
State Demonstrations Group

June 25, 2025

William Halsey
State Medicaid Director
Connecticut Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Director Halsey:

The Centers for Medicare & Medicaid Services (CMS) is updating the section 1115 demonstration monitoring approach to reduce state burden, promote effective and efficient information sharing, and enhance CMS's oversight of program integrity by reducing variation in information reported to CMS.

Federal section 1115 demonstration monitoring and evaluation requirements are set forth in section 1115(d)(2)(D)-(E) of the Social Security Act (the Act), in CMS regulations in 42 CFR 431.428 and 431.420, and in individual demonstration special terms and conditions (STCs). Monitoring provides insight into progress with initial and ongoing demonstration implementation and performance, which can detect risks and vulnerabilities to inform possible course corrections and identify best practices. Monitoring is a complementary effort to evaluation. Evaluation activities assess the demonstration's success in achieving its stated goals and objectives.

Key changes of this monitoring redesign initiative include introducing a structured template for monitoring reporting, updating the frequency and timing of submission of monitoring reports, and standardizing the cadence and content of the demonstration monitoring calls.

Updates to Demonstration Monitoring

Below are the updated aspects of demonstration monitoring for the Covered Connecticut (Project Number 11-W-00402/1) demonstration.

Reporting Cadence and Due Date

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, CMS is updating the cadence for this demonstration to annual monitoring reporting (see also section 1115(d)(2)(D)-(E) of the Act). This transition to annual monitoring reporting is expected to

alleviate administrative burden for both the state and CMS. In addition, CMS is extending the due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state’s work to draft, review, and submit the report timely.

CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. The standard for determining the frequency of monitoring reporting will ultimately be included in each demonstration’s STCs. CMS expects that this standard will permit CMS to make on-going determinations about reporting frequency under each demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. *See 42 CFR 431.420(d)(1)-(2).*

The Covered Connecticut demonstration will transition to annual monitoring reporting effective June 25, 2025. The next annual monitoring report will be due on June 29, 2026, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting cadence and due date.

Structured Monitoring Report Template

As noted in STC 25, “Monitoring Reports,” monitoring reports “must follow the framework provided by CMS, which is subject to change as monitoring systems are developed / evolve and be provided in a structured manner that supports federal tracking and analysis.” Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report’s content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

This structured template will include a set of base metrics for all demonstrations. For demonstrations with certain waiver and expenditure authorities, there are additional policy-specific metrics that will be collected through the structured reporting template.

CMS is also removing the requirement for a Monitoring Protocol deliverable, which has been required under certain types of section 1115 demonstration, including but not limited to the Substance Use Disorder (SUD), Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED), Health-Related Social Needs (HRSN), and reentry demonstrations. Removal of the Monitoring Protocol requirement simplifies and streamlines demonstration monitoring activities for states and CMS.

Demonstration Monitoring Calls

As STC 28 “Monitoring Calls” describes, CMS may “convene periodic conference calls with the state,” and the calls are intended “to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration.” Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

CMS will continue to be available for additional calls as necessary to provide technical assistance or to discuss demonstration applications, pending actions, or requests for changes to demonstrations. CMS recognizes that frequent and regular calls are appropriate for certain demonstrations and at specific points in a demonstration’s lifecycle.

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent Covered Connecticut section 1115 demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

If you have any questions regarding these updates, please contact Danielle Daly, Director of the Division of Demonstration Monitoring and Evaluation, at Danielle.Daly@cms.hhs.gov.

Sincerely,

Karen Llanos
Karen Llanos
Acting Director

Enclosure

cc: Maria DiMartino, State Monitoring Lead, Medicaid and CHIP Operations Group

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: **11-W-00402/1**

TITLE: **Covered Connecticut Section 1115 Demonstration**

AWARDEE: **Connecticut Department of Social Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration, December 15, 2022 through December 31, 2027, be regarded as expenditures under the state's Title XIX plan, but are further limited by the special terms and conditions (STCs) for the Covered Connecticut (Covered CT) section 1115 demonstration.

As discussed in the Centers for Medicare & Medicaid Services' (CMS') approval letter, the Secretary of Health and Human Services has determined that the Covered CT section 1115 demonstration, including the granting of the waiver and expenditure authority described below, is likely to assist in promoting the objectives of title XIX of the Social Security Act.

The following expenditure authority shall enable Connecticut to implement the Covered CT section 1115 demonstration:

- 1. Marketplace Subsidies.** Expenditures for the payments made through the state-operated health insurance exchange established by the state pursuant to 42 U.S.C. § 18031, which is known as Access Health Connecticut (Access Health CT) marketplace program to:
 - a. Provide cost sharing, premium subsidies, and program charges (determined based on increased beneficiary utilization resulting from the structure of Covered CT), for certain individuals described below with incomes described below. Subsidies will be provided on behalf of individuals who:
 - i. are adults aged between 19 and 64 who are not Medicaid eligible; and
 - ii. whose income, as determined by the state, does not exceed 175 percent of the Federal Poverty Limit (FPL);
 - iii. are eligible to receive advance premium tax credits; and
 - iv. enroll in a silver-level qualified health plan (QHP) through Access Health CT.

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Covered Connecticut Demonstration

Approval Period: December 15, 2022 through December 31, 2027

Technical Corrections on April 27, 2023

2. **Non-Emergency Medical Transportation (NEMT).** Expenditures for the payments made for individuals in Covered CT to receive non-emergency medical transportation (NEMT) benefits comparable to the state plan NEMT benefits.
3. **Dental.** Expenditures for the payments made for individuals in Covered CT to receive dental benefits comparable to the state plan dental benefits.

No Title XIX Requirements are Applicable to Expenditures for the Marketplace Subsidies, NEMT and Dental Services.

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: **11-W-00402/1**

TITLE: **Covered Connecticut Section 1115 Demonstration**

AWARDEE: **Connecticut Department of Social Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Covered Connecticut (Covered CT) section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Connecticut Department of Social Services (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authority authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. Enrollment into the demonstration is statewide and is approved through December 31, 2027.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Marketplace Subsidies
- V. Benefits
- VI. Premiums and Cost Sharing
- VII. Monitoring and Reporting Requirements
- VIII. General Financial Requirements
- IX. Monitoring Budget Neutrality for the Demonstration
- X. Evaluation of the Demonstration
- XI. Schedule of Deliverables

Attachments

Attachment A: Developing the Evaluation Design

Attachment B: Preparing the Interim and Summative Evaluation Reports

Attachment C: Approved Monitoring Protocol (reserved)

Attachment D: Approved Evaluation Design (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

Effective from the approval date on December 15, 2022 through December 31, 2027, the Covered CT demonstration will provide premium assistance and cost-sharing payments for certain low-income individuals, specifically adults aged 19 to 64, who have income that is above the Medicaid limit but does not exceed 175 percent of the federal poverty level (FPL), who enroll in a silver-level QHP on the Access Health CT marketplace using all available federal premium subsidies and cost-sharing reductions. The demonstration will also provide dental services and non-emergency medical transportation (NEMT) to these individuals. There will be no cost sharing associated with the demonstration benefits.

The enhanced QHP premium subsidies created by the American Rescue Plan Act of 2021 (ARP), Pub. L. 117-2 and extended in the Inflation Reduction Act of 2022 (IRA), Pub. L. 117-169, provide an opportunity for Connecticut, though this demonstration, to close the coverage gap for low-income individuals in the state who cannot otherwise afford QHP coverage through Access Health CT by leveraging state funding to make new investments to improve health care coverage, access, and equity.

Over the demonstration period, the state seeks to achieve several demonstration goals. A major goal of this demonstration is to help close the health insurance affordability gap in a cost-effective manner for low-income individuals who earn too much to qualify for Medicaid but not enough to afford coverage through the state's health insurance marketplace, Access Health CT. The state's goals will inform the state's Evaluation Design hypotheses, subject to CMS approval, as described in these STCs. The state's goals include, but are not limited to the following:

- 1) improve the affordability of health insurance coverage,
- 2) promote health insurance coverage,
- 3) ensure stable coverage,
- 4) reduce the statewide uninsured rate,
- 5) improve oral health, and
- 6) enable access to medical appointments.

Connecticut anticipates that the demonstration may expand access to health coverage for low-income individuals, leveraging the efficiencies and experience of the private market to improve continuity, access, and quality of care for Covered CT beneficiaries that should ultimately result in lowering the rate of growth in silver-level QHP premiums across population groups. The state anticipates that the demonstration may also drive structural health care system reform and more competitive premium pricing for all individuals purchasing coverage through the Access CT Marketplace by increasing the size of the population enrolling in silver-level QHPs offered through the Access CT Marketplace.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557).
- 2. Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP programs, expressed in federal law, regulation, and written policy, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or written policy, come into compliance with any changes in federal law, regulation, or written policy affecting the Medicaid and/or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a.** To the extent that a change in federal law, regulation, or written policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, as well as a modified allotment neutrality worksheet if applicable, to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b.** If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.
- 5. State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state

plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid and CHIP state plan governs.

6. **Changes Subject to the Amendment Process.** If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.
7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit reports required in the approved STCs and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
 - a. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;
 - b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
 - d. An explanation of the public process used by the state consistent with the requirements of STC 13; and
 - e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design

and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in the statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 CFR § 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.
9. **Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
 - a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan Amendment, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
 - b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will take to notify affected beneficiaries, including community resources that are available.
 - c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must begin no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

- d. **Transition Phase-out Procedures.** The state must comply with all fair hearing and notice requirements found in 42 CFR part 431 subpart E. If a demonstration participant requests a fair hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as required in 42 CFR Section 435.916 prior to determining a beneficiary is ineligible and terminating coverage. For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR § 435.1200(e) and 457.350.
- e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR § 431.416(g).
- f. **Federal Financial Participation (FFP).** FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- b. **Expiration Procedures.** The state must comply with all fair hearing and notice requirements found in 42 CFR part 431 subpart E. If a demonstration beneficiary requests a fair hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility prior to determining an individual is ineligible and terminating coverage as required in 42 CFR Section 435.916. For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR §§ 435.1200(e) and 457.350.

- c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
- d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling beneficiaries.

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

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

13. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration are proposed by the state.

