval to ensure that a comprehensive monitoring strategy will be implemented in alignment with the goals of this demonstration initiative. CMS is developing additional guidance to assist states with developing their implementation plan, monitoring plan and evaluation design for approved HAO demonstrations.

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| **Beneficiary Protections:**  |
| * The state will comply with the protection of beneficiary information and confidentiality requirements of section 1902(a)(7) and 42 CFR part 431 subpart F.
* The state will comply with the provisions of 42 CFR 435.908 to provide assistance with application and renewal, including for individuals who are limited English proficient.
* The state will comply with applicable federal statutes and implementing regulations relating to non-discrimination, including, but not limited to, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (PPACA); 42 CFR 435.901 (regarding eligibility determinations and the provision of information; and as to state laws prohibiting religious discrimination).
 |
|  |
| **Monitoring Provisions:**  |
| * The state will comply with monitoring and reporting requirements consistent with regulations at 42 CFR 431.420 and 431.428.
 |
| * The state will develop and submit an **Implementation Plan**, within 90 days of CMS approval of the demonstration (if not submitted as part of the demonstration application). The Implementation Plan should describe the state’s approach for implementing the approved demonstration, including key milestones of what the state will achieve, by when and how, as well as a program integrity plan. CMS will expect states, as a condition of demonstration approval, to complete tribal consultation and a public notice and comment process prior to submitting the Implementation Plan to CMS. The Implementation Plan will conform to a template provided by CMS.
 |
| * The state will make **Implementation Plan** changes over the course of the demonstration if CMS determines that a change in policy, design or operation of the demonstration by the state is likely to impact enrollment or otherwise represent a significant change from the policies, design and operational details set forth in the approved implementation plan. CMS will expect states, as a condition of demonstration approval, to complete tribal consultation and a public notice and comment process on the revised Implementation Plan in the same manner as provided for the initial Implementation Plan.
 |
| * The state will develop and submit, within 120 days post-demonstration approval, a **Monitoring Protocol** for CMS approval. The Monitoring Plan should align with the approved Implementation Plan and include performance metrics for quarterly and annual monitoring reports. The Monitoring Plan will conform to a template provided by CMS.
 |
| * The state will develop and submit **Quarterly Monitoring Reports** consistent with the CMS approved Monitoring Plan by no later than 60 days after the end of each demonstration quarter, except that for the fourth quarter, the state will report on fourth quarter activity as part of the **Annual Monitoring Report**.
 |
| * The state will develop and submit an**Annual Monitoring and Expenditure Report**consistent with the CMS approved monitoring plan by no later than 90 days after the end of each demonstration year.
 |
| * The state will develop and submit an **Independent Mid-Point Assessment** of the demonstration by no later than three years after CMS approval of the demonstration that provides recommendations for mid-course corrections for the state’s consideration. The assessment will be conducted by an independent assessor, and the scope of the assessment will meet the requirements provided by CMS. The state’s assessment plan, including how the results of the assessment will be considered by the state, will be provided in the Monitoring Protocol. The state will provide the independent assessment report and a report on the state’s address of the report findings and recommendations to CMS. The state’s report on how it plans to address the findings and recommendations in the Mid-Point Assessment report will be delivered to CMS 90 days after completion of the assessment report.
 |
| * The state will develop a process in the event that there is a decline, or in some cases an uptick, in one or more Continuous Performance Indicators identified in the state’s approved Implementation Plan, for determining whether corrective action is needed and for engagement with CMS and/or an independent assessor (as necessary) to conduct a rapid cycle evaluation of the approved demonstration.
 |
| * The state will develop and implement a corrective action plan if monitoring activity indicates that demonstration features are no longer likely to assist in promoting the objectives of title XIX. The corrective action process may be an interim step to CMS exercising its right to amend or withdraw expenditure and any other authorities approved under the demonstration.
 |
| * The state will comply with all data reporting requirements under Section 1903® of the Act, including but not limited to Transformed Medicaid Statistical Information Systems (T-MSIS) requirements.
