



December 23, 2021

Caylee Noggle  
Commissioner  
Georgia Department of Community Health  
2 Peachtree Street, NW  
Atlanta, Georgia 30303-3159

Dear Commissioner Noggle:

On February 12, 2021, the Centers for Medicare & Medicaid Services (CMS) sent you a letter regarding the October 15, 2020 approval of the section 1115 demonstration project entitled “Georgia Pathways to Coverage” (Project Number 11-W-00342/4).<sup>1</sup> The letter advised that CMS would commence a process of determining whether or not to withdraw the authorities previously approved in the Georgia Pathways to Coverage section 1115 demonstration that permit the state to implement a work requirement as a condition of initial and continued Medicaid eligibility for individuals who would become eligible under this demonstration, ages 19 through 64. A similar work requirement in other states has been referred to as a “community engagement requirement,” but this policy is called the “qualifying hours and activities requirement” under the Georgia Pathways to Coverage demonstration. The February 12, 2021 letter explained that in light of the ongoing disruptions caused by the COVID-19 pandemic, Georgia’s qualifying hours and activities requirements, hereinafter referred to as a work requirement, significantly compromises the demonstration’s effectiveness in promoting coverage for its intended beneficiaries. CMS did not take further action concerning the authorities approved on October 15, 2020, as Georgia voluntarily delayed implementation of the demonstration and began working cooperatively with CMS to develop an alternative approach to the Georgia Pathways to Coverage demonstration with the goal of amending the demonstration to not require a work requirement as a condition of initial or continued eligibility.

Georgia indicated in a letter sent to CMS on July 27, 2021 that it anticipated delaying implementation of the demonstration until the end of 2021, as it assessed options to resolve the issues CMS identified in its February 12, 2021 letter, in order to find a mutually agreeable path forward to increase access to coverage in Georgia. However, the state has not submitted a demonstration amendment request to CMS and, under the terms of the state’s July 27, 2021 letter to CMS, could begin implementing the demonstration with a work requirement as early as January 1, 2022. Therefore, for the reasons discussed below, CMS is withdrawing the approval of the work requirement policy in the Georgia Pathways to Coverage demonstration, which is not currently in effect, and which would have expired by the terms of the demonstration on September 30, 2025.

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<sup>1</sup> Letter from CMS to Georgia, February 12, 2021. Available at: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathways-to-coverage-cms-ltr-state-demo-02122021.pdf>.

In addition to the work requirement approved in the Georgia Pathways to Coverage demonstration, at this time, CMS has also made the determination to withdraw the premium authority that was also approved in the demonstration on October 15, 2020. Specifically, we are withdrawing the identification of section 1902(a)(14) of the Social Security Act (the Act), insofar as it incorporates sections 1916 and 1916A of the Act, as not applicable to expenditures under the demonstration (the “premium authority”). As we indicated in our February 12, 2021 letter to the state regarding the demonstration’s work requirement, CMS was at that time still reviewing the remaining authorities in the demonstration. Upon further review, and for reasons discussed below, CMS has determined that the premium authority, as approved in Georgia’s demonstration, is unlikely to assist in promoting the objectives of Medicaid. Otherwise, the demonstration still remains effective, including the targeted expansion of coverage component, through September 30, 2025.

Section 1115 of the Act provides that the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act. In so doing, the Secretary may waive Medicaid program requirements of section 1902 of the Act, and approve federal matching funds per section 1115(a)(2) for state spending on costs not otherwise matchable under section 1903 of the Act, which permits federal matching payments only for “medical assistance” and specified administrative expenses.<sup>2</sup> Under section 1115 authority, the Secretary can allow states to undertake projects to test changes in Medicaid eligibility, benefits, delivery systems, and other areas across their Medicaid programs that the Secretary determines are likely to promote the statutory objectives of Medicaid. As stated in the above-referenced letter sent on February 12, 2021, under section 1115 and its implementing regulations, CMS has the authority and responsibility to maintain continued oversight of demonstration projects in order to ensure that they are currently likely to assist in promoting the objectives of Medicaid. CMS may withdraw waivers or expenditure authorities if it “find[s] that [a] demonstration project is not likely to achieve the statutory purposes.”<sup>3</sup>

As the February 12, 2021 letter explained, the Georgia Pathways to Coverage section 1115 demonstration work requirement is not in effect. Although the demonstration was approved in October 2020, the state has not implemented the demonstration to date. CMS believes that the COVID-19 pandemic and its expected aftermath have made the state’s work requirement infeasible. In addition, implementation of the work requirement to suspend coverage or disenroll beneficiaries who become eligible under the demonstration during the public health emergency for COVID-19 would currently not be in compliance with the Families First Coronavirus Response Act (FFCRA)<sup>4</sup> temporary increase in federal Medicaid funding, which is conditioned on the state’s maintenance of certain existing Medicaid parameters. Because Georgia has chosen to claim the 6.2 percentage point FFCRA Federal Medical Assistance Percentage (FMAP) increase, to continue claiming such increase it must maintain the enrollment of beneficiaries who were enrolled as of, or who become enrolled after, March 18, 2020, through the end of the month in which the public health emergency ends. Georgia also must maintain eligibility standards, methodologies, and procedures that are no more restrictive than what the state has in place as of

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<sup>2</sup> 42 U.S.C. § 1315.

<sup>3</sup> 42 C.F.R. § 431.420(d); see 42 U.S.C. § 1315(d)(2)(D).

<sup>4</sup> Pub. L. No. 116-127, Div. F, § 6008, 134 Stat. 208 (2020).

January 1, 2020, through the end of the calendar quarter in which the public health emergency ends. Therefore, if Georgia implements this demonstration prior to the end of the public health emergency and begins enrolling beneficiaries, the state must maintain that Medicaid coverage as long as it continues to accept the FFCRA enhanced FMAP. Moreover, as further discussed below, CMS is concerned about the effects of the work requirement on potential beneficiaries who would not be eligible under the demonstration if they do not satisfy the requirement as a condition of initial and continued eligibility.

CMS has serious concerns about testing policies that can potentially create access barriers to health care coverage and cause harm to beneficiaries. Given the widespread uncertainties and limited understanding about the COVID-19 pandemic at the time of the approval of Georgia's demonstration, CMS was not in a position to foresee and adequately appreciate or take into consideration the full gravity of the longevity and deleterious effects of the pandemic, and how the work requirement would be likely to restrict substantially otherwise eligible low-income Georgians from becoming eligible for demonstration coverage. While the current administration is acting to accelerate the economic recovery from the pandemic,<sup>5</sup> as of November 2021, 2.5 million more Americans remained out of the labor force compared to pre-pandemic levels, and despite various mitigation efforts underway, the emergence of the newer Delta and Omicron variants of the SARS-CoV-2 virus that causes COVID-19 are proving difficult, especially for the low-income populations across the country, including in Georgia, to make a complete recovery.<sup>6</sup> In Georgia, the most current data available on employment rates stratified by wage quartiles reflect that, in August 2021, employment rates for low-wage earners (i.e., annual wages under \$27,000) in the state were still 21.6 percent lower compared to the corresponding pre-pandemic rates in January 2020.<sup>7</sup> Furthermore, the impacts of the pandemic and the economic fallout continue to remain particularly prevalent among Black and Latino<sup>8</sup> populations, and other people of color, as well as in households with children.<sup>9</sup>

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<sup>5</sup> The White House. (2021). FACT SHEET: The Biden-Harris Administration is Taking Action to Restore and Strengthen American Democracy. Retrieved from <https://www.whitehouse.gov/briefing-room/statements-releases/2021/12/08/fact-sheet-the-biden-harris-administration-is-taking-action-to-restore-and-strengthen-american-democracy/>.

<sup>6</sup> For November 2021 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved on December 13, 2021 from <https://www.bls.gov/web/empsit/cpseea08b.pdf>; for February 2020 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (March, 2020). The Employment Situation – February 2020. News Release. Retrieved from [https://www.bls.gov/news.release/archives/empsit\\_03062020.pdf](https://www.bls.gov/news.release/archives/empsit_03062020.pdf). Also see Smith, C. (2021). US job growth slows sharply in November. Financial Times. Retrieved from <https://www.ft.com/content/0775fe17-aabc-471a-aef0-dd119bb54c0e>; PBS. (2021). US Consumer Confidence Falls in November to Nine-month Low. Retrieved from <https://www.pbs.org/newshour/economy/u-s-consumer-confidence-falls-in-november-to-nine-month-low>.

<sup>7</sup> Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved on December 10, 2021 from <https://www.tracktherecovery.org/>; data not seasonally adjusted. Latest data available are for August 2021.

<sup>8</sup> This study focused on the Latino population as a subpopulation of interest. Throughout this letter, we have retained the population classification (e.g., Latino, Hispanic), as identified in the source article/study, and refrained from conveying the population identity through a single term, since there could be variations in these population definitions used in the different studies.

<sup>9</sup> Center on Budget and Policy Priorities (2021). Tracking the COVID-19 Economy's Effects on Food, Housing, and Employment Hardships. Retrieved from <https://www.cbpp.org/research/poverty-and-inequality/tracking-the-covid-19-economys-effects-on-food-housing-and-employment-hardships>.

As detailed further below, the COVID-19 pandemic has had a significant impact on the health of low-income people, and the effects of the pandemic are likely to continue after the pandemic has ended. Uncertainty regarding new variants of the virus, the duration of the pandemic and its overall aftermath, and its potential impact on economic opportunities (including job skills training, work and other activities used to satisfy the work requirement), as well as on access to transportation and affordable child care, have greatly increased the risk that implementation of the work requirement approved in this demonstration will create barriers to coverage in a time of great health care need among low-income people. The lingering health consequences of COVID-19 infections further exacerbate the harms of these barriers to coverage for low-income people.