- a. In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter (SMDL #01-024) or the consultation process in the state's approved Medicaid

state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

- b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).
- c. The state must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

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

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

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

IV. MARKETPLACE SUBSIDIES.

17. Marketplace Subsidies. The state may claim as allowable expenditures under the demonstration the marketplace subsidies as described below. The state may claim as allowable expenditures under the demonstration the payments made through its state-operated Access Health CT program to provide premium and cost sharing subsidies for

certain individuals described below. Subsidies will be provided on behalf of individuals who:

- a. are adults between ages 19 and 64 who are not eligible for Medicaid; and
- b. whose income, as determined by the state does not exceed 175 percent of the FPL;
- c. who are eligible for coverage with an advance premium tax credit (APTC); and
- d. enroll in a silver-level QHP through Access Health CT.
- e. Federal financial participation for the premium assistance and cost sharing portions of the Access Health CT marketplace subsidies for the individuals described above will be provided through the expenditure authority corresponding to this STC.

18. Reporting for Access Health CT. The state must provide data regarding the operation of this marketplace subsidy program in the Annual Monitoring Report required per STC 25. This data must, at a minimum, include:

- a. The number of individuals served by the program;
- b. The size of the subsidies; and
- c. A comparison of projected costs with actual costs.

V. BENEFITS

19. Access to Non-Emergency Medical Transportation. The state will provide NEMT services comparable to the benefits under Connecticut Medicaid and provided through the Medicaid delivery and payment system, HUSKY Health.

20. Access to Dental. The state will provide dental services comparable to the benefits under Connecticut Medicaid and provided through the Medicaid delivery and payment system, HUSKY Health.

VI. PREMIUMS & COST SHARING

21. Premiums & Cost Sharing. No beneficiary will be required to pay premium or cost sharing with respect to benefits provided under the demonstration.

VII. MONITORING AND REPORTING REQUIREMENTS

22. Submission of Post-approval Deliverables. The state shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs (“deliverables”). The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.

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

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

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state’s anticipated date of submission. Should CMS agree to the state’s request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state’s written extension request.
- c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required content in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

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

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

24. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments, if any. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment E. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conducting Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable. Any proposed deviations from CMS's guidance must be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration and specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., performance metrics as described in STC 25(a) below), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and/or geography) and demonstration component.

For the qualitative elements (e.g., operational updates as described in STC 25(a) below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

25. Monitoring Reports. The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each Demonstration Year (DY). The fourth-quarter

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

- a. Operational Updates - Per 42 CFR § 431.428, the Quarterly and Annual Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The Monitoring Reports shall provide sufficient information to document key challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. Performance Metrics – The performance metrics will provide data to demonstrate how the state is progressing toward meeting the demonstration's goals—including relative to their projected timelines—of the demonstration's program and policy implementation, and must cover all key policies under this demonstration. Additionally, per 42 CFR § 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The state's metrics reporting must cover categories to include, but not limited to: enrollment and renewal, including enrollment duration, access to providers, utilization of services, quality of care and health outcomes, and other metrics as may be relevant for the state's premium assistance program. The state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policy composition and objectives, to be reported for all demonstration populations as well as stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability

status, and/or geography) and demonstration component—to the extent feasible—to identify existing inequities and track progress towards reducing inequities.

- c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR § 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.
- d. Evaluation Activities and Interim Findings – Per 42 CFR § 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

26. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11. CMS will withdraw an authority, as described in STC 11, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

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

- a. The Close-Out Report must comply with the most current guidance from CMS.
- b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval

period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 59 and 60, respectively.

- c. The state will present to and participate in a discussion with CMS on the Close-Out report.
- d. The state must take into consideration CMS's comments for incorporation into the final Close-Out report.
- e. A revised Close-Out report is due to CMS no later than 30 calendar days after receipt of CMS's comments.
- f. A delay in submitting the draft or final version of the Close-Out report may subject the state to penalties described in STC 23.

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

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

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

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

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

- b. Ensure all section 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
- c. Submit deliverables to the appropriate system as directed by CMS.

VIII. GENERAL FINANCIAL REQUIREMENTS

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

- a. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

32. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

- a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
- b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.
- c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

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

- a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.
- b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR § 433.51(c).
- c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR § 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.
- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third

parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

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

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR §§ 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

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

- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR § 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR § 433.68(c).
- b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR § 433.68(d).
- c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR § 433.72.
- d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR § 433.68(f).
- e. All provider-related donations as defined by 42 CFR § 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR § 433.66, and 42 CFR § 433.54.

36. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration

approval. This deliverable is subject to the deferral as described in STC 23. This report must include:

- a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;
- b. Number of providers in each locality of the taxing entities for each locality tax;
- c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
- d. The assessment rate that the providers will be paying for each locality tax;
- e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
- f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
- g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR § 433.68(f); and
- h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

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

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

38. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also

ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

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

Table 1: Master MEG Chart					
MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Covered CT	Hypo 1	X		X	Expenditures for premium and cost sharing subsidies, program charges, NEMT and dental benefits under the demonstration.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

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

40. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00402/1). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as with waiver (WW) must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total

Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits. As noted above in STC 21, no beneficiary will be required to pay premiums or cost sharing with respect to benefits provided under the demonstration, so this paragraph does not apply.

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

- d. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section VII, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as without waiver (WOW) Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
- e. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 2: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Covered CT	Expenditures for premium and cost sharing subsidies, program charges, NEMT and dental benefits under the demonstration.		Report using Line 69 - Other Care Services	Date of service/ Date of payment	MAP	Y	12/21/ 2022	12/31/ 2027
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	12/21/ 2022	12/31/ 2027

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

Table 3: Demonstration Years

Demonstration Year 1	December 15, 2022 to December 31, 2022	About 1 month
Demonstration Year 2	January 1, 2023 to December 31, 2023	12 months
Demonstration Year 3	January 1, 2024 to December 31, 2024	12 months
Demonstration Year 4	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 5	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 6	January 1, 2027 to December 31, 2027	12 months

42. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics

database and analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing the demonstration’s actual expenditures to the budget neutrality expenditure limits described in section 2. CMS will provide technical assistance, upon request.¹

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

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

- a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
- b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

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

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

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

- a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 44(c). If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
- b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
 - i. Provider rate increases that are anticipated to further strengthen access to care;
 - ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;
 - iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

- iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
- v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
- vi. High cost innovative medical treatments that states are required to cover;
- vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely; or

- c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
 - i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,
 - ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 45. Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of one Hypothetical Budget Neutrality Test, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.
- 46. Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart and Table 2, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state

at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

47. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver per member per month (PMPM) cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
48. **Main Budget Neutrality Test.** This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of one Hypothetical Budget Neutrality Test. Any excess spending under the Hypothetical Budget Neutrality Test must be returned to CMS.
49. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition

of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

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

Table 4: Hypothetical Budget Neutrality Test 1 Covered CT										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5	DY 6
Covered CT	PC	Both	2021	5.5%	\$727.18	\$748.58	\$789.75	\$833.19	\$879.02	\$927.37

The PMPMs have been calculated and trended forward based on the level of federal Marketplace subsidies available in DY 1. If needed, the PMPMs may be updated through mid-course corrections (see STC 44) to reflect changes in projected expenditures.

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

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

determining when corrective action is required.

Table 5: Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 1 through DY 2	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 6	Cumulative budget neutrality limit plus:	0.0 percent

X. EVALUATION OF THE DEMONSTRATION

53. **Cooperation with Federal Evaluators.** As required under 42 CFR § 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they make data available for the federal evaluation as is required under 42 CFR § 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 23.
54. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.
55. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design for Covered CT no later than 180 days after the approval of the demonstration.

The Evaluation Design must be drafted in accordance with Attachment B (Developing the Evaluation Design) of these STCs, and any applicable CMS evaluation guidance and technical assistance. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must

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Covered Connecticut Demonstration

Approval Period: December 15, 2022 through December 31, 2027

Technical Corrections on April 27, 2023

include a timeline for key evaluation activities, including evaluation deliverables, as outlined in STC 25.

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

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

57. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact on beneficiary coverage, access to and quality

of care, and health outcomes, as well as its effectiveness in achieving the policy goals and objectives. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. The evaluation must also provide an assessment of the progression towards the demonstration’s goals. Specifically, hypotheses for the demonstration’s program component authorizing premium assistance and cost-sharing reduction payments for beneficiaries in QHPs must focus on outcomes such as beneficiary enrollment, take-up rates, access and health outcomes, and unmet need for care. To evaluate the dental program, the state should develop hypotheses related to (but not limited to): utilization of preventive dental care services and dental-related emergency department visits. To evaluate the effects of providing NEMT to beneficiaries, the state should attempt to obtain information about utilization of NEMT services, beneficiaries’ missed medical appointments, and other transportation-related barriers to accessing care. The state must also include descriptive research questions and hypotheses related to trends in overall demonstration enrollment, disenrollment, and reenrollment, beneficiary outreach, and challenges encountered during the implementation of this demonstration.

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not limited to: administrative costs of demonstration implementation and operation, and Medicaid health service expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration’s effects on the fiscal sustainability of the state’s Medicaid program.

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

The demonstration evaluation must also accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and/or geography) and demonstration component to inform a fuller understanding of existing disparities in access and health outcomes, and how the demonstration’s various policies might support bridging any such inequities. The state is furthermore strongly encouraged to consider principles of equitable evaluation, which incorporates applicable historical, cultural and

structural contexts to help assess the effects of the demonstration initiatives on different populations and the underlying systematic drivers of disparities.²

58. **Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.
59. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR § 431.412(c)(2)(vi). When submitting an application for extension, the Interim Evaluation Report should be posted to the state's website with the application for public comment.
 - a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design. In this report, the state must also describe its findings related unwinding the state's premium policies, and any potential lessons thereof.
 - b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.
 - c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
 - d. The state must submit a revised Interim Evaluation Report 60 days after receiving CMS's comments on the draft Interim Evaluation Report. Once approved by CMS,

² For more information about equitable evaluation, see Gaddy, Marcus and Kassie Scott. "Principles for Advancing Equitable Data Practice." Urban Institute, June 2020. Available at: https://www.urban.org/sites/default/files/publication/102346/principles-for-advancing-equitable-data-practice_0.pdf. CMS will soon release additional guidance on equitable evaluation with more relevant context for sections 1115 demonstrations.

the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

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

60. Summative Evaluation Report. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit the revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.