 |
| **Evaluation Provisions:** |
| * The state will obtain an **Independent Evaluator** that will design, conduct and produce the reports for the state’s interim and summative demonstration evaluations. The evaluations will be designed to assess the extent to which the demonstration was successful in meeting the measurable goals and objectives articulated in the Quality Assessment and Improvement Process plan approved for the demonstration.
 |
| * The state will develop and submit, within 180 days post-demonstration approval, a **Draft Evaluation Design** for both the interim and summative evaluations for CMS review and approval. Within 60 days of receiving CMS comments on the Draft Evaluation Design, the state will provide a **Final Evaluation Design** for approval that complies with CMS guidance. The state will post on its state Medicaid website, its Draft Evaluation Design and the Final Evaluation Design within 30 days of CMS approval of the Final Evaluation Design.
 |
| * The state will submit any updates to the approved Final Evaluation Design to CMS for approval within 60 days of CMS approval of corresponding changes to the CMS-approved Implementation Plan.
 |
| * The state will develop and submit for CMS comment a **Draft Interim Evaluation Report** by no later than one year prior to the expiration of the demonstration or with the extension application that reflects the CMS approved Evaluation Design and any revisions due to significant changes in the state’s approved Implementation Plan.
 |
| * The state will develop and submit for CMS approval, a **Final Interim Evaluation Report** within 60 days of receiving CMS comments on the Draft Interim Evaluation Report. The Final Interim Evaluation Report will reflect the CMS approved Evaluation Design, any revisions due to significant changes in the state’s approved Implementation Plan, and will address CMS comments, if provided, on the Draft Interim Evaluation Report(s) submitted to CMS.
 |
| * The state will develop and submit for CMS approval, a **Draft Summative Evaluation Report** by no later than 18 months following the end of the demonstration approval period. The Draft Summative Evaluation Report will reflect the CMS approved Evaluation Design, any revisions due to significant changes in the state’s approved Implementation Plan, and will include an analysis of the last year of the demonstration.
 |
| * The state will develop and submit for CMS approval, a **Final Summative Evaluation Report** within 60 days of receiving CMS comments on the Draft Summative Evaluation Report. The Final Summative Evaluation Report will reflect the CMS approved Evaluation Design, any revisions due to significant changes in the state’s approved Implementation Plan, and will address any CMS comments on the Draft Summative Evaluation Report.
 |
| **Quality Provisions:** |
| * The state will develop and submit, within 90 days post-demonstration approval, **Baseline Quality & Access Measure Reporting and Beneficiary Access to Care, Barriers of Care and Experience of Care** **Survey Results** for CMS review.
* The state will develop and submit, within 90 days post-demonstration approval, a **Quality Strategy and Performance Assessment** that is comprised of five key components: (1) measurable goals, (2) interventions, (3) performance measures, (4) baselines and targets, and (5) rapid-cycle assessment and continuous quality improvement. The Quality Strategy and Performance Assessment will address all populations covered under the demonstration and will include all of the components specified in Appendix E of the HAO demonstration SMDL guidance.
 |
| * The state will develop and submit an **Annual Quality and Access Measure Report** by no later than 90 days after the end of each demonstration year that meets the requirements of the CMS approved quality strategy for the demonstration. The state will ensure independent verification of the metric data reported in the Quality Strategy and Performance Assessment and in quarterly and annual demonstration monitoring reports.
 |
| * The state will develop and submit a **Report of the Annual Survey of Beneficiary Access to Care, Barriers of Care and Experience of Care** by no later than 90 days after the end of each demonstration year that meets the requirements of the CMS approved quality strategy for the demonstration.
 |
| **Budget Neutrality Provisions:** |
| * The state will ensure that demonstration expenditures are not used to supplant or duplicate funds from other federal programs according to Cost Principles at 2 CFR part 200 and implemented at 45 CFR part 75.
 |
| * The state will submit quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under the demonstration following routine CMS-37 and CMS-64 reporting instructions for section 1115 demonstrations as outlined in section 2500 of the State Medicaid Manual. This includes quarterly reporting of expenditures subject to the budget neutrality expenditure limit on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS and the two digit project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made.