In light of how the pandemic has progressed since the date of CMS's initial approval, CMS has reevaluated both the risks posed by the pandemic and its aftermath and the potential benefits of continuing the work requirement. Based on this reanalysis, CMS has determined that the earlier approval outweighed the potential benefits to Georgia's Medicaid program from the work requirement while under-weighting the requirement's potential negative effects, particularly in light of the ongoing pandemic. In particular, CMS is now of the view that the evidence supporting the earlier approval of the work requirement—which emphasized a connection between work and community engagement and health—did not sufficiently account for the likely loss of coverage that many of the intended beneficiaries subject to the requirement would experience, the inability of intended beneficiaries of the demonstration initially to enroll in coverage, or the evidence demonstrating that healthier individuals and individuals with coverage are more likely to find and retain employment.<sup>10</sup> The prior approval also did not adequately consider the likely difficulties in completing, and reporting compliance with, the work requirement during and following the pandemic, or the significant uncertainties concerning the pandemic's future effects on the health of and economic opportunities available to beneficiaries and potential beneficiaries.

Considering the physical, mental, social and economic toll the public health emergency has taken on individuals, CMS believes it is especially important that the low-income individuals who are the intended beneficiaries of the Georgia Pathways to Coverage demonstration be able to access coverage and care, without the initial and continued eligibility obstacle of a work requirement that may be unreasonably difficult or impossible for individuals to meet under the circumstances of COVID-19 and its likely aftermath. Access to coverage and care is essential to promoting health; healthier individuals and individuals with coverage tend to be more successful in finding

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<sup>10</sup> Gehr, J. & Wikle, S. (2017). The Evidence Builds: Access to Medicaid Helps People Work. CLASP. Retrieved from <https://www.clasp.org/sites/default/files/publications/2017/04/The-Evidence-Builds-Access-to-Medicaid-Helps-People-Work.pdf>; The Ohio Department of Medicaid. (2018). 2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment. Retrieved from <https://www.medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf>. [Beneficiaries participating in substance use disorder treatment are exempt from the community engagement requirement](#); Tipirmeni R., Ayanian J., Kullgren J., Goold S., Kieffer E., Chang T., Haggins A., Clark S. & Lee S. (2017). Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches. The Institute for Healthcare Policy and Innovation (IHPI). Retrieved from <https://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches>; Musumeci M., Rudowitz R. & Lyons B. (2018). Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees-issue-brief/>.

and retaining jobs. Therefore, conditioning initial and continued access to health coverage on completing a work requirement during an ongoing pandemic will only work to hinder the overall wellbeing of low-income Georgians, including with respect to their health and employment status. CMS currently does not believe that any potential benefits of the work requirement outweigh their likely negative consequences, and thus does not believe that the demonstration is likely to further the purposes of Medicaid with this requirement included.

As indicated in the February 12, 2021 letter,<sup>11</sup> taking into account the totality of circumstances, we preliminarily determined that allowing the work requirement to take effect in Georgia would not promote the objectives of the Medicaid program. Therefore, CMS provided the state notice that we were commencing a process of determining whether to withdraw the authorities approved in the Georgia Pathways to Coverage section 1115 demonstration that would permit the state to implement a work requirement as a condition of initial and continued Medicaid eligibility. The letter explained that if CMS ultimately determined to withdraw those authorities, it would “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.” The February 12, 2021 letter indicated that, if the state wished to submit to CMS any additional information that in the state’s view may warrant not withdrawing those authorities, such information should be submitted to CMS within 30 days.

On March 12, 2021, Georgia submitted additional information in response to CMS’s February 12, 2021 letter. As further discussed below, the additional information that Georgia submitted did not resolve the concerns CMS raised in the February 12, 2021 letter. The state has not addressed how Georgia’s work requirement will not compromise the demonstration’s effectiveness in promoting coverage for its intended beneficiaries. CMS is not aware that Georgia has put adequate measures in place to ensure the expansion of coverage to individuals intended to benefit from this demonstration, or to reduce the potential risks of the demonstration resulting in sizable suspensions of eligibility and disenrollments at a time when losing access to health care coverage would cause significant harm to beneficiaries.

Additionally, while the state claimed that the COVID-19 pandemic would not make it infeasible for individuals to engage in a work, throughout the course of the pandemic, Georgia has experienced an overall higher rate of COVID-19 infections compared to the corresponding national rates,<sup>12</sup> while the vaccination rates in the state remain lower in comparison to the national rates.<sup>13</sup> We also remain concerned that the lingering effects of COVID-19 for some patients, including chronic fatigue, confusion, memory loss, and joint pain,<sup>13</sup> (hereafter referred to as

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<sup>11</sup> Letter from CMS to Georgia, February 12, 2021. Available at: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathways-to-coverage-cms-ltr-state-demo-02122021.pdf>.

<sup>12</sup> Worldometer. (2021). United States Coronavirus Cases. Retrieved on December 10, 2021 from <https://www.worldometers.info/coronavirus/country/us/>; The Mayo Clinic. (2021). U.S. COVID-19 vaccine tracker: See your state’s progress. Retrieved on December 10, 2021 from <https://www.mayoclinic.org/coronavirus-covid-19/vaccine-tracker>.

<sup>13</sup> Aiyegbusi, O. L., Hughes, S. E., Turner, G., Rivera, S. C., McMullan, C., Chandan, J. S., Haroon, S., Price, G., Davies, E. H., Nirantharakumar, K., Sapey, E., & Calvert, M. J. (2021). Symptoms, complications and management of long COVID: a review. *Journal of the Royal Society of Medicine*, 114(9), 428–442.

“long COVID”) may continue to impede individuals’ ability to complete a work requirement in Georgia. The long-term effects of COVID-19 also underscore the risks of implementing policies that could potentially limit access to initial and continued coverage for the demonstration’s intended beneficiaries.

The state also did not provide information or data on its plans to ease access to transportation or affordable child care, which evidence indicates continue to be affected in Georgia in the wake of the pandemic despite mitigation efforts that have been underway both at the state and federal levels.<sup>14</sup> Georgia’s demonstration is structured to include no qualifying exemptions for non-compliance with the work requirement, and notably, it does not provide an exemption or good cause exception, or count caregiving time as qualifying hours, for individuals who cannot otherwise meet the requirement because they are taking care of children or have other family caregiving obligations. The burden of such a work requirement may have increased as a result of the public health emergency, due to illness as well as the reduced availability of affordable child care.<sup>15</sup> In light of the duration of the public health emergency to-date and its likely aftermath, and with Georgia facing child care availability issues as described below, CMS does not believe that Georgia’s work requirement is feasible for compliance by low-income parents and caregivers. Specifically, we are concerned that the requirement is likely to prevent such individuals from gaining access to or maintaining demonstration coverage for which they would otherwise be eligible.

Furthermore, research shows that complex and frequent reporting requirements, associated administrative burden, and challenges of informing and educating beneficiaries about a work requirement has contributed to significant barriers to compliance with community engagement requirements in other states.<sup>16</sup> The Georgia Pathways to Coverage demonstration involves a

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<https://doi.org/10.1177/01410768211032850>. Retrieved from <https://journals.sagepub.com/doi/full/10.1177/01410768211032850>.

<sup>14</sup> Guillory, A. (2021). MARTA bus service to be cut as COVID-19 sparks staffing shortage. WABE. Retrieved from <https://www.wabe.org/marta-bus-service-to-be-cut-as-covid-19-sparks-staffing-shortage/>; Donsky, P. (2021). How Traffic Patterns in ATL Have Changed in Pandemic. Atlanta Regional Commission. Retrieved from <https://atlantaregional.org/whats-next-atl/articles/how-traffic-patterns-in-atl-have-changed-during-pandemic/>; Workman, S. & Jessen-Howard, Steven. (2020). The True Cost of Providing Safe Child Care During the Coronavirus Pandemic. Center for American Progress. Retrieved from <https://www.americanprogress.org/article/true-cost-providing-safe-child-care-coronavirus-pandemic/>; Tagami, T. (2021). More Georgia families to get child care subsidy. The Atlanta Journal-Constitution. Retrieved from <https://www.ajc.com/education/more-georgia-families-to-get-childcare-subsidy/GQFRREPWV5C4FGDL6YCCOFKSKI/>.

<sup>15</sup> Ranji, U., Frederiksen, B., Salganicoff, A. & Long, M. (2021). Women, Work, and Family During COVID-19: Findings from the KFF Women’s Health Survey. The Kaiser Family Foundation. Retrieved from <https://www.kff.org/womens-health-policy/issue-brief/women-work-and-family-during-covid-19-findings-from-the-kff-womens-health-survey/>; Pepalis, B., (2021). Families continue to struggle with childcare availability, affordability. Retrieved from: <https://reporternewspapers.net/2021/08/03/families-continue-to-struggle-with-childcare-availability-affordability/>.

<sup>16</sup> Solomon, J. (2019). Medicaid Work Requirements Can’t Be Fixed: Unintended Consequences are Inevitable Result. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>; Wagner, J., & Schubel, J. (2020). States’ experiences confirming harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements>; Garfield, R., Rudowitz, R., & Musumeci, M. (2018). Implications of a Medicaid Work Requirement:

monthly reporting requirement for six consecutive months during a 12-month benefit period, along with a requirement to periodically verify documentation and to report changes in circumstances, such as income, employment or other qualifying activities, that could impact eligibility. We are concerned that these reporting and administrative challenges, as have been experienced in other states implementing community engagement requirements, would substantially hinder initial and continued eligibility for demonstration coverage for low-income Georgians who are the intended beneficiaries of this demonstration. Therefore, as addressed further below, the information available to CMS, including that which was submitted in Georgia's March 12, 2021 letter, does not provide an adequate basis to resolve the concerns stated in our February 12, 2021 letter.

In light of these concerns, for the reasons set forth below related to the COVID-19 public health emergency and its expected aftermath, CMS has determined that, on balance, the authorities that permit Georgia to implement a work requirement as a condition of initial and continued eligibility are not likely to promote the objectives of the Medicaid statute. Therefore, we are withdrawing the authority for the work requirement that was approved on October 15, 2020 within the Georgia Pathways to Coverage section 1115 demonstration. As noted above and further discussed below, the authority to require premiums not consistent with section 1902(a)(14) of the Act, insofar as it incorporates sections 1916 and 1916A of the Act, is also withdrawn as it is not likely to promote the objectives of the Medicaid statute.