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

61. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

62. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

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

64. Additional Publications and Presentations. For a period of 12 months following CMS's approval of deliverables, CMS will be notified prior to presentation of these

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

XI. SCHEDULE OF DELIVERABLES

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date – Specific	Deliverable	Section Reference
Within 150 days of demonstration approval date	Monitoring Protocol	STC 24
Within 60 days of receiving CMS comments	Revised Monitoring Protocol	STC 24
Within 180 calendar days of demonstration approval date	Draft Evaluation Design	STC 55
Within 60 days of receiving CMS comments	Revised Evaluation Design	STC 56
One year prior to demonstration expiration or with extension application	Draft Interim Evaluation Report	STC 59
Within 60 days of receiving CMS comments	Revised Interim Evaluation Report	STC 59(d)
Within 18 months after the expiration of this demonstration period	Draft Summative Evaluation Report	STC 60
Within 60 days of receiving CMS comments	Revised Summative Evaluation Report	STC 60(a)
Within 120 days after the end of the demonstration	Draft Close-Out Report	STC 27
Within 30 days after receiving CMS comments	Revised Close-Out Report	STC 27(e)
<i>Annually</i>		
90 days after the end of each DY	Annual Monitoring Report (including Q4 monitoring information and budget neutrality)	STC 25
Within 30 days of receiving CMS comments	Revised Annual Monitoring Report	STC 25
<i>Quarterly</i>		
60 days following the end of the quarter	Quarterly Monitoring Reports	STC 25
30 days following the end of the quarter	Quarterly Expenditure Reports	STC 25(b)
60 days following the end of the quarter, except for Q4 which is submitted with Annual Report	Quarterly Budget Neutrality Report	STC 25(b)

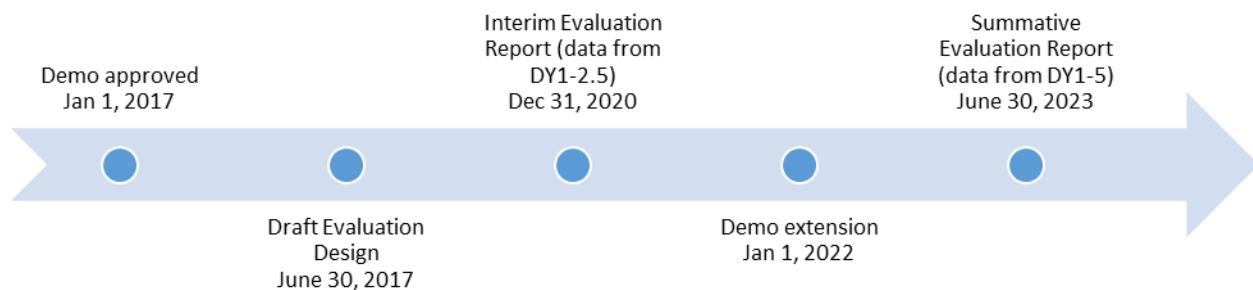
ATTACHMENT A **Developing the Evaluation Design**

Introduction

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

Submission Timelines

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



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If

the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

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

The format for the Evaluation Design is as follows:

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

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

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

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

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams:
<https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>.

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

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure. Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling

methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate. The state also should include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.
5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
 - a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
 - b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).

- c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
- d. Consider the application of sensitivity analyses, as appropriate.

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

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

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

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

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
 - a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
 - b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes;
 - b. No or minimal appeals and grievances;
 - c. No state issues with CMS-64 reporting or budget neutrality; and
 - d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.
2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR § 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

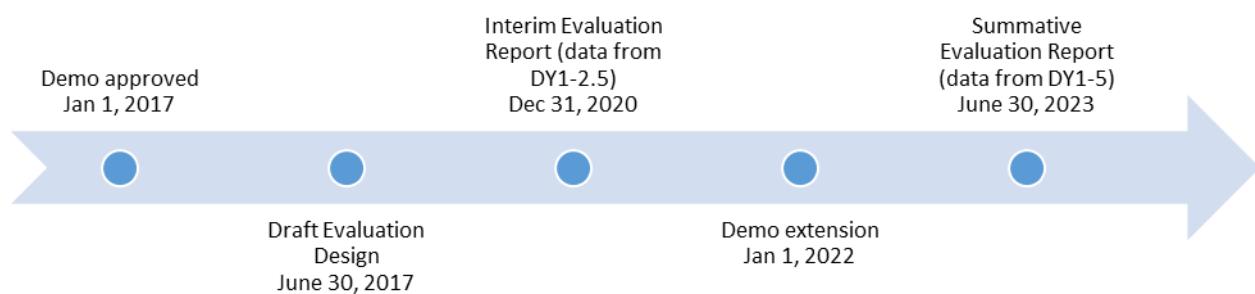
Attachment B: Preparing the Interim and Summative Evaluation Reports

Introduction

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

Submission Timelines

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



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses,

which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

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

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

Intent of this Attachment

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

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

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

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

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

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:

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

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

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of titles XIX and XXI.

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

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

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

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
2. *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected.
4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

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

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. If the state did not fully achieve its intended goals, why not?
3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

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

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as

significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

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

ATTACHMENT C: APPROVED MONITORING PROTOCOL (RESERVED)

Covered Connecticut Demonstration
Approval Period: December 15, 2022 through December 31, 2027
Technical Corrections on April 27, 2023

ATTACHMENT D: APPROVED EVALUATION DESIGN (RESERVED)

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Covered Connecticut Demonstration

Approval Period: December 15, 2022 through December 31, 2027

Technical Corrections on April 27, 2023

Covered Connecticut (Covered CT)

1115 Waiver

Evaluation Design

State of Connecticut

Updated April 19, 2024

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Section 1

General Background Information

The Challenge: Affordable Coverage for the Near-Poor

Connecticut (State) has a strong history of working to make health care coverage affordable and accessible to its residents. Yet while significant gains have been made, coverage remains unaffordable to many, including some of the State's lowest-income individuals and families.

The rate of uninsured low-income people is generally not the result of a lack of coverage options, but rather a lack of affordable coverage choices. Individuals who are not eligible for Medicaid can buy coverage from a Qualified Health Plan (QHP) available through Access Health CT. That coverage is subsidized by the federal government, but still costly for low-income residents who are just above Medicaid eligibility levels.

Research shows that monthly premiums can deter low-income individuals straining to meet their basic needs from enrolling in health care coverage. These findings are particularly relevant to Connecticut, one of the costliest states to live in. In 2018, Connecticut ranked eighth across states for cost of living, leaving the near-poor in this State particularly cost-sensitive when it comes to affording health coverage.¹ Analyses have shown that people in Connecticut must have incomes well above the federal poverty threshold just to meet their basic needs, including housing, childcare, food, transportation, and taxes, as well as to afford health care and other items.

The cost of coverage can be a particular issue for individuals who lose Medicaid eligibility when their income rises due to a new job or a wage increase. These individuals are exposed to a significant jump in cost for coverage (and out-of-pocket costs when they get care) even with subsidized commercial plans available through Access Health CT.

The Uninsured and Medicaid Coverage in Connecticut

Of Connecticut's more than 3.5 million residents, nearly 190,000 were uninsured in 2018. This results in a State uninsured rate of about 5%, which is on par with the average across New England, but lower than the national average.^{2,3} Approximately 48,000 of Connecticut's uninsured residents in 2018 had incomes between 100% and 200% federal poverty level (FPL),⁴ accounting for a quarter of the State's uninsured population even though this income range makes up just 13% of the State's population.⁵ Some of these uninsured individuals are eligible for Medicaid based on the State's current eligibility requirements (i.e., childless individuals with income under 138% FPL and parents and caretaker relatives earning less

¹ Cohn, S. (July 10, 2018). 10 Most Expensive Places to Live in America. CNBC. Retrieved from: <https://www.cnbc.com/2018/06/28/these-are-americas-most-expensive-states-to-live-in-for-2018.html>.

² Access Health CT. (February 20, 2020). 2020 Open Enrollment Summary.

³ State Health Access Data Assistance Center. (October 17, 2019). SHADAC Uninsurance Rates for Connecticut in 2017 and 2018. Retrieved from: https://www.shadac.org/sites/default/files/publications/1_year_ACS_2018/aff_s2701_CT_2017_2018.pdf.

⁴ Ibid.

⁵ In this section, data on the uninsured and the shifts in Connecticut's coverage landscape include all non-elderly State residents (i.e., State residents who are 64 years old or younger).

than 160% FPL).⁶ People earning above those levels are likely to be eligible for subsidized coverage through a QHP available through Access Health CT.

The number of uninsured individuals in Connecticut with incomes between 100% and 199% FPL increased from 36,300 (10% of individuals in this income range) in 2016 to 48,000 (13%) in 2018; this group includes both Medicaid and non-Medicaid eligible individuals.⁷ For individuals between 139% and 250% FPL (a group that includes many adults not eligible for Medicaid), the number of uninsured grew from approximately 42,000 to 48,000 people during the same period. Between 2016 and 2018, for people with incomes between 139% and 250% FPL, employer coverage declined by approximately 6,700 and enrollment in individual market coverage (both on and off Access Health CT) dropped by approximately 7,400. During this same period (2016–2018), the share of individuals between 139% and 250% FPL who were covered by Medicaid grew modestly (from approximately 128,500 to 132,000), suggesting that the drops in coverage noted above have mostly occurred among those with incomes above Medicaid eligibility levels.

Looking ahead, Connecticut's uninsured rate for the near-poor is likely to rise. Since the start of the Coronavirus Disease 2019 (COVID-19) pandemic, more than 400,000 State residents have filed for unemployment.⁸ Some people losing jobs and job-based coverage will qualify for Medicaid, while others will have family incomes that put them over Medicaid eligibility limits, and their sudden loss of income will mean a diminished ability to pay premiums.

Recent estimates suggest that the uninsured rate in states like Connecticut that have expanded Medicaid, will grow by 12% on average and an additional 36,000 to 77,000 state residents may become uninsured as a result of the COVID-19-related economic downturn.^{9,10} Those with the least ability to afford new coverage will be the people with incomes below 200% FPL, but above the Medicaid thresholds. The end of the COVID-19 public health emergency and the continuous enrollment requirements of the Families First Coronavirus Response Act will be particularly impactful for this population.

Medicaid Coverage in Connecticut

Most of the lowest-income State residents are eligible for coverage through HUSKY Health, Connecticut's Medicaid program. Connecticut has a strong history of using Medicaid to provide comprehensive health coverage to low-income residents. According to monthly data reported to the federal government, Connecticut's Medicaid program currently covers approximately 961,000 people, or about one out of four State residents.¹¹ Before the

⁶ Note: Throughout this document, the applicable Medicaid eligibility FPL limits, including references to 138%, 160%, and 201%, each incorporates the 5% income disregard.

⁷ Kaiser Family Foundation. (2016). Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL). Retrieved from: <https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-federal-poverty-level-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁸ CT Data Collaborative. (May 24, 2020). Unemployment in Connecticut During COVID-19 Crisis. Retrieved from: <https://www.ctdata.org/covid19-unemployment>.

