Mercer

Government Human Services Consulting

Covered Connecticut (Covered CT) 1115 Waiver

Evaluation Design

State of Connecticut

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Contents

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

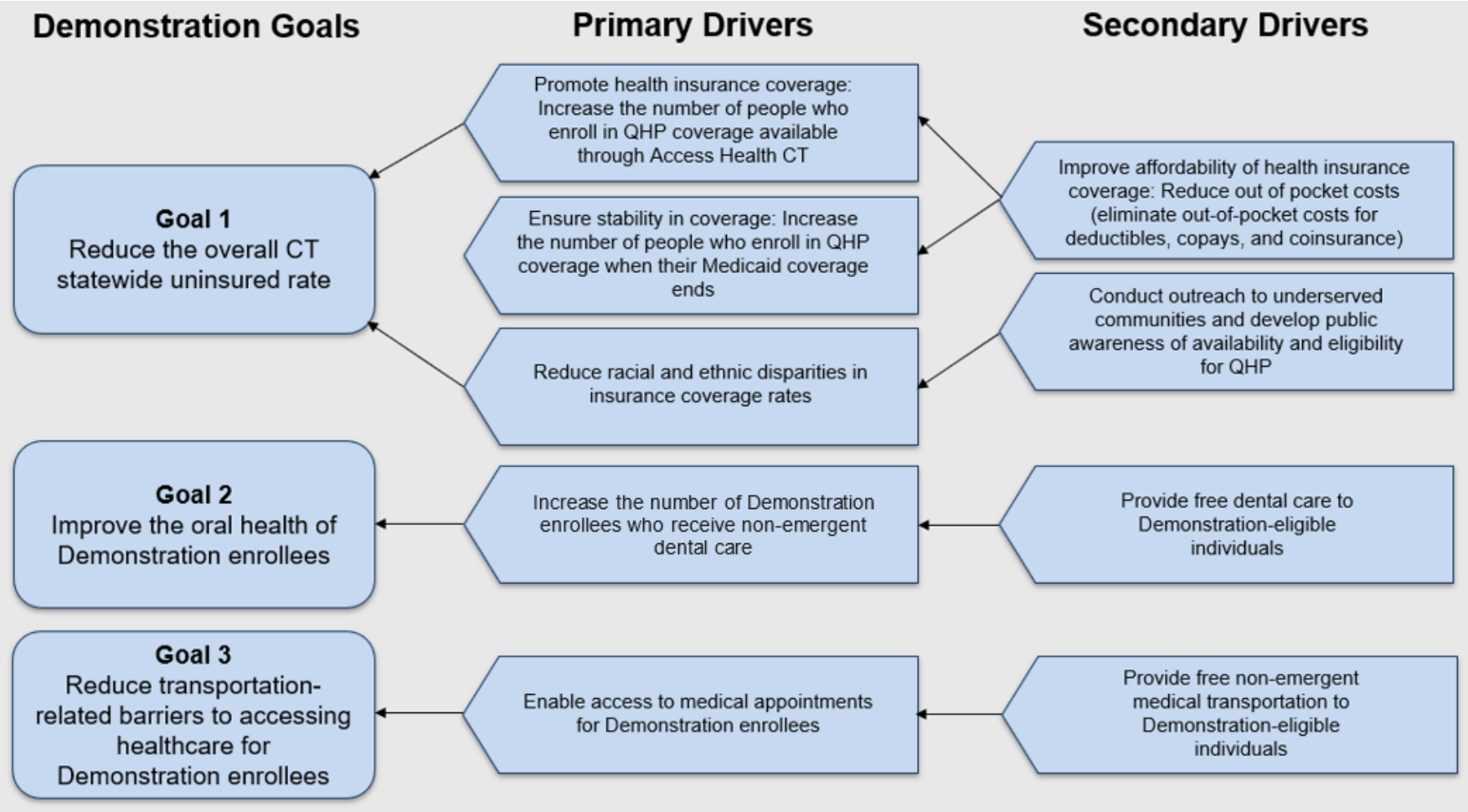
The three goals of the Covered CT waiver with Targets for Improvement are listed in the table below.

Program Goals	Targets
Reduce the overall Connecticut statewide uninsured rate.	• 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.	• 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.	• 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
Primary Driver: Ensure stability in coverage: Increase the number of people who enroll in QHP coverage when their Medicaid coverage ends. **Hypothesis 2: The Demonstration will increase the number of people who maintain health care coverage when their Medicaid coverage ends.**							
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. **Hypothesis 7: Cost increases will align with the intent of the Demonstration.**							
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.bmj.com/content/350/bmj.h2750.

[23] Ibid.

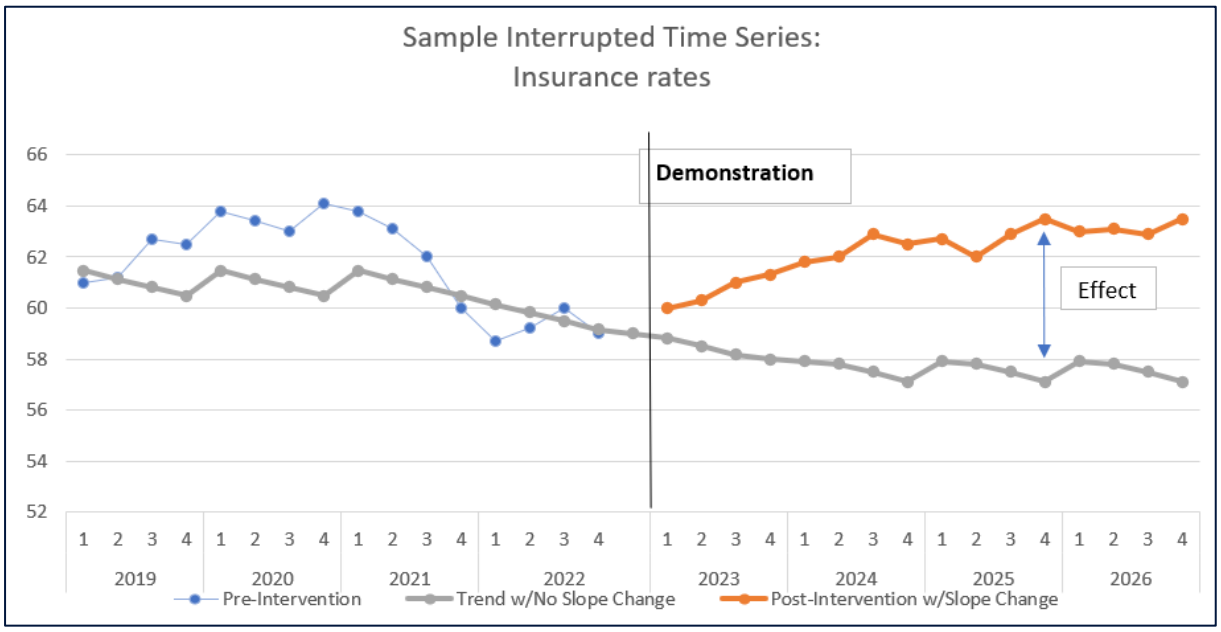
level and slope in the post-intervention period compared to the predicted trend (see Effect in the graph below).

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

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 heath 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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