### **Background of the Georgia Pathways to Coverage Demonstration**

On October 15, 2020, CMS approved Georgia's request for a new section 1115 demonstration, entitled the "Georgia Pathways to Coverage." While the state has not implemented the premium authority or the work requirement previously approved in the demonstration, CMS authorized these policies as follows. The state would require initial and ongoing premium payments for some beneficiaries (except beneficiaries who qualify for an exemption) as a condition of eligibility. Beneficiaries with income below 50 percent of the FPL, beneficiaries with employer sponsored insurance who are enrolled in the health insurance premium program (HIPP), and beneficiaries enrolled in certain vocational education programs would be exempt from paying premiums. Beneficiaries with income from 50 percent up to 85 percent of the FPL would be required to pay a \$7.00 monthly premium, while beneficiaries with income from 85 percent up to 95 percent FPL (effectively, 100 percent of the FPL with the 5 percent income disregard) would be required to pay an \$11.00 monthly premium. Medicaid coverage would not begin until the initial premium payment has been made, and applicants would have 90 days following the initial eligibility determination to make the first premium payment. Failure to make the initial premium payment would result in closure of the individual's Medicaid application, and the individual would be required to reapply for health care coverage, if desired in the future.

After making the initial premium payment, beneficiaries who miss one or two subsequent premium payments would receive a maximum of two grace period months in a benefit year to avoid suspension of their Medicaid coverage. Beneficiaries who miss a total of three premium

payments in a benefit year would have their coverage suspended and would have up to 90 days to submit a payment to prospectively reinstate coverage. Beneficiaries who fail to make a payment within 90 days of the suspension date would be disenrolled from Medicaid and would need to reapply for health care coverage.

The demonstration also authorizes the state to require all individuals ages 19 through 64 with incomes up to 95 percent of the FPL (effectively 100 percent, after applying the 5 percent income disregard), who are not otherwise eligible for Medicaid coverage, to meet the work requirement at application and thereafter to be eligible for demonstration coverage. Applicants and enrolled beneficiaries would be required to participate in and timely document and report at least 80 hours per month of qualifying activities, such as employment, education, specified job readiness activities, or community service, as a condition of initial and continued Medicaid eligibility. Applicants and beneficiaries could satisfy these eligibility requirements through a variety of qualifying activities, including unsubsidized employment, subsidized private sector employment (including self-employment), on-the-job training, specified job readiness activities, certain community service activities, specified vocational educational training, and enrollment in an institution of higher education. If an applicant is not in compliance with the work requirement at the time of application (including if the requirement would be modified as a reasonable accommodation), and is not eligible for Medicaid under another eligibility category not subject to the work requirement, then the application would be denied and the individual could reapply at any time.

Upon implementation of the work requirement, Georgia would provide reasonable accommodations to enable individuals with disabilities (but who are not otherwise eligible for Medicaid on the basis of such disability) to meet the work requirement. Individuals who report a disability as defined by the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and Section 1557 of the Patient Protection and Affordable Care Act, either at the time of application, or after enrollment in the demonstration, and who are unable to meet the work requirement as a result of this disability, would be assessed to determine eligibility for another Medicaid category of assistance. Individuals or beneficiaries who are ineligible for other categories of assistance could request a reasonable accommodation to assist in meeting the work requirement. Reasonable accommodations could include: a referral to a state vocational rehabilitation program for an assessment to determine the appropriate reasonable accommodation, which could include a reduction in the number of hours required to participate in a qualifying activity, or an alternate way to report compliance with the work requirement. Individuals referred to a qualifying vocational rehabilitation program would be required to engage in the number of hours and type of qualifying activities specified by the vocational rehabilitation program within 90 days of the referral in order to enroll in the demonstration.

In order to maintain eligibility in Georgia Pathways to Coverage, a beneficiary would be required to continue meeting the work requirement threshold of 80 hours per month and to report their hours monthly. Beneficiaries who report their qualifying activities and corresponding hours and demonstrate that they meet the work requirement for six (6) consecutive months would be exempt from the monthly reporting requirement for the remainder of the beneficiary's 12-month benefit year. The state would perform periodic and random audits to verify documentation and compliance with the work requirement.

If a beneficiary did not meet the work requirement threshold, the beneficiary would have eligibility suspended and would no longer receive demonstration coverage during the suspension. The beneficiary would have 90 days to come in compliance with the work requirement, and document and report this compliance to the state, for the suspension to be lifted. If the beneficiary was unable to comply and successfully report compliance with the work requirement during this period, the beneficiary would be disenrolled from the demonstration. The beneficiary could regain eligibility at any time after suspension or disenrollment by meeting and reporting compliance with the work requirement in a single month, although after disenrollment, a new application would be required.

Beneficiaries who have been compliant with the work requirement, but become unable to comply with the requirement due to circumstances that give rise to good cause for non-compliance, could qualify for a maximum of 120 “good-cause” hours during the 12-month benefit period. The good cause circumstances would include, but not be limited to: the beneficiary experiencing the birth, adoption, or death of an immediate family member; the beneficiary accepting a foster child or kin-ship care placement; the beneficiary experiencing a natural or human-caused disaster (including those related to a public health emergency); the beneficiary having a family emergency or other life event (e.g., divorce, civil legal matter, or is a victim of domestic violence); the beneficiary temporarily experiencing homelessness; or other good cause reasons as defined and approved by the state.

### **Evidence on the Effects of Premiums in Medicaid Section 1115 Demonstrations**

As the Georgia Pathways to Coverage demonstration has not yet been implemented, the premium authority approved within the demonstration is not in effect and we do not have state-specific evidence on how beneficiaries would be affected by this policy in Georgia. However, while CMS approved the premium authority in the state’s section 1115 demonstration, CMS has since determined that, generally, charging beneficiaries premiums can present a barrier to coverage, and therefore, any premiums beyond those specifically permitted under the Medicaid statute are not likely to advance the objectives of Medicaid. This determination is informed by evidence from research conducted across different states with premiums in their section 1115 demonstrations.

Overall, the findings in recent research on premiums under section 1115 demonstrations show that charging beneficiaries premiums beyond those authorized under the statute resulted in shorter enrollment spells, and were associated with lower initial enrollment rates and increased obstacles to accessing care in several states. Specifically, with regard to initial and re-enrollment rates, an evaluation of section 1115 demonstrations in several states showed that living in states with monthly payment requirements resulted in a lower probability of enrolling in Medicaid or demonstration coverage.<sup>17</sup> The reduction in probability of enrollment varied by estimated monthly payment amount; the estimated effects in the study suggest that, for example, for an

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<sup>17</sup> Bradley, K., Niedzwiecki, M., Maurer, K., Chao, S., Natzke, B., & Samra, M. (2020). Medicaid Section 1115 Demonstrations Summative Evaluation Report: Premium Assistance, Monthly Payments, and Beneficiary Engagement. Retrieved from <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/alt-medicaid-exp-summ-eval-report.pdf>.

adult who is likely to be eligible, lives in a state with a monthly payment requirement, and is expected to have a \$10 payment, the likelihood of enrolling in Medicaid was an estimated 5.5 percentage points lower than the enrollment rate in comparison states. The evaluation also found that both employed and unemployed individuals were less likely to enroll if it meant owing monthly payments. This study also found a relatively low probability of renewal after the first year of enrollment in several states implementing premiums through section 1115 demonstrations. In addition, in a state evaluation of Indiana's section 1115 demonstration, premiums were reported to have had prevented initial enrollment for a sizable, otherwise eligible population due to non-payment of the first premium contribution.<sup>18</sup>

Premium policies have also been shown to result in shorter enrollment spells, and may increase the likelihood of beneficiary disenrollment from section 1115 demonstrations. Specifically, in Wisconsin's demonstration, premium increases from \$0 to \$10 per month resulted in beneficiaries being enrolled for 1.4 fewer months.<sup>19</sup> Additionally, an evaluation of the Healthy Michigan Plan demonstration found that beneficiaries who were subject to premiums were more likely to disenroll from the demonstration than beneficiaries who were not subject to premiums.<sup>20</sup> Therefore, because most of the intended beneficiaries in Georgia Pathways to Coverage with incomes between 50 percent and 95 percent of the FPL would be subject to premiums,<sup>21</sup> this policy may further limit the number of beneficiaries who are expected to gain coverage under the demonstration.

Research on premiums in section 1115 demonstrations also indicate that a lack of beneficiary awareness and limited understanding about premium requirements may contribute to the lower enrollment levels and higher disenrollment rates. Specifically, while beneficiaries in certain states noted that the opportunity to contribute toward their coverage reduced the stigma or personal guilt associated with "relying on government" for traditional Medicaid coverage, beneficiaries also reported misperceptions about the affordability of Medicaid coverage under demonstrations with premium requirements and reported concerns about their ability to make monthly contributions, which may lead to lower initial enrollment rates.<sup>22</sup> Additionally, disenrolled beneficiaries have expressed confusion about the premium amounts they owed, the correct methods to pay their premiums, and how to request or claim any available exemptions

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<sup>18</sup> The Lewin Group Inc. (2017). Health Indiana Plan 2.0: POWER Account Contribution Assessment. Retrieved from <https://www.medicaid.gov/sites/default/files/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf>.

<sup>19</sup> Dague, L. (2014). The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach. *Journal of Health Economics*. 37: 1-12. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0167629614000642>.