⁹ Banthin J, Simpson M, Buettgens, M, et al. (July 2020) Changes in Health Insurance Coverage Due to the COVID-19. Retrieved from: https://www.urban.org/sites/default/files/publication/102552/changes-in-health-insurance-coverage-due-to-the-covid-19-recession_4.pdf.

¹⁰ Health Management Associates (April 3, 2020). COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State. Retrieved from: <https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf>.

¹¹ Centers for Medicare and Medicaid Services (last updated December 21, 2021). June 2021 Medicaid & CHIP Enrollment. Retrieved from: <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

Affordable Care Act (ACA), federal Medicaid rules allowed states considerable flexibility to cover parents and caretaker relatives, but not childless adults. The ACA created a new eligibility pathway and enhanced federal matching funds for states to expand coverage to all adults (subject to immigration requirements) up to 138% FPL. Connecticut had already expanded coverage for parents and caretaker relatives before the ACA and it was the first State to implement the ACA early option for coverage of childless adults in 2010. The ACA also created a pathway to regular federal matching funds for states to expand coverage to childless adults with income above 138% FPL.

Over the years, Connecticut made several changes to its Medicaid parent and caretaker relatives eligibility levels. Before the ACA, parents and caretaker relatives could qualify for Medicaid in Connecticut if they earned up to 201% FPL. After Access Health CT began offering insurance in 2014, State lawmakers reduced eligibility for this group to 155% FPL, reasoning that parents and caretaker relatives above that income level could buy subsidized coverage through Access Health CT.¹² Since then, lawmakers have raised the Medicaid eligibility limit for parents and caretaker relatives to 160% FPL. State data shows that of those who lost Medicaid coverage as a result of the change, while many returned to Medicaid (approximately 40%), only a small fraction enrolled in Access Health CT coverage (approximately 12%) and nearly half appeared to have become uninsured, as they were not enrolled in either Medicaid or QHP coverage available through Access Health CT.¹³

QHP Coverage Available through Access Health CT in Connecticut

Access Health CT is Connecticut's official health insurance marketplace for QHPs. State residents can qualify for federal financial assistance to buy insurance through Access Health CT if they do not qualify for Medicaid, Medicare, or other government programs and do not have access to affordable insurance through a job.¹⁴ The federal subsidies, which take the form of tax credits, are available to those with incomes below 400% FPL. In addition to the tax credits, people with incomes below 250% FPL are eligible to buy QHP coverage with lower cost-sharing or cost-sharing reductions. In February 2020, enrollment in Access Health CT was approximately 110,000; at the time, 21% of State residents enrolled in Access Health CT earned between 139% and 200% of poverty. As of June 2020, enrollment had grown by 37,000 at the early part of the COVID-19 pandemic.

Costs of Access Health CT Coverage

People who enroll in Access Health CT have different costs depending primarily on their income, age, where they live, and the plan they select.¹⁵ Tax credits established by the ACA

¹² Levin Becker, A. 39 Percent of Parents Affected by HUSKY Cut Still in Program (December 9, 2016). The CT Mirror. Retrieved from: <https://ctmirror.org/2016/12/09/39-percent-of-parents-affected-by-husky-cut-still-in-program/>.

¹³ Department of Social Services (DSS) Data. Also note that for the six-month period from January 1, 2018 through June 30, 2018, State lawmakers reduced eligibility for that group to 138% FPL, which was restored back to 155% FPL effective July 1, 2018.

¹⁴ Those who are eligible for employer-sponsored insurance can also be eligible for subsidies through the exchange if their employer coverage would cost more than 9.78% of their income. Kaiser Family Foundation. (January 16, 2020). Explaining Health Care Reform: Questions About Health Insurance Subsidies. Retrieved from: <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/>.

¹⁵ Among the other factors that contribute to the cost of Access Health CT coverage are the scope of covered benefits, reimbursement levels for participating providers, and the overall health of the risk pool (i.e., groups of people purchasing health insurance together). A key factor that influences consumers' out-of-pocket costs is the actuarial value of the plan, which refers to the percentage of benefit costs for covered benefits paid by the insurance plan. As described above, exchange plans are categorized by a "metal level" based on how the consumer and insurer split the costs of care; actuarial value of plans increase across the metal tiers from bronze to platinum plans.

to help lower premiums are available to individuals with income under 400% FPL on a sliding-scale basis. Approximately half of households enrolled in Access Health CT qualify for tax credits that cover 80% or more of the cost of their premium.¹⁶ People with incomes under 250% FPL also qualify for cost-sharing subsidies if they choose a benchmark silver-level plan through Access Health CT. (The benchmark silver plan refers to the second-lowest cost silver plan available by Access Health CT; individuals who are eligible forgo the federal cost-sharing subsidies if they do not enroll in silver coverage.)

For individuals buying coverage through Access Health CT who have incomes between 139% and 200% FPL, the average monthly premium for a benchmark silver plan ranges from \$56 to \$143, respectively.¹⁷ Out-of-pocket costs also vary based on income levels, based on differing levels of subsidies that can lower deductibles and other cost-sharing.

The consequences of being uninsured are significant, with coverage gaps being a key driver of health disparities. The ACA requires the Secretary of the Department of Health and Human Services to establish data collection standards for race, ethnicity, sex, primary language, and disability status. Data collected show clear disparities in rates of health insurance coverage among Black and Latinx populations.¹⁸ The use of fewer preventative services results in poorer health outcomes, higher mortality and disability rates, lower annual earnings because of sickness and disease, and advanced stages of illness. The uninsured tend to be disproportionately poor, young, and from racial and/or ethnic minority groups.¹⁹

Affordability Options to Promote Coverage

In the 2021 regular session and the June 2021 Special Session of the Connecticut General Assembly, State lawmakers considered two options for closing the health insurance affordability gap for low-income individuals: expanding Medicaid eligibility for adults or providing a State subsidy for plans available through Access Health CT.

Improving subsidies for low-income individuals can increase enrollment in Access Health CT coverage and reduce the uninsured rate. Evidence suggests that consumers are highly sensitive to premium costs when choosing health care coverage.²⁰ An analysis of Massachusetts' subsidy program found that reducing monthly premiums by about \$40 increased enrollment in marketplace coverage among eligible individuals by 14% to 24%, with larger impacts seen at lower incomes.²¹

Connecticut's Approach

State lawmakers ultimately chose the State subsidies for QHP coverage approach paired with a section 1115 waiver. Their rationale was that by leveraging both federal subsidies for QHP coverage available through Access Health CT and federal funding for the Medicaid

¹⁶ Access Health CT. (February 20, 2020). 2020 Open Enrollment Summary.

¹⁷ Ibid.

¹⁸ Pew Charitable Trusts, "How Income Volatility Interacts With American Families' Financial Security," March 9, 2017, <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/03/how-income-volatility-interacts-with-american-families-financial-security>.

¹⁹ Riley W. J. (2012). Health disparities: gaps in access, quality and affordability of medical care. *Transactions of the American Clinical and Climatological Association*, 123, 167–174.

²⁰ Holahan, J., Blumberg, L. J., & Wengle, E. (March 2016). Marketplace Plan Choice: How Important Is Price? An Analysis of Experiences in Five States. The Urban Institute. Retrieved from: https://www.researchgate.net/publication/301685561_Marketplace_Plan_Choice_How_Important_Is_Price_An_Analysis_of_Experiences_in_Five_States.

²¹ MassHealth Medicaid Section 1115 Demonstration Special Terms & Conditions, (June 26, 2019). Department of Health and Human Services, Centers for Medicare and Medicaid Services.

program, the State could, with the same amount of State funds, provide affordable health insurance coverage to more people than by expanding Medicaid.

Demonstration Approval

On December 15, 2022, Connecticut received approval for its application for a new demonstration project, entitled Covered Connecticut (Covered CT) (Project Number 11-W-00402/1), in accordance with section 1115(a) of the Social Security Act (the Act), December 15, 2022, through December 31, 2027.

Population Groups Impacted by the Waiver

Eligible for the Demonstration are two populations: (1) parents and caretaker relatives and (2) childless adults. Eligibility criteria for these populations are as follows:

1. Parents and Caretaker Relatives, and their tax dependents under 26 years of age, who:
 - A. Are ineligible for Medicaid because their income exceeds the Medicaid income limits, but does not exceed 175% FPL, and
 - B. Enroll in a silver-level QHP available through Access Health CT using federal premium subsidies and cost-sharing reductions.
2. Childless Adults who:
 - A. Are ages 19 years to 64 years of age,
 - B. Are not pregnant,
 - C. Are ineligible for Medicaid because their income exceeds the Medicaid income limits, but does not exceed 175% FPL, and
 - D. Enroll in a silver-level QHP available through Access Health CT using federal premium subsidies and cost-sharing reductions.

Eligibility for the Demonstration will be determined through the existing application and redetermination processes and the eligibility and enrollment system shared by Access Health CT and Department of Social Services (DSS) for the Medicaid, Children's Health Insurance Program (CHIP), and marketplace programs. The system will apply Demonstration eligibility criteria in conjunction with the eligibility criteria for Medicaid, CHIP, and marketplace programs.

Description of the Demonstration

The Demonstration will not affect or modify the State's current Medicaid program and CHIP. It will not change State Plan benefits, cost-sharing requirements, delivery system, or payment rates.

Benefits, Delivery System, and Payment Rates

Demonstration benefits for both the parent and caretaker relatives and the childless adult populations will include:

1. **Premium and cost-sharing subsidies** sufficient to provide free coverage under a silver-level QHP available through Access Health CT with federal premium subsidies and cost-sharing reductions.

The State will directly reimburse plans for the monthly premium and the cost-sharing amounts that the enrollee would normally need to pay with the plan, such as out-of-pocket costs for deductibles, copays, and coinsurance. Benefits provided by a plan will be delivered by plan providers and paid at plan reimbursement rates.

2. **Dental care** comparable to the benefits under Connecticut Medicaid, except where dental care is provided by a QHP to dependents under 26 years of age. State law requires QHPs available through Access Health CT to cover dental care for dependents under 26 years of age.

For all others, the Demonstration dental care benefit will align in amount, duration, and scope with the comparable benefit available through HUSKY Health, be delivered through the HUSKY Health dental fee-for-service delivery system and be paid at State Plan payment rates.

3. **Non-emergent medical transportation (NEMT) services** comparable to the benefits under Connecticut Medicaid. The Demonstration NEMT benefit will align in amount, duration, and scope with the comparable benefit available through HUSKY Health, be delivered through the HUSKY Health NEMT broker, and be paid at State Plan payment rates.