 |
| * The state will track demonstration expenditures subject to the limit on the amount of federal title XIX funding as established in the STCs for the period of demonstration approval. The state will have a process for monitoring its spending against the budget neutrality expenditure limits that are set on a yearly basis. CMS’ assessment of the state’s compliance with the annual limits will be done using the Schedule C reports from the CMS-64.
 |
| * The state will complete and submit quarterly CMS' Budget Neutrality Workbook for tracking demonstration expenditures subject to the expenditure limit specified in the approved STCs for the demonstration. The state will use the Budget Neutrality Workbook to assist in tracking expenditures incurred during the period of demonstration approval and eligible for Federal Financial Participation (FFP) at the applicable federal matching rates.
 |
| * The state will realign demonstration spending if circumstances occur where CMS exercises its right to adjust the budget neutrality expenditure limit to:
	+ To be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration; and/or
	+ To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration that necessitates the state submit for CMS approval a modified budget neutrality agreement to comply with such change.

In this circumstance, if mandated changes in the federal law require state legislation, the state will effectuate such changes on the day that such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law. |
| * The state will ensure that its sources of non-federal share meet the following conditions:
	+ Units of government, including governmentally-operated health care providers, certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration;
	+ To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, the state submits for CMS approval a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures;
	+ To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state’s claim for federal match; and,
	+ The state uses intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. No pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments.
 |
| * FOR PER CAPITA CAP demonstrations, states will develop a process for reporting member months for each demonstration population as part of the Quarterly and Annual Monitoring Reports described in section XIII of this application. The state will have a process for calculating and reporting the actual number of "eligible member months" in a manner consistent with reported enrollment on MBES Form CMS-64.ENROLL.
 |
| * The state will develop a process for corrective action if it is ever determined that the demonstration has exceeded its annual budget neutrality expenditure limit, either by the state or by CMS, that includes submission of a written corrective action plan to CMS within 21 days of the date the state is informed of the problem. The state's corrective action plan should also include procedures for returning excess funds to CMS following the CMS-64 process for reporting negative adjustments to claimed expenditures.
 |
| **Program Integrity Provisions:** |
| * The state will make accurate and timely eligibility determinations, complying with the requirements of section 1903(u) of the Act, participating in reviews under PERM and MEQC, and, as determined necessary by CMS, will cooperate with enhanced monitoring of Medicaid eligibility determinations as outlined in the 2018 CMS Medicaid Program Integrity Strategy and other relevant regulatory or sub-regulatory guidance.
 |
| * The state will have a process for tracking actual expenditures incurred under the approved demonstration consistent with the state’s budget neutrality parameters established in the approved STCs and for ensuring that Medicaid payment requirements of section 1903 of the Act are being applied under this demonstration.
 |
| * The state will have a process for complying with CMS' process for demonstration deferrals in accordance with the requirements for 42 CFR part 430 subpart C as described below:
* CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by the STCs that will govern the approved demonstration (e.g., required data elements, analyses, reports, design documents, presentations, and any other specified items (hereafter singularly or collectively referred to as “deliverable(s)”)) are not submitted timely to CMS or are found to not be consistent with the STC requirements approved by CMS. Additionally, the state’s failure to submit all required reports, evaluations and other STC deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.
* Any CMS-issued deferral will not exceed the value of the federal amount for the demonstration. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of the approved STCs.
* CMS intends to use the following process in the event that either: (1) the state has not submitted a written request to CMS for approval of an extension, as described below, within thirty (30) days after a deliverable was due, or (2) the state has not submitted a revised submission or a plan for corrective action to CMS within thirty days after CMS has notified the state in writing that a deliverable was not accepted for being inconsistent with the requirements of this agreement including the information needed to bring the deliverable into alignment with CMS requirements:
1. 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). For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state’s anticipated date of submission. Should CMS agree to the state’s request, a corresponding extension of the deferral process can be provided.
2. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state’s written extension request.
3. If CMS agrees to an interim corrective process in accordance with paragraph b, and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

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

1. All references to statutory sections made in this document are references to the Social Security Act, unless otherwise stated. Similarly, all references to regulations made in this document are references to regulations in title 42 of the Code of Federal Regulations (CFR), unless otherwise stated. [↑](#footnote-ref-2)