<sup>20</sup> University of Michigan Institute for Healthcare Policy & Innovation. (2018). Report on the Impact of Cost Sharing in the Healthy Michigan Plan: Healthy Michigan Plan Evaluation Domains V/VI. Retrieved from [https://deepblue.lib.umich.edu/bitstream/handle/2027.42/154759/UM\\_HMP\\_Eval\\_Domain\\_VVI\\_Report\\_7-30\\_Appendix\\_Included\\_629937\\_7.pdf?sequence=1&isAllowed=y](https://deepblue.lib.umich.edu/bitstream/handle/2027.42/154759/UM_HMP_Eval_Domain_VVI_Report_7-30_Appendix_Included_629937_7.pdf?sequence=1&isAllowed=y).

<sup>21</sup> The Centers for Medicare & Medicaid Services. (2020). Georgia Pathways to Coverage Section 1115 Demonstration Special Terms and Conditions. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf>.

<sup>22</sup> The Lewin Group Inc. (2017). Health Indiana Plan 2.0: POWER Account Contribution Assessment; [see also](#) University of Michigan Institute for Healthcare Policy & Innovation (2018).

from premium requirements.<sup>23</sup> Under Georgia's demonstration, beneficiaries would have to complete program requirements and make an initial premium payment prior to obtaining coverage. Therefore, any confusion about premium payments or other enrollment requirements could further limit initial enrollment in the demonstration.

Studies have also found that premium policies can exacerbate health disparities, as certain populations, including racial minority groups and individuals with lower incomes, may be disproportionately affected by these policies. For example, research shows that premium policies led to decreased enrollment and shorter enrollments spells for Black beneficiaries compared to their White counterparts,<sup>24</sup> and individuals with lower incomes compared to those with higher incomes.<sup>25</sup> In Georgia, Black, Hispanic,<sup>26</sup> and multi-racial individuals are already more likely than White individuals to avoid care due to cost, and individuals with incomes under \$25,000 per year are more than twice as likely to avoid care due to cost than those who make between \$50,000 and \$74,999 per year.<sup>27</sup> Therefore, implementing the premium requirement under this demonstration is likely to increase health disparities across groups that already experience barriers to accessing care in Georgia.

Overall, based on findings from other states with section 1115 demonstrations that authorized charging beneficiaries premiums beyond those authorized under the statute, we do not have reason to believe that the premium policy, as approved in the Georgia Pathways to Coverage demonstration, is likely to directly or indirectly promote coverage. Rather, there is evidence that impediments to coverage for demonstration beneficiaries, including eligibility suspension, disenrollment, or inability to access demonstration coverage in the first place, could be detrimental to the health of the demonstration's intended beneficiaries.<sup>28</sup> Further, premiums

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<sup>23</sup> Askelson, N.M., Brady, P., Wright, B., Bentler, S., Momany & E.T., Damiano, P. (2019). Purged from the Rolls: A Study of Medicaid Disenrollment in Iowa. *Health Equity*. 3(1): 637-643. Retrieved from <https://www.liebertpub.com/doi/full/10.1089/heq.2019.0093>; Social & Scientific Systems, Inc. and the Urban Institute. (2020). Federal Evaluation of Montana Health and Economic Livelihood. Retrieved from <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-montana-2020.pdf>; see also University of Michigan Institute for Healthcare Policy & Innovation (2018).

<sup>24</sup> University of Wisconsin-Madison Institute for Research on Poverty. (2019). Evaluation of Wisconsin's BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2014 Waiver Provisions. Retrieved from <https://www.irp.wisc.edu/wp/wp-content/uploads/2019/11/BC-2014-Waiver-Provisions-Final-Report-08302019.pdf>; and The Lewin Group, Inc. (2020). Healthy Indiana Plan Interim Evaluation Report. Retrieved from [https://www.in.gov/fssa/hip/files/IN\\_HIP\\_Interim\\_Evaluation\\_Report\\_Final.pdf](https://www.in.gov/fssa/hip/files/IN_HIP_Interim_Evaluation_Report_Final.pdf).

<sup>25</sup> Finkelstein, A., Hendren, N., & Shepard, M. (2019). Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts. *American Economic Review*. 109(4): 1530-67. Retrieved from <https://www.aeaweb.org/articles?id=10.1257/aer.20171455>.

<sup>26</sup> This study focused on the Hispanic population as a subpopulation of interest. Throughout this letter, we have retained the population classification (e.g., Latino, Hispanic), as identified in the source article/study, and refrained from conveying the population identity through a single term, since there could be variations in these population definitions used in the different studies.

<sup>27</sup> United Health Foundation. (2021). America's Health Rankings: Annual Report (2021). Retrieved from <https://www.americashealthrankings.org/explore/annual/measure/costburden/state/GA>.

<sup>28</sup> Ku, L. & Ross, D.C. (2002). Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families. The Commonwealth Fund. Retrieved from [https://www.commonwealthfund.org/sites/default/files/documents/media\\_files\\_publications\\_fund\\_report\\_2002\\_dec\\_staying\\_covered\\_the\\_importance\\_of\\_retaining\\_health\\_insurance\\_for\\_low\\_income\\_families\\_ku\\_stayingcovered\\_586.pdf](https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2002_dec_staying_covered_the_importance_of_retaining_health_insurance_for_low_income_families_ku_stayingcovered_586.pdf); Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J. & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. *Health Affairs*,

beyond those specifically permitted under the Medicaid statute are unlikely to facilitate our priority in advancing health equity. For these reasons, CMS has decided to withdraw the premium authority as approved in the Georgia Pathways to Coverage demonstration.

### **Early Experience from the Implementation of Community Engagement Requirements through Medicaid Section 1115 Demonstrations in Other States**

The Special Terms and Conditions governing Georgia’s demonstration stated an intention to start implementing the work requirement on July 1, 2021, and Georgia indicated to CMS on June 24, 2021 that it would be delaying implementation until at least August 1, 2021. On July 27, 2021, the state informed CMS that it would further defer implementation of the demonstration until the end of 2021. The state began working with CMS to find a mutually agreeable path forward to increase access to health care in Georgia without implementing a work requirement as a condition of eligibility. However, at this time, Georgia has not submitted a proposed demonstration amendment to CMS.

Since the demonstration has not yet been implemented, there is no direct evidence illustrating how the demonstration and its work requirement would affect the initial and continued eligibility of individuals who could be eligible for demonstration coverage. According to estimates from the state, if implemented, approximately 31,093 individuals would have received coverage under the demonstration during the first year of the demonstration.<sup>29</sup> Furthermore, the state projected that over the five-year demonstration approval period, approximately 64,336 Georgians would enroll in the demonstration coverage or subsidized employer-sponsored insurance through the demonstration.<sup>30</sup> Data from independent research show that without the work requirement, at least 269,000 Georgians could become covered through the demonstration just in the first year.<sup>31</sup> Between 2017 and 2019, an average of 28 percent of non-elderly adults in Georgia below 100 percent of the FPL were uninsured.<sup>32</sup> Additionally, 60 percent of the entire uninsured population over the age of 16 was already working at least part-time.<sup>33</sup> The rate of employment among this group was similar to that of Georgia’s Medicaid beneficiary population. For example, research

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39(9), 1522-1530. Retrieved from <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538>; See also University of Wisconsin-Madison Institute for Research on Poverty (2019).

<sup>29</sup> The Centers for Medicare & Medicaid Services. (2020). Georgia Pathways to Coverage Section 1115 Demonstration Special Terms and Conditions.

<sup>30</sup> The Centers for Medicare & Medicaid Services. (2020). Georgia Pathways to Coverage Section 1115 Demonstration Special Terms and Conditions.

<sup>31</sup> This would cost the state about \$650 million in the first year, higher than the \$76 million proposed in the fiscal year 2022 budget under the demonstration. See Harker, L. (2021). Expand Medicaid Fully; Reject Risky and Expensive State Plan. Georgia Budget & Policy Institute. Atlanta, Georgia. Retrieved from <https://gbpi.org/expand-medicaid-fully-reject-risky-and-expensive-state-plan/>; Garfield, R., Orgera K. & Damico, A. (2021). The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. The Kaiser Family Foundation. Retrieved from <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

<sup>32</sup> Kaiser Family Foundation. (2017-2019). Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL). State Health Facts. 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>.

<sup>33</sup> Georgia Department of Community Health. (2019). Georgia “Pathways to Coverage” Section 1115 Demonstration Waiver Application. Retrieved from <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ga-pathways-to-coverage-pa1.pdf>.

from the Kaiser Family Foundation using the Current Population Survey (CPS) data show that, in Georgia, 56 percent (63 percent nationally) of Medicaid beneficiaries aged 19 to 64 without Supplemental Security Income (SSI) in 2019 were working.<sup>34</sup> Of those who were not working in Georgia, 30 percent (27 percent nationally) indicated that their reason for not working was due to illness or disability, and under Georgia's demonstration, illness and disability could give rise to a good cause exception.<sup>35</sup>

A sizable number of non-working Georgians may be absent from the labor force due to caregiving responsibilities, which would neither excuse an individual from the work requirement nor count toward meeting them under the Georgia Pathways to Coverage demonstration. According to the same Kaiser Family Foundation study based on the CPS data cited above, of those who were not working in Georgia in 2019, 30 percent (32 percent nationally) indicated that they were caring for a child or a family member.<sup>36</sup> That caregiving activities would not be considered to give rise to a good cause exception, and that the Georgia Pathways to Coverage demonstration design does not accommodate any type of qualifying exemption from completing the work requirement, is particularly concerning in light of emerging data on the potential impacts of long COVID, including on caregiving. For example, among adults with post-COVID conditions, 36 percent reported that the conditions affected their ability to care for children, and 26 percent noted that they struggled to care for other adults.<sup>37</sup>

Overall, research shows that most Medicaid beneficiaries are already working or are likely to be exempt from a potential community engagement requirement (as most states' approved community engagement requirements are structured to include numerous exemptions from such requirements, albeit such accommodations are not present in Georgia Pathways to Coverage).<sup>38</sup> Thus, prior to the pandemic, the available data indicated that the substantial majority of the population that would be targeted by the work requirement in Georgia's demonstration were already meeting the terms of this requirement. This makes it challenging for such a requirement to produce any meaningful impact on employment outcomes by incentivizing behavioral changes in a small fraction of beneficiaries or potential beneficiaries, all the while heightening the risk of denying or suspending eligibility among those subject to the requirement.