This waiver Demonstration seeks to:

- Reduce the overall Connecticut statewide uninsured rate.
- Improve the oral health of Demonstration enrollees.
- Reduce transportation-related barriers for Demonstration enrollees to accessing health care.

The Demonstration addresses system changes and activities needed to achieve these goals:

- Promote health insurance coverage and increase the number of people who enroll in QHP coverage available through Access Health CT.
- Ensure stability in coverage by increasing the number of people who enroll in QHP coverage when their Medicaid coverage ends.
- Reduce racial and ethnic disparities in insurance coverage rates.
- Increase the number of people who receive routine and preventative dental care in Connecticut.
- Enable access to medical appointments by providing transportation support.

Demonstration Evaluation

This Evaluation Design intends to produce a comprehensive and independent evaluation of the Covered Connecticut 1115 Waiver Demonstration, as described above, that complies fully with Special Terms and Conditions (STCs) 53 through 64. The Demonstration will evaluate whether the Covered CT program increased insurance coverage and improved health outcomes for enrollees, particularly those that have historically been underserved.

Connecticut's independent evaluation will measure and monitor the outcomes of the Covered CT Demonstration. The evaluation will focus on the key goals and drivers of the Demonstration. The evaluators will assess the impact of removing financial barriers to coverage on insurance rates, oral health, and access to primary care. The State will submit a draft of the interim evaluation report when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. A summative evaluation report will be completed no later than 18 months after the end of the approval period of the demonstration. The evaluation will be designed to demonstrate achievement of the Demonstration's goals, objectives, and metrics. As required by the Centers for Medicare & Medicaid Services (CMS), the Evaluation Design will include the following elements:

- General background information.
- Evaluation questions and hypotheses.
- Methodology.
- Methodological limitations.
- Attachments.

Section 2

Evaluation Questions and Hypotheses

Evaluation questions and hypotheses to be addressed were derived from and organized based on the Driver Diagrams below. The overall goals of the project are to: 1) Reduce the overall Connecticut statewide uninsured rate, 2) Improve the oral health of Demonstration enrollees, and 3) Reduce transportation-related barriers to accessing health care for Demonstration enrollees.

To accomplish these goals, the Demonstration includes several key activities, organized by **primary drivers** of change as they occur in the driver diagrams below:

- Promote health insurance coverage and increase the number of people who enroll in QHP coverage available through Access Health CT.
- Ensure stability in coverage by increasing the number of people who enroll in QHP coverage when their Medicaid coverage ends.
- Reduce racial and ethnic disparities in insurance coverage rates.
- Increase the number of Demonstration enrollees who receive routine and preventative dental care.
- Enable access to medical appointments for Demonstration enrollees by providing transportation support.

The specific evaluation questions to be addressed were selected based on the following criteria:

1. Potential for improvement, consistent with the key activities of the Demonstration listed above.
2. Potential for measurement, including (where possible and relevant) baseline measures that can help to isolate the effects of Demonstration initiatives and activities over time.
3. Potential to coordinate with ongoing performance evaluation and monitoring efforts.

Questions were selected to address the Demonstration's major program goals, to be accomplished by Demonstration activities associated with each of the primary drivers. These goals are designed to promote the overall objectives of Titles XIX and XXI: To help defray the costs of providing medical services to financially needy children and adults. Specific hypotheses regarding the Demonstration's impact are posed for each of these evaluation questions. These are linked to the primary drivers in the diagrams and tables labeled Driver Diagrams, Research Questions, and Hypotheses, directly following the next subsection: Targets for Improvement.

Targets for Improvement

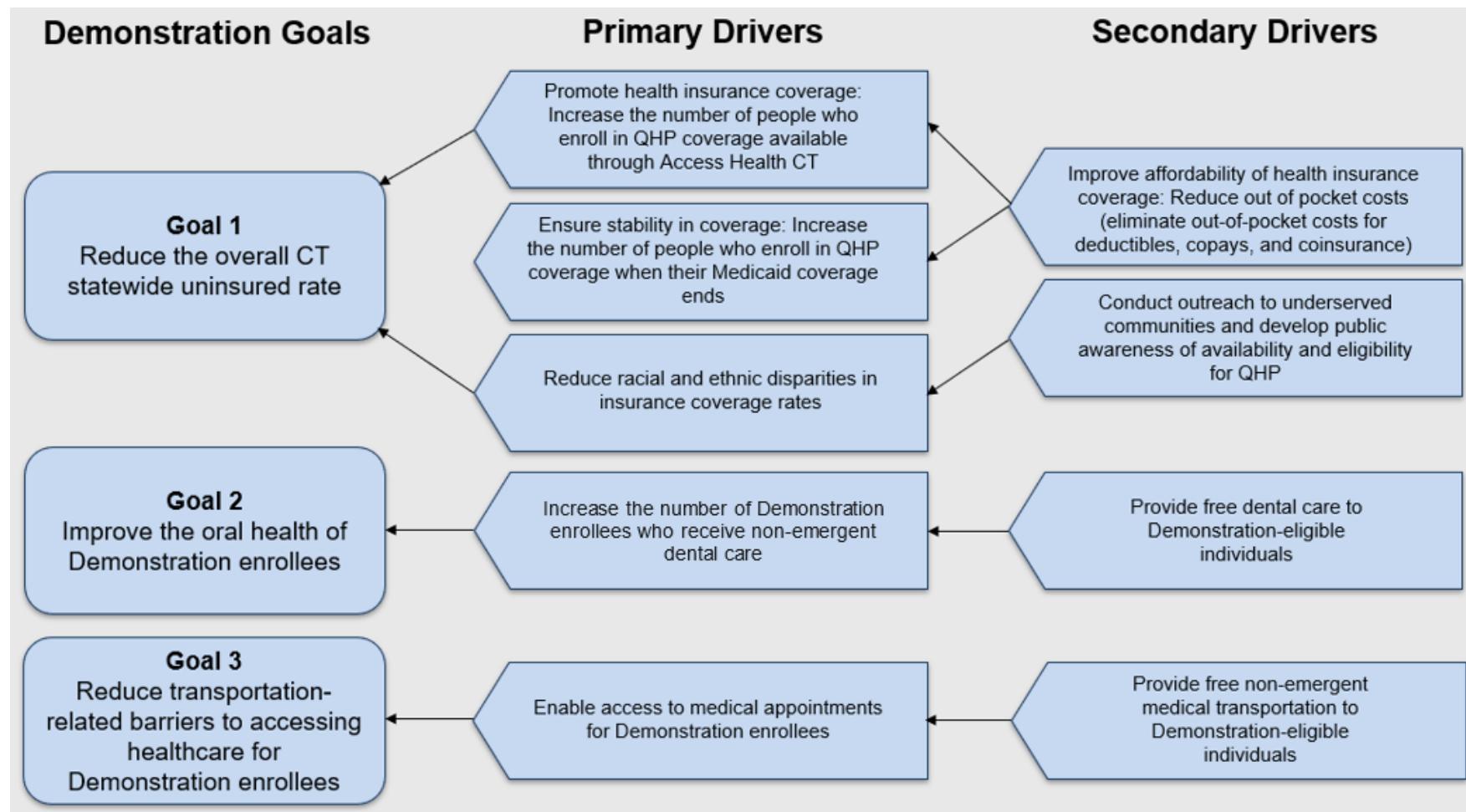
The three goals of the Covered CT waiver with Targets for Improvement are listed in the table below.

Program Goals	Targets
Reduce the overall Connecticut statewide uninsured rate.	<ul style="list-style-type: none">• Increase the number of people who enroll in QHP coverage available through Access Health CT.• Increase the number of people who enroll in QHP coverage when their Medicaid coverage ends.• Reduce racial and ethnic disparities in insurance coverage rates.
Improve the oral health of Demonstration enrollees.	<ul style="list-style-type: none">• Increase the number of Demonstration enrollees who receive routine and preventative dental care.• Reduce emergency department (ED) visits for preventative oral health issues for Demonstration enrollees.
Reduce transportation-related barriers to accessing health care for Demonstration enrollees.	<ul style="list-style-type: none">• Provide NEMT services to Demonstration enrollees.

Driver Diagrams, Research Questions, and Hypotheses

The three goals represent the ultimate intentions of the Demonstration. The primary drivers are strategic improvements necessary to achieve the goals. The secondary drivers describe the interventions targeted for improvement to achieve the strategic improvements.

Figure 1: High Level Driver Diagram



Research Questions and Hypotheses

For the outcome evaluation, select performance measures will be used to demonstrate observed changes in outcomes, using an interrupted time-series (ITS) design where sufficient pre-demonstration data is available, or with pre-post comparisons or comparisons to national benchmarks where sufficient pre-demonstration data is not available. Additional performance measures will be collected to monitor progress on meeting the activities and project goals. These performance measures are grouped and described under the related primary drivers.

The research design table in Section 3, outlines the **research questions and hypotheses** of the evaluation, organized by each primary driver.

Section 3

Methodology

Evaluation Design

The evaluation of the Covered CT 1115 Waiver Demonstration will utilize a mixed-methods Evaluation Design with three main goals:

1. Describe the progress made on specific Demonstration-supported activities (process/implementation evaluation).
2. Demonstrate change/accomplishments in each of the Demonstration drivers (short-term outcomes).
3. Demonstrate progress in meeting the overall project goals.

A combination of qualitative and quantitative approaches will be used throughout the evaluation. It will identify and describe the Demonstration implementation and changes occurring during the Demonstration for QHP enrollees. The qualitative analysis will include key informant interviews with DSS, Access Health CT, Medicaid, and Community-Based Organizations (CBOs) conducting outreach to key uninsured populations, and other identified stakeholders regarding Demonstration activities, as well as document reviews of plan features and cost reductions, policy guides, and outreach materials.

Quantitative methods will include descriptive statistics and time series analyses showing change over time in both counts and rates for specific metrics and ITS analysis to assess the degree to which the timing of waiver interventions affect changes across specific outcome measures. Using a combination of case study methods, including document review, telephone interviews, and face-to-face meetings, a descriptive analysis of the key Covered CT Demonstration features will be conducted.

The evaluation will analyze how the State is carrying out its implementation plan and track any changes it makes to its initial design as implementation proceeds, both planned changes that are part of the Demonstration design (e.g., providing subsidies, dental, and NEMT services) and operational and policy modifications the State makes based on external changing circumstances (other Medicaid changes, for example). Finally, it is possible that, in some instances, changes in the policy environment in the State will trigger alterations to the original Demonstration implementation plan.

Detailed information will be collected from the State on how each driver has been implemented, including information surrounding State efforts to provide public information and outreach about the availability of subsidies, dental, and NEMT services. The evaluation will analyze the scope of each driver as implemented and the extent to which the State conducts these functions (e.g., directly, through contract) and whether internal structures are established to promote implementation of the Demonstration activities.

Key informant interviews and document reviews will occur at three critical junctures: initially, prior to the interim evaluation report being written, and prior to the final summative evaluation report being finalized.

As the independent evaluator/contractor, Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC will calculate the quantitative performance measures, according to metrics specifications, and based on data provided by DSS, other State agencies, and QHPs offered through Access Health CT, as needed. Mercer is currently receiving monthly transfers of Connecticut's Medicaid Management Information System data, through a Health Insurance Portability and Accountability Act-compliant secure portal. Mercer does not currently receive, but will work with Access Health CT to arrange the secure transfer of QHP data, as needed.

The Demonstration is open to all individuals who meet the eligibility criteria specified here, so a concurrent comparison group of Connecticut Medicaid members is not available. Changes in insurance rates will be assessed using an ITS quasi-experimental design. The ITS analysis projects metrics derived from a pre-demonstration time period into the post-demonstration implementation time period as a comparison for actual post-demonstration implementation metrics. In cases where there are not enough data points for reliable projections or where there is no available pre-demonstration data, we will use a descriptive time series analysis, or pre-post analyses, to describe changes over time.

Comparison Populations

Because there is not an available comparison population, the comparison population groups in this design will be a projection of each measure, based on historical data, of what the group would look like in the absence of the Demonstration. The State will evaluate opportunities to identify Medicaid beneficiaries who do not meet the demonstration's eligibility criteria, based on the availability of income data within Medicaid eligibility categories (e.g., childless adults), for comparison purposes. To the extent possible, we will use this group as a comparison group for the Demonstration using a discontinuity regression approach.

The Target population includes adults who meet the Demonstration eligibility criteria. Based on Demonstration goals and activities, we anticipate that the Demonstration will have *intentional* differential impacts on specific subgroups, particularly people who traditionally experience health insurance disparities due to their race, ethnicity, culture, or language. All members who are eligible for and/or receive services will be included in all descriptive time series and ITS analysis, so no sampling strategy is needed.

Evaluation Period

The evaluation period is December 15, 2022, through December 31, 2027. The Draft Interim Evaluation is due December 31, 2026 or with the extension application. Draft interim results derived from a portion of this evaluation period, December 14, 2022 through December 31, 2025 (with six months run out of claims data) will be reported in the Draft Interim Evaluation Report due to CMS on December 31, 2026. The Draft Summative Evaluation Report analysis will allow for a six-month run out of claims data. Results across this time period will be included in the Draft Summative Evaluation Report due to CMS by June 30, 2029.

Evaluation Measures and Data Sources

The evaluation design and evaluation measures are based on sources that provide valid and reliable data that will be readily available throughout the demonstration and final evaluation. To determine if data to be used for the evaluation are complete and accurate, the independent evaluator will review the quality and completeness of data sources. Example analyses the independent evaluator will use to determine reliability and accuracy of claims data include, but are not limited to frequency reports, valid values, missing values, date and numerical distributions, and duplicates.

As often as possible, measures in the evaluation have been selected from nationally recognized measure stewards for which there are strict data collection processes and audited results. The State will leverage measures from such national sources to the extent that sufficient data is available (e.g., geographic areas, race/ethnicity indicators). Once the monitoring protocol is finalized, we will explore opportunities to add measures from the protocol to enhance this evaluation. The interim evaluation report will document our efforts and final disposition of a potential comparison group.

The following tables summarize: the primary drivers and hypotheses, process (implementation) and outcome measures for the evaluation, measure steward (if applicable), numerator and denominator definitions where appropriate, types of data (quantitative or qualitative), and data sources.

Mercer will calculate all performance measures for the Demonstration period using claims data from DSS and Access Health CT, as needed.

The State is committed to gathering beneficiary perspectives either through a survey or focus group conducted with beneficiaries or a consumer advisory board. Mercer will either 1) work with providers to add questions to existing beneficiary surveys being conducted regarding satisfaction with services and perceptions regarding access and availability; or 2) conduct consumer focus groups, convened for this evaluation or as part of existing efforts to include consumer voice already happening in the State.

Goal 1: Reduce the overall Connecticut statewide uninsured rate.

Research Question	Measure	Measure Steward	Time Period	Numerator	Denominator	Data Sources	Analytic Method
Primary Driver: Promote health insurance coverage: Increase the number of people who enroll in QHP coverage available through Access Health CT (AHCT).							
Hypothesis 1: The Demonstration will increase the number and rate of people insured.							
Research Question 1.1: Did the State remove health insurance cost barriers for eligible individuals?	Internal/administrative challenges and barriers	N/A	Cumulative from start	None	None	Key informant interviews (DSS, AHCT, Medicaid, CBOs)	Thematic analysis
	Description of outreach and engagement activities	N/A	Cumulative from start	None	None	Key informant interviews (DSS, AHCT, Medicaid, CBOs)	Thematic analysis of interviews Beneficiary focus groups, leveraged through existing participatory and advocacy organizations

Research Question	Measure	Measure Steward	Time Period	Numerator	Denominator	Data Sources	Analytic Method
Research Question 1.2: Did the number of individuals enrolling in a QHP increase after Demonstration implementation?	Total enrollment in the Demonstration	N/A	Quarterly	Unduplicated number of individuals enrolled in the demonstration at any time during the measurement period	N/A	Administrative Records from the State eligibility and enrollment system shared by Medicaid, CHIP, and AHCT	Descriptive time series
	New enrollees	N/A	Quarterly	Number of enrollees who began a new enrollment spell during the measurement period	N/A	Administrative Records	Descriptive time series
Research Question 1.3: Did the statewide uninsured rate for the targeted population decrease after the Demonstration began?	Uninsured rate of adults aged 19–64 years old	Census	Quarterly	Number of adults ages 19 years through 64 years old without insurance, by race/ethnicity	Population by race/ethnicity	Census Bureau, American Community Survey	ITS analysis; Difference in difference testing (using MD and DE as Comparisons)

Research Question	Measure	Measure Steward	Time Period	Numerator	Denominator	Data Sources	Analytic Method
<p>Primary Driver: Ensure stability in coverage: Increase the number of people who enroll in QHP coverage when their Medicaid coverage ends.</p> <p>Hypothesis 2: The Demonstration will increase the number of people who maintain health care coverage when their Medicaid coverage ends.</p>							
Research Question 2.1: Did the Demonstration increase the number of people maintaining coverage?	Enrollment in Demonstration without a break in coverage	N/A	Monthly	Beneficiaries who lost Medicaid eligibility and transitioned to a QHP offered in the marketplace	Number of people who lost Medicaid coverage	State eligibility and enrollment system shared by Medicaid, CHIP, and AHCT	Time series analysis

Research Question	Measure	Measure Steward	Time Period	Numerator	Denominator	Data Sources	Analytic Method
Primary Driver: Reduce racial and ethnic disparities in insurance coverage rates.							
Hypothesis 3: The Demonstration will reduce racial and ethnic disparities in insurance rates.							
Research Question 3.1: Did disparities in insurance rates decrease after the Demonstration?	Insured rate	Census	Yearly	Number of adults ages 19 years through 64 years without insurance, by race/ethnicity	Population by race/ethnicity	Census Bureau, American Community Survey	Pre-Post Analysis of Variance (ANOVA) Compare rates by race/ethnicity Compare rates to MD and DE
	Description of outreach efforts to underserved populations, specifically racial and ethnic minorities	N/A	Cumulative	None	None	Key informant interviews, focus groups	Thematic analysis of interviews and documents
	Consumer perspectives of access to care	N/A	Cumulative	None	None	Survey or focus group with Demonstration enrollees	Thematic analysis of surveys and documents

Goal 2: Improve the oral health of Demonstration enrollees.

Research Question	Measure	Measure Steward	Time Period	Numerator	Denominator	Data Sources	Analytic Method
Primary Driver: Increase the number of Demonstration enrollees who receive non-emergent dental care.							
Hypothesis 4: The Demonstration will increase the number of people who receive preventative dental care.							
Research Question 4.1: Did the number of people who received non-emergent dental care increase after the Demonstration?	Number of enrollees with at least one non-emergent dental care visit	N/A	Monthly	Number of enrollees with at least one non-emergent dental care visit	All enrollees	Claims	Descriptive time series; Regression analysis (using a discontinuity design), if an appropriate comparison group is identified
Primary Driver: Increase the number of Demonstration enrollees who receive non-emergent dental care.							
Hypothesis 5: The Demonstration will decrease the rate of emergent dental care.							
Research Question 5.1: What is the impact of the Demonstration on emergency dental health care utilization by Demonstration enrollees?	Number of emergency dental care visits per 100,000 member months for adults enrolled in the Demonstration	N/A	Monthly	Number of emergency dental care visits	All enrollees	Claims for specific diagnosis codes (D9110, D0140)	Descriptive time series; Regression analysis (using a discontinuity design), if an appropriate comparison group is identified

Goal 3: Reduce transportation-related barriers to accessing health care for Demonstration enrollees.

Research Question	Measure	Measure Steward	Time Period	Numerator	Denominator	Data Sources	Analytic Method
Primary Driver: Enable access to medical appointments for Demonstration enrollees.							
Hypothesis 6: Providing free NEMT to Demonstration enrollees will reduce transportation-related barriers to accessing health care.							
Research Question 6.1: Did the Demonstration provide free NEMT to Demonstration enrollees?	Internal/administrative challenges and barriers	N/A	Cumulative	N/A	N/A	Key informant interviews, focus groups	Thematic analysis of interviews
	Number of enrollees who received non-emergent transportation services	N/A	Monthly	Number of enrollees receiving NEMT services	All Demonstration enrollees	Administrative claims-based data from the NEMT broker for HUSKY Health	Descriptive time series; Regression analysis (using a discontinuity design), if an appropriate comparison group is identified
	NEMT ride-days per Demonstration enrollee	N/A	Monthly	Average number of ride-days per Demonstration enrollee	N/A	Administrative claims-based data from the NEMT broker for HUSKY Health	
	Consumer perceptions of access to care	N/A		Consumer reports of satisfaction with NEMT services, perceptions of access to care	N/A	Surveys or focus group with Demonstration enrollees	Thematic analysis of interviews, descriptive statistics (surveys)

Goal 4: Monitor administrative costs of implementation and assess the Demonstration's effects on Medicaid health service expenditures and on the fiscal sustainability of the State's Medicaid program.