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<sup>34</sup> Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/>.

<sup>35</sup> Garfield et al. (2021). Work Among Medicaid Adults.

<sup>36</sup> Garfield et al. (2021). Work Among Medicaid Adults.

<sup>37</sup> Ziauddeen, N., Gurdasani, D., O'Hara, M.E., Hastie, C., Roderick, P., Yao, G. & Alwan, N.A. (2021). Characteristics of Long Covid: findings from a social media survey. Medrxiv. <https://doi.org/10.1101/2021.03.21.21253968>. Retrieved from <https://www.medrxiv.org/content/10.1101/2021.03.21.21253968v2.full-text>.

<sup>38</sup> Garfield et al. (2021). Work Among Medicaid Adults; Huberfeld, N. (2018). Can Work be Required in the Medicaid Program? New England Journal of Medicine. 378:788-791. DOI: 10.1056/NEJMp1800549; Goldman, A.L., Woolhandler, S., Himmelstein, D.U., Bor, D.H. & McCormick, D. (2018). Analysis of work requirement exemptions and Medicaid spending. JAMA Intern Med, 178:1549-1552. DOI:10.1001/jamainternmed.2018.4194; see also Solomon, J. (2019).

While the Georgia Pathways to Coverage demonstration is distinct in that its work requirement must be met in order to become eligible for demonstration coverage, there is evidence of the potential impact of community engagement requirements in several other states that tied such requirements to continued eligibility for Medicaid coverage. Arkansas, Indiana, Michigan, New Hampshire, and Utah all implemented a community engagement requirement approved under each state's section 1115 demonstration; however, not every state's requirement was in place long enough to trigger penalties associated with non-compliance with the requirement or to obtain meaningful data.

Arkansas, Michigan, and New Hampshire provide some early evidence on potential enrollment impacts from implementation of a community engagement requirement.<sup>39</sup> Experience from these states indicates that large portions of the beneficiaries subject to these states' community engagement requirements failed to comply with the community engagement reporting requirements or became disenrolled once the requirements were implemented. In Arkansas, for instance, before the court halted the community engagement requirement, the state reported that from August 2018 through December 2018, more than 18,000 individuals were disenrolled from coverage for "non-compliance with the work requirement."<sup>40</sup> During these five months, the monthly rate of coverage loss as a percentage of those who were required to report work and community engagement activities fluctuated between 20 and 47 percent.<sup>41</sup> In New Hampshire, almost 17,000 beneficiaries (about 40 percent of those subject to the requirement) were set to be suspended for non-compliance with the requirement and lose Medicaid coverage within the span of just over a month when the state's community engagement requirement was in effect.<sup>42</sup> Based on those early data, another study projected that between 30 and 45 percent of New Hampshire beneficiaries subject to the community engagement requirement would have been

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<sup>39</sup> Utah and Indiana each also briefly implemented a section 1115 demonstration with a community engagement requirement, but these states did not impose any non-compliance penalties because beneficiaries were not late in meeting their respective reporting requirements. In Indiana, while the state suspended the community engagement requirement in October 2019, a beneficiary could report compliance or exemption status any time until the last day of the calendar year 2019. In Utah, beneficiaries were required to report compliance, or eligibility for a qualifying exemption or a good cause exception, within three months after receiving the notice to comply. Since Utah suspended the requirement right after the third month of its implementation, no beneficiaries experienced a non-compliance penalty for the community engagement requirement. See also Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from <https://aspe.hhs.gov/pdf-report/medicaid-demonstrations-andimpacts>.

<sup>40</sup> Arkansas Department of Human Services (DHS). (2018 & 2019). Arkansas Works Section 1115 Demonstration Annual Reports. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf>; <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-annl-rpt-jan-dec-2019.pdf>.

<sup>41</sup> Arkansas Department of Human Services (DHS). (2018). Arkansas Works Section 1115 Demonstration Annual Report: January 1, 2018 – December 31, 2018.

<sup>42</sup> New Hampshire Department of Health and Human Services. (2019). DHHS Community Engagement Report: June 2019. Retrieved from <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>; Hill, I., Burroughs, E. & Adams, G. (2020). New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results. Urban Institute. Retrieved from <https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results>; see also Wagner, J. & Schubel, J. (2020).

disenrolled within the first year of implementation.<sup>43</sup> And in Michigan, before the policy was vacated by the courts, 80,000 beneficiaries—representing nearly 33 percent of individuals subject to the community engagement requirement—were at risk of loss of coverage for failing to report compliance with the community engagement requirement.<sup>44</sup>

The work requirement in the Georgia Pathways to Coverage demonstration is likely to have more deleterious effects on beneficiaries than those experienced in other states that implemented a community engagement requirement. For example, the demonstration coverage at the outset would be conditional on compliance with meeting the requirement, thereby restricting initial enrollment. Compliance is also likely to be more difficult in Georgia since the requirement is not structured to include any qualifying exemptions, good cause exceptions, or credits toward required hours to accommodate caregiving obligations. This type of flexibility for parents and caregivers was offered in all states that implemented a community engagement requirement, including those where beneficiaries faced substantial coverage losses even with accommodations for caregiving responsibilities, and before such responsibilities might have increased due to the public health emergency.

The coverage losses in other states are at least partly attributable to beneficiaries' lack of awareness of and administrative barriers associated with community engagement requirements.<sup>45</sup> Notwithstanding Georgia's assurances in the demonstration's Special Terms and Conditions that the state would provide the necessary outreach to Medicaid beneficiaries, Georgia indicated in its monitoring report for demonstration year 1, quarter 2 (January 1, 2021 – March 31, 2021), submitted to CMS in May 2021, that while the state had started preparations for implementation, several design features had not yet been developed or finalized, including outreach services and supports for beneficiaries that would be provided through care management organizations (CMOs).<sup>46</sup> The state noted that its CMOs would be expected to submit Engagement Plans to describe each organization's "approach to conducting outreach and providing services and supports to Pathways members to help them remain compliant with the program." However, as of December 13, 2021, the state has not provided any further updates on the Engagement Plans, nor does CMS have adequate details on whether the CMOs' plans to provide beneficiary supports are sufficiently robust to make potential demonstration beneficiaries aware of initial and continuing eligibility requirements. CMS is not privy to information about any outreach that has been conducted to-date to reach potential demonstration beneficiaries.

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<sup>43</sup> The Commonwealth Fund Blog. (2019). New Hampshire's Medicaid Work Requirements Could Cause More Than 15,000 to Lose Coverage. Retrieved from <https://www.commonwealthfund.org/blog/2019/new-hampshires-medicaid-work-requirements-could-cause-coverage-loss>.

<sup>44</sup> Wagner & Schubel (2020).

<sup>45</sup> Solomon, J. (2019).

<sup>46</sup> As of December 1, 2021, CMS has received from the Georgia Department of Community Health, three quarterly and one annual monitoring reports covering the period from October 1, 2020 through September 30, 2021. The reports are under review by CMS.

Early experiences in other states implementing their community engagement requirements were characterized by evidence of widespread confusion and lack of awareness among demonstration beneficiaries regarding the requirements.<sup>47</sup> For example, many beneficiaries in New Hampshire reportedly did not know about the community engagement reporting requirement or received confusing and often contradictory notices about whether they were subject to the requirement.<sup>48</sup> In Arkansas, Michigan, and New Hampshire, evidence suggests that even individuals who were working or those who had serious health needs, and therefore should have been eligible for exemptions, lost coverage or were at risk of losing coverage because of complicated administrative and paperwork requirements.<sup>49</sup> Beneficiaries also reported barriers to obtaining exemptions from the community engagement requirement. For example, beneficiaries with physical and behavioral health conditions reported that their providers were resistant to signing forms needed to establish that the beneficiary was unable to work so that the beneficiary could qualify for an exemption.<sup>50</sup> While, as noted above, Georgia Pathways to Coverage does not include any exemptions, similar resistance on the part of providers could be an obstacle for demonstration beneficiaries seeking a temporary good cause exception (for up to 120 hours) for illness or injury.

Although Georgia's demonstration would not eliminate coverage for currently-enrolled Medicaid beneficiaries, the work requirement would prevent enrollment by potential demonstration beneficiaries who are not meeting or who do not document and successfully report that they are meeting the requirement, which also would result in eligibility suspension and possible disenrollment for beneficiaries who become enrolled but cease to successfully report their compliance with the requirement. As described above, evidence from states that implemented similar community engagement requirements shows that these requirements are administratively complex, confusing and burdensome, whereas there is no evidence available to suggest that imposing these requirements is likely to have a positive effect on beneficiary coverage, health care access or health outcomes.

As noted earlier in this letter, evidence indicates that coverage obstacles, including those that potentially deter initial enrollment or lead to eligibility suspensions and disenrollments, could be harmful to the health of the demonstration's intended beneficiaries. For example, one study found that low-income individuals without insurance coverage were more likely to avoid or delay needed care, which can lead to greater risk of avoidable illnesses or even death.<sup>51</sup> Further, disenrollment and coverage gaps have been associated with increased barriers to care, lower quality care, and greater medical debt among beneficiaries disenrolled from Medicaid, even after

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<sup>47</sup> Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from <https://aspe.hhs.gov/pdf-report/medicaid-demonstrations-andimpacts>.

<sup>48</sup> Solomon, D. (2019). Spreading the Word on Medicaid Work Requirement Proves Challenging. Union Leader. Retrieved from [https://www.unionleader.com/news/health/spreading-the-word-on-medicaid-work-requirement-proves-challenging/article\\_740b99e7-9f48-52d4-b2d8-030167e66af8.html](https://www.unionleader.com/news/health/spreading-the-word-on-medicaid-work-requirement-proves-challenging/article_740b99e7-9f48-52d4-b2d8-030167e66af8.html); Moon, J. (2019). Confusing Letters, Frustrated Members: N.H.'s Medicaid Work Requirement Takes Effect. New Hampshire Public Radio. Retrieved from <https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0>.