Research Question	Measure	Measure Steward	Time Period	Numerator	Denominator	Data Sources	Analytic Method
Primary Driver: Promote health insurance coverage: Increase the number of people who enroll in QHP coverage available through Access Health CT.							
Research Question 7.1: How did costs change after the Demonstration was implemented?	Total spending on dental benefits delivered through HUSKY Health	N/A	Monthly	NA	NA	Invoices	ITS analysis, pending availability of historical cost data
	Total spending on NEMT benefits delivered through HUSKY Health	N/A	Monthly	NA	NA	Invoices	ITS analysis, pending availability of historical cost data
	Total spending on QHP coverage (premiums, cost sharing reductions and program charges)	N/A	Monthly	NA	NA	Invoices	ITS analysis, pending availability of historical cost data
	Costs by source of care for high-cost individuals	N/A	Monthly	NA	NA	Invoices	ITS analysis, pending availability of historical cost data

Analytic Methods

Multiple analytic techniques will be used, depending on the type of data for the measure and the use of the measure in the Evaluation Design (e.g., process measure versus outcome measures). Descriptive, content analysis will be used to present data related to process evaluation measures gathered from document reviews, key informant interviews, etc., as discussed previously. Qualitative analysis software (R Qualitative, ATLAS, or similar) will be used to organize documentation, including key informant interview transcripts. Analysis will identify common themes across interviews and documents. The data will be summarized in order to describe the activities undertaken for each project milestone, including highlighting specific successes and challenges.

Descriptive statistics including frequency distributions and time series (presentation of rates over time) will be used for quantitative process measures to describe the output of specific waiver activities. These analysis techniques will also be used for some short-term outcome measures in cases where the role of the measure is to describe changes in the population, but not to show specific effects of the waiver Demonstration. Where pre-demonstration and post-demonstration rates are comparable, pre-post distributional test will be made to quantify statistical differences in process measures before and after the demonstration.

An ITS will be used to describe the effects of waiver implementation on insurance rates. Specific outcome measure(s) will be collected for multiple time periods both before and after start of intervention. Segmented regression analysis will be used to measure statistically the changes in level and slope in the post-intervention period (after the waiver) compared to the pre-intervention period (before the waiver). The ITS design will be dependent on being able to use similar historical data on specific outcome measures collected from DSS and Access Health CT based on services provided prior to the Demonstration. The ITS design uses historical data to forecast the counterfactual of the evaluation, that is to say, what would happen if the Demonstration did not occur. We propose using basic time series linear modeling to forecast these counterfactual rates for three years following the Demonstration implementation.²² The more historical data available, the better these predictions will be. ITS models are commonly used in situations where a contemporary comparison group is not available.²³ The State has considered options for a contemporary comparison group. Since the Demonstration will target all adults who meet the eligibility criteria specified, a viable group for comparison within the State is not available.

For this Demonstration, establishing the counterfactual is somewhat nuanced. The driver diagram and evaluation hypotheses assume that Demonstration activities will have overall positive impacts on outcome measures. The figure below illustrates an ITS design that uses basic regression forecasting to establish the counterfactual — this is represented by the grey line in the graphic. The counterfactual is based on historical data (the blue line). It uses time series averaging (trend smoothing) and linear regression to create a predicted trend line (shown below as the grey line). The orange line in the graph is the (sample) actual observed data. Segmented regression analysis will be used to measure statistically the changes in

²² E Kontopantelis (2015). Regression based quasi-experimental approach when randomisation is not an option: interrupted time series analysis. *British Medical Journal (BMJ)*. Available at: <https://www.bmjjournals.org/content/350/bmj.h2750>.

²³ Ibid.

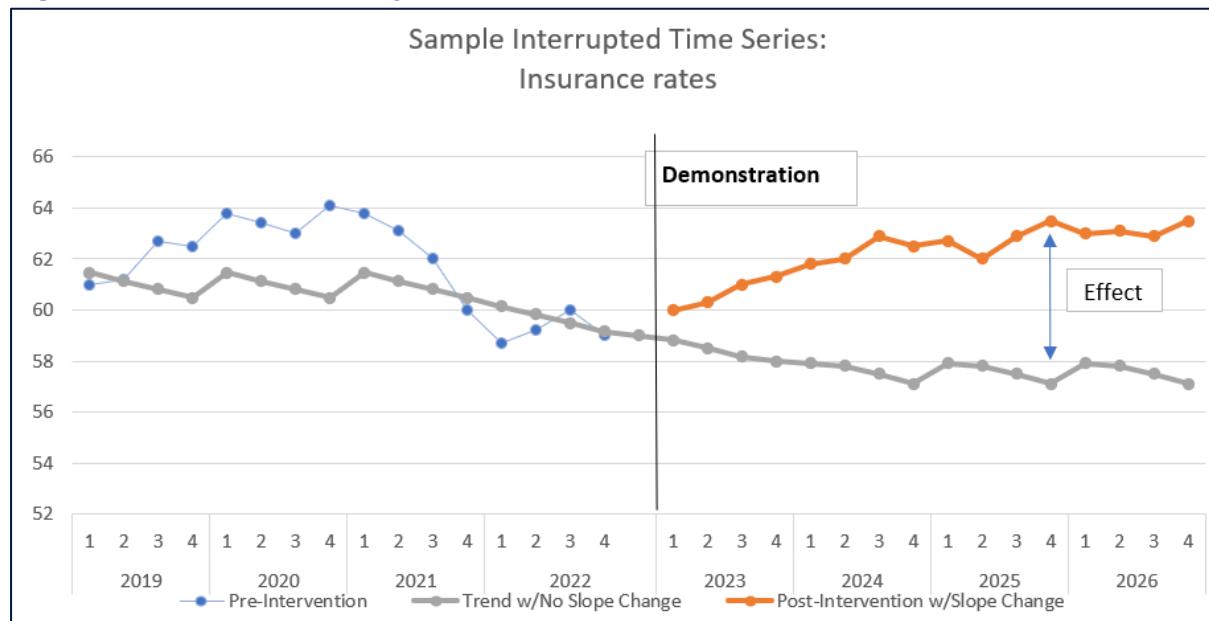
level and slope in the post-intervention period compared to the predicted trend (see Effect in the graph below).

$$Y_t = \beta_0 + \beta_1 T + \beta_2 X_t + \beta_3 TX_t$$

Where β_0 represents the baseline observation, β_1 is the change in the measure associated with a time unit (quarter or year) increase (representing the underlying pre-intervention trend), β_2 is the level change following the intervention and β_3 is the slope change following the intervention (using the interaction between time and intervention: TX_t).²⁴

This can be represented graphically as follows.

Figure 2: (SAMPLE data only) Insurance Rates



Pre-demonstration data from January 1, 2019 to December 30, 2022 will be calculated using the monthly, quarterly, or annual period of time as specified in the CMS technical specifications (or other data source) for each metric. Trends in these data for each measure will be used to predict the counterfactual (what would have happened without the Demonstration). Outcomes measures will be calculated beginning January 1, 2023 through the end of the waiver Demonstration project (December 31, 2027). A discussion of including confounding variables (e.g., COVID-19, other State efforts) is included in the next section.

Quantitative outcome measures with yearly measurement periods that are expressed as averages or proportions will be analyzed with pre-post tests. While two or three pre-demonstration measurement periods for yearly metrics may not be enough information to establish a trend for the ITS analysis, pre-post analyses may reveal differences in outcomes before and after the Demonstration. One-way analysis of covariance, or t-tests will be used to compare pre-demonstration averages with post-demonstration averages, and chi-square

²⁴ Bernal JL, Cummins S, Gasparrini A. "Interrupted time series regression for the evaluation of public health interventions: a tutorial" (2017 Feb.). International Journal of Epidemiology 46(1): 348-355.

tests will be used to compare proportions. We will use descriptive time series analyses for most measures, given that pre-demonstration data will not be available.

Qualitative analysis will utilize data collected from two main sources: 1) key informant interviews with State staff working on implementation efforts, Access Health CT, CBOs conducting consumer education and outreach activities, and providers; and 2) key process documentation (e.g., policy and procedure manuals, guidance documents). Informant sampling will be largely based on convenience snowball sampling where key stakeholders provide initial lists of potential interviewees, based on their perspective on Demonstration implementation activities. Meeting minutes listing attendees will also be reviewed to identify potential interviewees. DSS staff and Access Health CT staff will also be included. Because this likely will be a large number of people, the independent evaluator will work with the State to determine whether to conduct focus groups with these populations, or to engage in a strategic stratified sampling process. The latter will ensure representation across the industry, and from providers stratified by geography/location, size, and services provided. Document reviews will include meeting minutes, policy and procedure documents, and other documents identified during the qualitative analysis process. Themes will be identified by multiple coders who review documents, identify initial themes, then collaborate in the creation of a central list of primary and secondary themes.

Section 4

Methodological Limitations

There are two primary limitations to the evaluation methodology presented here. The first involves issues of data quality and data sources that either: 1) are not sufficient to conduct the analysis proposed here (e.g., not enough historical data for needed prior time periods), or 2) contain errors. An additional limitation is related to the design itself because this evaluation plan relies heavily on descriptive, time series analysis, and qualitative data, this evaluation will describe what happened after the Demonstration was implemented, but it will be difficult to isolate why changes occurred. In other words, it will be difficult to directly attribute changes after waiver implementation to the activities undertaken as part of the waiver.

The design will rely on claims data for some metrics. We are aware that for dental claims, there is a need to carefully select the correct procedures' codes and to determine how to use these codes (e.g., how many to use to identify the correct type of claim) to include specific claims in a measure. We will work carefully with the State prior to the first evaluation report to test claims data extracts to look for potential data issues and to ensure claims are being pulled correctly.

While the ITS design is the strongest available research method, in the absence of a randomized trial or matched control group, there are some threats to the validity of results in the design.²⁵ The primary threat is that of history, or other changes over time happening during the waiver period. This ITS design is only valid to the extent that the Demonstration program was the only thing that changed during the evaluation period. Other changes to policies or programs could affect the outcomes being measured under the Demonstration. Mercer will attempt to control this threat by considering other policy and program changes happening concurrent to the waiver period interventions. At a minimum, we will use qualitative methods, in the form of key informant interviews, to identify other initiatives or events that may have occurred during the Demonstration that might influence Demonstration effects. Mercer will conduct a qualitative assessment of these likely impacts and will use time series analysis to show how trends may have changed at these critical time periods. To isolate the effects of these efforts, Mercer will also conduct additional iterations of the ITS. Using identified critical time points as additional variables, we will test whether other major efforts had a statistically significant impact in the post-demonstration waiver trend. The analysis will note the dates of other changes and analyze the degree to which the slope of the trend line changes after implementation of other interventions are made.