<sup>49</sup> Wagner, J. & Schubel, J. (2020).

<sup>50</sup> Hill, I., Burroughs, E. & Adams, G. (2020).

<sup>51</sup> Ku, L. & Ross, D.C. (2002).

their coverage resumed.<sup>52</sup> Another study using data from Arkansas found that adults ages 30–49 in the state who had lost Medicaid or Marketplace coverage in the prior year experienced significantly higher medical debt and financial barriers to care, compared to similar Arkansans who maintained coverage.<sup>53</sup> Specifically, 50 percent of Arkansans affected by disenrollment in that age group reported serious problems paying off medical bills; 56 percent delayed seeking health care; and 64 percent delayed taking medications because of cost considerations.<sup>54</sup> These rates were all significantly higher than among individuals who retained coverage in Medicaid or the Marketplace all year. Evidence also indicates that those with chronic conditions were more likely to lose coverage,<sup>55</sup> potentially leading to worse health outcomes in the future. These consequences could have serious impact in Georgia, which ranked 50th among the 50 states and the District of Columbia in terms of health insurance coverage among people under age 65 and below 138 percent of the FPL; specifically, in Georgia, 27.5 percent of people in this group did not have health coverage at any time during 2019.<sup>56</sup>

In all states, consistent and stable employment is often out of reach for beneficiaries who might be subject to a community engagement requirement. Many low-income beneficiaries face a challenging job market, which often offers only unstable or low-paying jobs with unpredictable or irregular hours, sometimes resulting in spells of unemployment, particularly in seasonal work.<sup>57</sup> For example, one study found that, among Medicaid beneficiaries likely to be subject to a community engagement requirement who did not always work 20 hours per week, about half reported not working or not working more hours for reasons related to the labor market or the nature of their employment, such as difficulty finding work, employer restrictions on their work schedule, employment in temporary positions, or reduced hours because business was slow.<sup>58</sup> Given the range of labor market and employment barriers facing Medicaid beneficiaries who could be subjected to community engagement requirements, Georgia’s work requirement to

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<sup>52</sup> University of Wisconsin-Madison Institute for Research on Poverty. (2019).

<sup>53</sup> Sommers et al. (2020).

<sup>54</sup> Sommers et al. (2020).

<sup>55</sup> Chen, L. & Sommers, B.D. (2020). Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018. *American Journal of Public Health*, 110, 1208-1210. DOI <https://doi.org/10.2105/AJPH.2020.305697>.

<sup>56</sup> Center for American Progress. (2020). Talk Poverty: Georgia. Retrieved from <https://talkpoverty.org/state-year-report/georgia-2020-report/>.

<sup>57</sup> Butcher, K. & Schanzenbach, D. (2018). Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in>; Center on Budget and Policy Priorities. (2020). Taking Away Medicaid for Not Meeting Work Requirements Harms Low-Wage Workers. Retrieved from <https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-low-wage-workers>; Gangopadhyaya, A., Johnston, E., Kenney, G. & Zuckerman, S. (2018). Kentucky Medicaid Work Requirements: What Are the Coverage Risks for Working Enrollees? Urban Institute. Retrieved from [https://www.urban.org/sites/default/files/publication/98893/2001948\\_kentucky-medicaid-work-requirements-what-are-the-coverage-risks-for-working-enrollees.pdf](https://www.urban.org/sites/default/files/publication/98893/2001948_kentucky-medicaid-work-requirements-what-are-the-coverage-risks-for-working-enrollees.pdf); Karpman, M. (2019). Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment. The Urban Institute. Retrieved from <http://hrms.urban.org/briefs/hrms-medicaid-work-requirements-2019.pdf>.

<sup>58</sup> Karpman, M. (2019).

complete an average of 80 hours of qualifying activities per month as a condition of initial and continued enrollment is a concern, even for low-income adults who are already working.<sup>59</sup>

Furthermore, research examining the outcomes of statutorily authorized work requirements in other public assistance programs, such as Temporary Assistance for Needy Families (TANF) and SNAP, indicates that such requirements generally have only modest and temporary effects on employment, failing to increase long-term employment or reduce poverty.<sup>60</sup> Additionally, studies have found that imposing work requirements in the SNAP program led to substantial reductions in enrollment, even after controlling for changes in unemployment and poverty levels.<sup>61</sup> Evidence suggests that there were large and rapid caseload losses in selected areas after SNAP work requirements went into effect, similar to what early data from Arkansas show and what appeared would be likely to happen in New Hampshire and Michigan after these states began implementing community engagement requirements, if those states' community engagement requirements had been implemented long enough to reach the scheduled suspensions or disenrollments.

Therefore, existing evidence from states that have implemented community engagement requirements through Medicaid demonstrations, evidence from other public programs with work requirements, and the overall work patterns and job market opportunities for the low-income adults who would be subject to such requirements, all highlight the potential ineffectiveness of community engagement requirements at impacting employment outcomes for the target population. And while there are variations in the design and implementation of community engagement requirements in each state that has implemented such a requirement, as well as differences in employment and economic opportunities, findings from the states that implemented community engagement requirements point in the general direction of challenges with beneficiary outreach efforts to ensure understanding of program requirements, various barriers to complying with reporting requirements, and subsequent coverage losses among individuals subject to such requirements. Under the design of the Georgia Pathways to Coverage work requirement, these challenges could lead not just to coverage losses among demonstration

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<sup>59</sup> Aron-Dine, A., Chaudhry, R. & Broaddus, M. (2018). Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements. Retrieved from <https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements>; See also Solomon, J. (2019).

<sup>60</sup> Katch, H., Wagner, J. & Aron-Dine, A. (2018). Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce>; Danziger, S.K., Danziger, S., Seefeldt, K.S. & Shaefer, H.L. (2016). From Welfare to a Work-Based Safety Net: An Incomplete Transition. *Journal of Policy Analysis & Management*, 35(1), 231-238. DOI: <https://doi.org/10.1002/pam.21880>; Pavetti, L. (2016). Work Requirements Don't Cut Poverty, Evidence Shows. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>; Gray, C., Leive, A., Prager, E., Pukelis, K.B. & Zaki, M. (2021). Employed in a SNAP? The Impact of Work Requirements on Program Participation and Labor Supply. National Bureau of Economic Research, Working Paper 28877. Retrieved from <https://www.nber.org/papers/w28877>.

<sup>61</sup> Ku, L., Brantley, E. & Pillai, D. (2019). The Effects of SNAP Work Requirements in Reducing Participation and Benefits From 2013 to 2017. *American Journal of Public Health* 109(10), 1446-1451. DOI: <https://doi.org/10.2105/AJPH.2019.305232>. Retrieved from <https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305232>; see also Gray et al. (2021).

beneficiaries, but inability of intended demonstration beneficiaries to access coverage in the first place, due to the imposition of this requirement as a condition of initial demonstration eligibility.

CMS does not expect that the work requirement, as a condition of initial and continued eligibility in Georgia's Medicaid demonstration, would have a different outcome than what was observed during the initial implementation of similar requirements in other states. In effect, the narrow pool of beneficiaries who could potentially be targeted by the requirement, and the inherent complexity and possible adverse effects of implementing a work requirement, make it challenging to realize the state's goals for the program.

Considering all available information, CMS believes there is a substantial risk that the work requirement in the Georgia Pathways to Coverage demonstration, as approved in October 2020, would prevent many potential demonstration beneficiaries from initially enrolling in coverage and would lead to a sizable number of eligibility suspensions and eventual disenrollments among beneficiaries who are initially able to enroll. This risk is exacerbated by the ongoing COVID-19 public health emergency and its likely aftermath, the longevity and associated health and economic repercussions of which CMS could not wholly appreciate when the demonstration was initially approved in October 2020.

### **Further Information on the Impact of COVID-19 and its Aftermath**

The COVID-19 pandemic and the uncertainty surrounding the long-term effects on economic activity and opportunities across the nation exacerbate the risks of tying a community engagement requirement to eligibility, making Georgia's work requirement infeasible under the current circumstances. Although CMS approved Georgia's work requirement within the state's demonstration in the midst of the COVID-19 pandemic in October 2020, CMS has since assessed more recently-available evidence about the effects of the pandemic and its implications for the feasibility of this requirement. Given how long the pandemic has lasted, and taking into consideration the available data on the various health and infrastructure indicators in Georgia—as discussed further below—CMS is concerned that the enrollment-limiting requirements in Georgia's demonstration would be substantially detrimental to the well-being of the potential beneficiaries this demonstration intended to cover and to the overall objectives of Medicaid. In addition to health-related concerns and challenges around transportation and child care availability, there is a substantial risk that the COVID-19 pandemic and its aftermath will have a negative impact on economic opportunities for potential beneficiaries. Furthermore, low-wage earners, women, and racial and ethnic minority populations in Georgia continue to experience disproportionately lower employment rates than other populations,<sup>62</sup> while also experiencing overall higher rates of COVID cases and deaths.<sup>63</sup> If employment opportunities are limited,

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<sup>62</sup> Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment; Butler, T.S. (2021). Georgia Women Bear the Brunt of COVID-19 Pandemic. The Atlanta Women's Foundation. Retrieved from <https://atlantawomen.org/georgia-women-bear-the-brunt-of-covid-19-pandemic/>; Moore, K. (2021). State Unemployment by Race and Ethnicity. Economic Policy Institute. Retrieved from <https://www.epi.org/indicators/state-unemployment-race-ethnicity/>.

<sup>63</sup> Worldometer. (2021). United States Coronavirus Cases. Retrieved on December 10, 2021 from <https://www.worldometers.info/coronavirus/country/us/>.

beneficiaries and potential beneficiaries may continue to have difficulty meeting the work requirement in the aftermath of the COVID-19 pandemic.<sup>64</sup>

Further, long-term health complications from long COVID may affect hundreds of thousands of Georgians. According to recent research on the lingering effects of COVID-19 among the general population, 86 percent of COVID-19 survivors experienced at least one symptom at their follow-up visits,<sup>65</sup> and as many as 30 percent still experienced symptoms at least six months after their infections.<sup>66</sup> Similarly, a survey of individuals with self-reported long COVID found that 89 percent of respondents had symptoms for at least 12 weeks, and 40 percent had symptoms for at least one year.<sup>67</sup> Nearly one-third of individuals with long COVID reported difficulty living alone without any assistance, while 34.5 percent said they had moderate functional limitations and 84 percent said that long COVID affected their ability to complete domestic chores.<sup>68</sup> Medical specialists have also estimated that up to 1.3 million of the nearly 50 million people infected with the COVID-19 virus will remain sick for extended periods, thereby preventing many of them from returning to work.<sup>69</sup> In fact, one study found that, of hospitalized COVID-19 survivors who were working before hospitalization, 40 percent were unable to return to work within 60 days after hospitalization, and a quarter of those had reduced their work hours or modified their duties because of lingering health complications.<sup>70</sup> As discussed in HHS Office for Civil Rights guidance from July 2021, long COVID can be considered a disability under the Americans with Disabilities Act (ADA),<sup>71</sup> and therefore, may qualify a potential demonstration beneficiary for reasonable accommodations. However, the administrative complexity in seeking such accommodations may be significant and may deter or prevent potential demonstration beneficiaries from becoming initially enrolled. Further, potential beneficiaries may have difficulty obtaining disability exemptions if they cannot afford to see a provider to substantiate a

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<sup>64</sup> Garfield et al. (2021). Work Among Medicaid Adults; Gangopadhyaya, A. & Garrett, B. (2020).

<sup>65</sup> Sykes, D.L., Holdsworth, L., Jawad, N., Gunasekera, P., Horice, A.H. & Crooks, M.G. (2021). Post-COVID-19 Symptom Burden: What is Long-COVID and How Should We Manage It? *Lung*;199. <https://doi.org/10.1007/s00408-021-00423-z>. Retrieved from <https://link.springer.com/article/10.1007/s00408-021-00423-z>.

<sup>66</sup> Berard, Y. (2021). Georgia's Next Public Health Crisis Already Unfolding, Health Experts Fear. *The Atlanta Journal-Constitution*. Retrieved from <https://www.ajc.com/news/investigations/georgias-next-public-health-crisis-already-unfolding/LIFCKJOQRBCXLP5VQUWU2OW22U/>; Logue, J.K., Franko, N.M., McCulloch, D.J., McDonald, D., Magedson, A. Wolf, C.R. & Chu, H.Y. (2021). Sequelae in Adults at 6 Months After COVID-19 Infection. *JAMA Network*;4(2). doi:10.1001/jamanetworkopen.2021.0830. Retrieved from <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776560>.

<sup>67</sup> Ayoubkhani, D. & Pawelek, P. (2021). Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 1 July 2021. Office for National Statistics. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1july2021>.

<sup>68</sup> Ziauddeen et al. (2021).

<sup>69</sup> Rowland, C. (2021). Long covid is destroying careers, leaving economic distress in its wake. *The Washington Post*. Retrieved from <https://www.washingtonpost.com/business/2021/12/09/long-covid-work-unemployed/>.

<sup>70</sup> Chopra, V., Flanders, S. A., O'Malley, M., Malani, A. N., & Prescott, H. C. (2021). Sixty-Day Outcomes Among Patients Hospitalized With COVID-19. *Annals of internal medicine*;174(4). <https://doi.org/10.7326/M20-5661>. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7707210/>.

<sup>71</sup> U.S. Department of Health and Human Services. (2021). Guidance on “Long COVID” as a Disability Under the ADA, Section 504, and Section 1557. Retrieve from <https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/guidance-long-covid-disability/index.html>.

claim, or because many potentially disabling conditions cannot be easily and quickly diagnosed.<sup>72</sup>

The challenge of finding full-time or even part-time employment may be further complicated due to a lack of affordable child care, as well as increased transportation barriers that have only compounded during the pandemic.<sup>73</sup> The Georgia Pathways to Coverage demonstration would not exempt or provide a good cause exception for individuals unable to meet the work requirement due to caregiving responsibilities, nor count caregiving as a qualifying activity. Yet, due to the COVID-19 pandemic, caregivers across the United States have experienced intensified caregiving responsibilities both in terms of the types of care provided and hours spent in caregiving, all of which can affect the physical and mental health of caregivers.<sup>74</sup>

Even though schools across the country, including in Georgia, began opening up gradually for in-person learning, parents' ability to comply with the work requirement may continue to be impacted by quarantining guidelines when children are exposed to COVID-19 and unforeseen school closures due to high-levels of community transmission. In the fall of 2021, four public school districts in Georgia were forced to close, and others have enforced quarantining procedures, due to the high rates of COVID-19 cases among students and teachers.<sup>75</sup> These school closures affected tens of thousands of students and their families, potentially interfering with parents' attendance at and hours of work. Further, as of December 2021, vaccination rates of children aged 5 to 11, who are less likely to be able to quarantine without a parent at home, are much lower in Georgia than the national average (8.6 percent compared to 16.8 percent, respectively).<sup>76</sup>

The pandemic has also disproportionately impacted female caregivers. A survey that analyzed a sample of nearly 5,000 parents with roughly even split between men and women from across the United States exhibited that more than one third of women that were sampled had to utilize unpaid sick leave due to COVID-19 illness or the need to quarantine due to COVID-19, and almost half of the surveyed women had to utilize unpaid sick leave due to their child's day care center or school closure.<sup>77</sup> Working mothers were more likely to reduce work hours to aid in

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<sup>72</sup> Davenport, K. (2021). COVID "Long Haulers" Can Carry Additional Burden of Getting Insurers to Cover Care. Georgetown University Health Policy Institute. Retrieved from <http://chirblog.org/covid-long-haulers-can-carry-additional-burden-getting-insurers-cover-care/>; and Konish, L. (2021). What Covid-19 Long Haulers Should Know About Claiming Social Security Disability Benefits. Retrieved from <https://www.cnbc.com/2021/08/14/what-covid-19-long-haulers-should-know-about-social-security-disability.html>.

<sup>73</sup> McGrath, J. (2021). Child Care in Crisis. Third Way. Retrieved from <https://www.thirdway.org/memo/child-care-in-crisis#:~:text=Child%20care%20in%20America%20was,now%20it's%20a%20deep%20crisis.&text=Thirty%2Dfive%20states%20are%20seeing,tune%20of%201.2%20million%20workers; see also> Guillory, A. (2021).

<sup>74</sup> Cohen, S., Kunicki, Z., Drohan, M. & Greaney, M. (2021). Exploring Changes in Caregiver Burden and Caregiving Intensity due to COVID-19. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7919204/>.

<sup>75</sup> Amy, J. (2021). 4 Georgia Districts Stop In-Person Classes Due to COVID. Associated Press. Retrieved from <https://www.usnews.com/news/best-states/georgia/articles/2021-08-11/4-georgia-districts-stop-in-person-classes-due-to-covid>.

<sup>76</sup> KFF. (2021). An Update on Vaccine Roll-Out for 5-11 Year-olds in the U.S.. Retrieved on December 10, 2021 from <https://www.kff.org/coronavirus-covid-19/issue-brief/an-update-on-vaccine-roll-out-for-5-11-year-olds-in-the-u-s/>.

<sup>77</sup> Ranji et al. (2021).

caregiving activities compared to working fathers during the pandemic.<sup>78</sup> Additionally, while women have been responsible for the majority of childcare obligations during the pandemic, they are also more likely to experience long COVID.<sup>79</sup> For example, women were more likely than men to report anxiety, fatigue, memory impairment, and sleep disturbances at follow-up appointments from COVID-19 diagnoses.<sup>80</sup>

Additionally, low-wage earners may continue to find it difficult to access transportation, in light of ongoing public transportation issues in the state. Low-income Georgians, like their counterparts throughout the country, are still adjusting to transportation changes and barriers for commuting to work and other activities. Furthermore, 16.8 percent of Georgians live in rural areas, and the poverty rate of Georgians in rural areas (19.4 percent) is 7 percent higher than that of Georgians living in urban areas (12.4 percent).<sup>81</sup> Despite efforts from programs such as the Rural Transit Assistance Program, the Georgia Department of Transportation estimates that there is an unmet need of approximately 700,000 to 1.5 million annual trips in 37 rural Georgian counties.<sup>82</sup> As of November 2021, many public transportation systems continue to operate at limited capacity, on modified schedules, and/or with higher fare rates.<sup>83</sup>

Meanwhile, the economic effects of COVID-19 continue to negatively affect Georgians, as employment rates for low-wage earners have not returned to pre-pandemic levels. For example, from January 2020 to August 2021, employment rates for low-wage earners (i.e., annual wages under \$27,000) in the state declined by 21.6 percent, compared to a 12.5 percent increase in employment rates for high-wage earners (i.e., wages over \$60,000 per year).<sup>84</sup> Pandemic-related job and income losses nationally have been more acute among the low-income population—those with the least wherewithal to withstand economic shocks, and who are disproportionately enrolled in Medicaid.<sup>85</sup> In fact, 52 percent of lower income adults (annual income below \$37,500) live in households where someone lost a job or took a pay cut due to the pandemic.<sup>86</sup> Understandably, households with a job or income loss were two-to-three times more likely to experience economic hardship than those who did not experience such a loss.<sup>87</sup>

<sup>78</sup> Collins, C. (2020). COVID-19 and the gender gap in work hours. *Gender, Work & Organization*. Retrieved from <https://onlinelibrary.wiley.com/doi/full/10.1111/gwao.12506>.

<sup>79</sup> Logue et al. (2021).

<sup>80</sup> Sykes et al. (2021).