The impact of COVID-19 most likely affected the pre-demonstration period, and Mercer anticipates a statistically significant impact on most metrics. The ITS for this evaluation will create various counterfactual scenarios using historical data to evaluate the impact of COVID-19 on the forecasts. In order to help minimize the impact of this threat, Mercer will incorporate the use out-of-state comparison groups from Maryland and Delaware to control

²⁵ Penfold RB, Zhang F. "Use of interrupted time series analysis in evaluating health care quality improvements." Academic Pediatrics, 2013 Nov–Dec, 13(6Suppl): S38-44.

for potential COVID-19 on changes in insurance rates among adults, leveraging national survey data (outcomes under RQs 1.3 and 3.1).

A related threat to the validity of this evaluation is external (other things happening in the State that may affect the measures outside of the Demonstration). Because we have not identified a comparison group (a group of Medicaid members who would be eligible for the waiver interventions, but who will not receive them and/or for whom data will not be collected), it will be difficult to attribute causality. It will be less certain whether the changes observed in outcomes are due entirely to the waiver interventions, rather than some external, outside cause (including other program and policy changes described earlier). However, the ITS design controls for this threat to some degree, by linking what would have likely happened (e.g., forecasting the trajectory of counts and rates over time) without any program changes and comparing this forecast to actual changes over time. To strengthen this design as much as possible, as many data points will be collected as possible across multiple years preceding waiver changes. This will allow for adjustment of seasonal or other, cyclical variations in the data. Additionally, the design will examine multiple change points and identifying key areas of major program and policy adjustments, so that with each major milestone accomplishment, corresponding changes to metrics can be observed.

The ITS analysis will also include a sensitivity analysis to determine the degree to which specific ITS assumptions impact the analysis. Specifically, the degree to which the assumption that trends in time are linear versus non-linear will be addressed. Additionally, this model assumes that changes will occur directly after the intervention. However, it is possible that for some outcomes, there will be a lag between the start of the waiver and observed outcomes.

Mercer will also attempt to limit this threat to validity by triangulating our data. Claims data trends across multiple time periods will be compared to trends happening at other points in time (other large policy or program shifts that might influence the slope of the trend in addition to the demonstration). Also, key informant interviews will be used to inform the quantitative findings and explain the degree to which individuals are seeing demonstration impacts.

According to the literature on ITS analysis, estimating the level and slope parameters requires a minimum of eight observations before and after implementation in order to have sufficient power to estimate the regression coefficients.²⁶ Evaluators will need to work closely with the DSS, Access Health CT, and their respective data teams to gather as many data points as possible and discuss limitations within the evaluation findings if enough points cannot be collected.

It should also be noted that ITS cannot be used to make inferences about any one individual's outcomes as a result of the waiver. Conclusions can be drawn about changes to population rates, in aggregate, but not speak to the likelihood of any individual member having positive outcomes as a result of the waiver.

Qualitative data, while useful in confirming quantitative data and providing rich detail, can be compromised by individual biases or perceptions. Key informant interviews, for example, represent a needed perspective around context for Demonstration activities and outcomes. However, individuals may be limited in their insight or understanding of specific

²⁶ Ibid.

programmatic components, meaning that the data reflects perceptions, rather than objective program realities. The evaluation will work to address these limitations by collecting data from a variety of different perspectives to help validate individuals' reports. In addition, standardized data collection protocols will be used in interviews and interviewers will be trained to avoid leading the interviewee or inappropriately biasing the interview. It will also utilize multiple coders to analyze data and will create a structured analysis framework, based on research questions that analysts will use to organize the data and to check interpretations across analysts. Finally, results will be reviewed with stakeholders to confirm findings.

Section 5

Attachments

As part of the STCs, as set forth by CMS, the Demonstration project is required to arrange with an independent party to conduct an evaluation of the Demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. Mercer contracts to provide technical assistance to DSS, including this independent evaluation work.

Mercer was selected as the waiver evaluator. Mercer will develop the Evaluation Design, calculate the results of the study, evaluate the results for conclusions, and write the Interim and Summative Evaluation Reports.

Mercer has over 25 years of experience assisting state governments with the design, implementation, and evaluation of publicly sponsored health care programs. Mercer currently has over 25 states under contract and has worked with over 35 different states in total. They have assisted states like Arizona, Missouri, and New Jersey in performing independent evaluations of their Medicaid programs; many of which include 1115 Demonstration waiver evaluation experience. Given their extensive experience, the Mercer team is well equipped to work effectively as the external evaluator for the Demonstration project. The table below includes contact information for the lead coordinators from Mercer for the evaluation:

Name	Position	Email Address
Charles Lassiter	Engagement Leader	charles.lassiter@mercer.com
Michal Rudnick	Program Manager	michal.rudnick@mercer.com
Danielle Arsenault	Project Manager	danielle.arsenault@mercer.com
Tonya Aultman-Bettridge, PhD	Evaluator	taultman-bettridge@triwestgroup.net
Sanket Shah	Financial Analytics Sector	sanket.shah@mercer.com

Appendix A

Conflict of Interest Statement

Connecticut (DSS) has taken steps to ensure that Mercer is free of any conflict of interest and will remain free from any such conflicts during the contract term. DSS considers it a conflict if Mercer currently 1) provides services to Administrative Services Organizations (ASOs) or health care provider doing business in Connecticut under the Health First Connecticut program; or 2) provides direct services to individuals in DSS or Access Health CT-administered programs included within the scope of the technical assistance contract. If DSS discovers a conflict during the contract term, DSS may terminate the contract pursuant to the provisions in the contract.

Mercer's Government specialty practice does not have any conflicts of interest, such as providing services to any ASOs or health care providers doing business in Connecticut under the Connecticut program or to providing direct services to individual recipients. One of the byproducts of being a nationally operated group dedicated to the public sector is the ability to identify and avoid potential conflicts of interest with our firm's multitude of clients. To accomplish this, market space lines have been agreed to by our senior leadership. Mercer's Government group is the designated primary operating group in the Medicaid space.

Before signing a contract to work in the Medicaid market, either at the state-level or otherwise, we require any Mercer entity to discuss the potential work with Mercer's Government group. If there is a potential conflict (i.e., work for a Medicaid health plan or provider), the engagement is not accepted. If there is a potential for a perceived conflict of interest, Mercer's Government group will ask our state client if they approve of this engagement, and we develop appropriate safeguards such as keeping separate teams, restricting access to files, and establish process firewalls to avoid the perception of any conflict of interest. If our client does not approve, the engagement will not be accepted. Mercer has collectively turned down a multitude of potential assignments over the years to avoid a conflict of interest.

Given that Mercer is acting as both technical assistance provider and independent evaluator for this project, DSS and Mercer have implemented measures to ensure there is no perceived conflicts of interest. This contract was awarded following a competitive bidding process that complied with all Connecticut State laws, the Mercer evaluation team (TriWest) is functionally and physically separate from the technical assistance team, and the contract does not include any performance incentives that would contribute to a perception of conflicted interests between technical assistance services and the independence of the evaluation process.

In regards to Mercer's proposed subcontractors, all have assured Mercer there will be no conflicts and that they will take any steps required by Mercer or DSS to mitigate any perceived conflict of interest. To the extent that we need to implement a conflict mitigation plan with any of our valued subcontractors, we will do so.

Mercer, through our contract with DSS, has assured that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services. Mercer has further assured that in the performance of this

contract, it will not knowingly employ any person having such interest. Mercer additionally certified that no member of Mercer's Board or any of its officers or directors has such an adverse interest.

Appendix B

Evaluation Budget

	DY1	DY2	DY3	DY4	DY5	DY6	Final Evaluation	Total Evaluation Cost
	Dec 15, 2022– Dec 31, 2022	Calendar Year 2023 (CY2023)	CY2024	CY2025	CY2026	CY2027	Jun 30, 2029	
State of Connecticut								
DSS	\$0	\$44,200	\$45,500	\$46,900	\$48,300	\$49,700	\$52,800	\$287,400

Evaluation Budget — Independent Evaluator/Contractor — Mercer Hours				
	Senior Consultant	Junior Consultant	Project Management	Total Hours
Develop and draft Evaluation Design	100	72	30	202
Revise drafted Evaluation Design	28	7	10	45
Draft Interim Evaluation Report	144	36	52	232
Finalize Interim Evaluation Report	40	10	10	60
Draft Summative Evaluation Report	288	72	52	412
Finalize Summative Evaluation Report	40	10	10	60

Evaluation Budget — Independent Evaluator/Contractor — Mercer Hours					
		Senior Consultant	Junior Consultant	Project Management	Total Hours
Initial Programming of Evaluation Measures		135	135	40	310
Evaluation Measures for Annual Reports (210 hours per submission)		400	400	250	1,050
Evaluation Measures for Interim and Final Reports (190 hours per report)		160	160	60	380
Statistical measures for the evaluation: Interim and Final report (210 hours per report)		200	200	20	420
Total		1,535	1,102	534	3,171

Evaluation Budget — Independent Evaluator/Contractor — Mercer Costs									
	DY1	DY2	DY3	DY4	DY5	DY6	DY7	DY8	Total Cost
Evaluation Activities		\$83,620			\$101,060		\$146,920	\$21,100	\$352,700
Data Activities		\$170,850	\$67,700	\$67,700	\$201,900	\$67,700		\$134,200	\$710,050
Total		\$254,470	\$67,700	\$67,700	\$302,960	\$67,700	\$146,920	\$155,300	\$1,062,750

Appendix C

Potential Timeline and Major Deliverables

The table below highlights key evaluation milestones and activities for the waiver and the dates for completion.

Deliverable	STC Reference	Date
Submit Evaluation Design plan to CMS	55	June 23, 2023
Final Evaluation Design due 60 days after comments received from CMS	56	60 days after comments received from CMS
Draft Interim Report due	59	December 31, 2026
Final Interim Report due 60 days after CMS comments received	59(d)	60 days after comments received from CMS
Draft Summative Evaluation Report due 18 months following demonstration	60	Within 18 months after December 31, 2027 if the waiver is not renewed
Final Summative Evaluation Report due 60 days after CMS comments received	60(a)	60 days after comments received from CMS



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