<sup>81</sup> United States Department of Agriculture Economic Research Service. (2021). State Fact Sheet: Georgia. Retrieved on December 13, 2021 from

<https://data.ers.usda.gov/reports.aspx?StateFIPS=13&StateName=Georgia&ID=17854>.

<sup>82</sup> Georgia Department of Transportation. (2020). Georgia Statewide Transition Plan. Retrieved from [http://www.dot.ga.gov/InvestSmart/Transit/StatewideTransitPlan/PublicMeeting/2020/GeorgiaStatewideTransitPlan\\_DRAFT.pdf](http://www.dot.ga.gov/InvestSmart/Transit/StatewideTransitPlan/PublicMeeting/2020/GeorgiaStatewideTransitPlan_DRAFT.pdf).

<sup>83</sup> Marques, J.R. (2021). Will the Pandemic Ruin MARTA's Plans for its Biggest Expansion in Decades? *Atlanta Magazine*. Retrieved from <https://www.atlantamagazine.com/great-reads/will-the-pandemic-ruin-martas-plans-for-its-biggest-expansion-in-decades/>; see also Donsky, P. (2021) and WABE (2021).

<sup>84</sup> Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment.

<sup>85</sup> Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from <https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/>.

<sup>86</sup> Parker, K., Horowitz, J.M. & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from <https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/>

<sup>87</sup> Despard et al. (2020); Gangopadhyaya, A. & Garrett, B. (2020).

Furthermore, unemployment during the pandemic has disproportionately impacted the state's non-White communities, as unemployment claims for Black Georgians were 71 percent higher than those of White Georgians.<sup>88</sup> Between July and September of 2021, Black workers were approximately 1.4 times more likely to be unemployed compared to White workers in Georgia.<sup>89</sup> Also in Georgia, Black and Hispanic women held 79 percent of all poverty-wage jobs prior to the pandemic, making them more susceptible to job losses during the public health emergency.<sup>90</sup>

In fact, across the United States, the COVID-19 pandemic has disproportionately impacted Black and Hispanic households compared to White households, in terms of financial insecurity, food insufficiency, and job loss.<sup>91</sup> A recent study suggests that low-income earners were nearly 2.8 times more likely to experience a moderate to severe negative impact on family income and employment.<sup>92</sup> Moreover, in a survey of adults living in renter households, approximately 30 percent of respondents reported difficulty covering usual expenses in October 2021.<sup>93</sup> There are also racial and ethnic disparities in the likelihood of reporting hardships; for example, compared to White households, Black and Latino households were more likely to say they sometimes or often did not have enough to eat during the past week, and they were less likely to be caught up on rental payments.<sup>94</sup>

Job losses and disruptions in employment due to the COVID-19 pandemic may create more challenges in Medicaid beneficiaries' ability to meet premium requirements even after the public health emergency ends.<sup>95</sup> As such, the potential for intended demonstration beneficiaries to be unable to initially access or to maintain coverage—especially due to a premium requirement that may be difficult for beneficiaries to understand and that exacerbates health disparities—could be particularly harmful, given the pandemic-related challenges outlined in this letter.

Existing disparities in access to computers and reliable internet may also exacerbate issues in finding, maintaining, and reporting employment during and after the pandemic, particularly as more jobs have shifted to telework or “work from home” during the public health emergency. For example, 29 percent of adults in United States households with annual incomes below \$30,000 did not own a smartphone, and 44 percent did not have home broadband services in 2019.<sup>96</sup> In Georgia, 286,000 individuals did not have access to an internet provider as of

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<sup>88</sup> Khalfani, R. (2021). State of Working Georgia: Pandemic Job Numbers are Improving, But Inequitably. GBPI. Retrieved from <https://gbpi.org/state-of-working-georgia-pandemic-job-numbers-are-improving-but-inequitably/>.

<sup>89</sup> Moore, K. (2021).

<sup>90</sup> Butler, T.S. (2021).

<sup>91</sup> Monte, L. (2021). COVID-19 Pandemic Hit Black Households Harder Than White Households, Even When Pre-Pandemic Socio Economic Disparities Are Taken Into Account. U.S Census Bureau. Retrieved from <https://www.census.gov/library/stories/2021/07/how-pandemic-affected-black-and-white-households.html>.

<sup>92</sup> Hall, L. da Grace, B. Bennett, M. Powers, M. Warren, A. (2021). Income Differences and COVID-19: Impact on Daily Life and Mental Health. Population Health Management.

<sup>93</sup> Center on Budget and Policy Priorities (2021). Tracking the COVID-19 Economy's Effects on Food, Housing, and Employment Hardships.

<sup>94</sup> Center on Budget and Policy Priorities. (2021). Tracking the COVID-19 Economy's Effects on Food, Housing, and Employment Hardships.

<sup>95</sup> Collins et al. (2021); Gangopadhyaya, A. & Garrett, B. (2020).

<sup>96</sup> Anderson, M. & Kumar, M. (2019). Digital Divide Persists Even as Lower-Income Americans Make Gains in Tech Adoption. Pew Research Center. Retrieved from <https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/>.

November 2021.<sup>97</sup> These discrepancies in internet accessibility are expected to affect available opportunities for beneficiaries to timely comply with reporting for the work requirement.

The state noted in its demonstration year 1 quarter 2 monitoring report that the online system to report qualifying hours and activities was still undergoing necessary pre-launch testing.<sup>98</sup> At that time, Georgia estimated that this system would be ready by July 1, 2021—the state’s initially scheduled implementation date for the Georgia Pathways to Coverage demonstration; however, to-date the state has not provided findings from preliminary testing, or described its consideration of whether limited beneficiary broadband access could pose challenges to complying with reporting requirements.<sup>99</sup> As of December 13, 2021, the state has yet to provide further updates. While under Georgia Pathways to Coverage, individuals would be able to report compliance with the work requirement through different modes, the COVID-19 pandemic could impact both in-person as well as remote methods of completing reporting requirements.<sup>100</sup>

The pandemic also has disproportionately impacted the physical health of racial and ethnic minority groups, who already experience disparities in health outcomes. Racial minorities and people living in low-income households are more likely to work in industries that are considered “essential services,” which have remained open during the pandemic;<sup>101</sup> therefore, these groups may be at a higher risk of contracting COVID-19 through their employment. In fact, in Georgia, Black men were approximately 2.4 times more likely to die of COVID-19 than White men, and Black women were approximately 1.5 times more likely to die of COVID-19 than White women.<sup>102</sup> Further, the risk of experiencing long COVID is greater for those who live in poverty and for non-White populations, including Black, Latinx,<sup>103</sup> American Indian/Alaska Native, Asian, and Native Hawaiian and Pacific islander populations.<sup>104</sup> Individuals in these groups are

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<sup>97</sup> Broadband Now. (2021). Internet Service in Georgia. Retrieved on December 16 from <https://broadbandnow.com/Georgia>.

<sup>98</sup> Georgia Department of Community Health. (2021). Georgia Pathways to Coverage Section 1115 demonstration year 1 quarter 2 Monitoring Report. January 1, 2021 – March 31, 2021. Submitted on May 28, 2021. Under CMS Review.

<sup>99</sup> As of December 1, 2021, CMS has received from the Georgia Department of Community Health, three quarterly and one annual monitoring reports covering the period from October 1, 2020 through September 30, 2021. The reports are under review by CMS.

<sup>100</sup> Georgia Department of Community Health. (2021). Georgia Pathways to Coverage Section 1115 demonstration year 1 quarter 2 Monitoring Report. January 1, 2021 – March 31, 2021. Submitted on May 28, 2021. Under CMS Review; Garfield et al. (2021). Work Among Medicaid Adults; Gangopadhyaya, A. & Garrett, B. (2020).

<sup>101</sup> Raifman, M.A. & Raifman, J.R. (2020). Disparities in the Population at Risk of Severe Illness From COVID-19 by Race/Ethnicity and Income. *American Journal of Preventive Medicine*, 59(1), 137–139. <https://doi.org/10.1016/j.amepre.2020.04.003>.

<sup>102</sup> Rushovich, T. (2021). Sex Disparities in COVID-19 Mortality Vary Across US Racial Groups. *Journal of General Internal Medicine*. Retrieved from [https://scholar.harvard.edu/files/srichard/files/11606\\_2021\\_6699\\_onlinepdf.pdf](https://scholar.harvard.edu/files/srichard/files/11606_2021_6699_onlinepdf.pdf).

<sup>103</sup> This study focused on the Latinx population as a subpopulation of interest. Throughout this letter, we have retained the population classification (e.g., Latinx, Hispanic), as identified in the source article/study, and refrained from conveying the population identity through a single term, since there could be variations in these population definitions used in the different studies.

<sup>104</sup> Berger, Z., Altieri DE Jesus, V., Assoumou, S. A., & Greenhalgh, T. (2021). Long COVID and Health Inequities: The Role of Primary Care. *The Milbank Quarterly*; 99(2). <https://doi.org/10.1111/1468-0009.12505>. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8241274/>.

also more likely to live with comorbidities and pre-existing conditions, which are also linked to a higher risk of experiencing long COVID symptoms.<sup>105</sup>

Furthermore, Black and Hispanic adults have been more likely than White adults to report symptoms of anxiety and/or depressive disorder during the pandemic.<sup>106</sup> These pandemic-related health disparities add to existing inequities in Georgia, where Black and Hispanic adults already experience more barriers to accessing care than White adults. For example, 56 percent of Hispanic adults reported they did not have a personal doctor or health care provider, compared to 26 percent of Black adults and 21 percent of White adults.<sup>107</sup> Similarly, Hispanic and Black adults were more likely than White adults to report not seeing a doctor in the past 12 months because of costs.<sup>108</sup>

The impact of the COVID-19 public health emergency on the economy has been significant, and, importantly, experience with previous recessions suggests the impact is likely to persist for an extended period of time. Despite various federal, state, and local governments efforts, the labor force participation rate (i.e., the percentage of the civilian non-institutional population age 16 or older who are working or actively seeking work during the prior month) likewise dipped from 63.3 percent in February 2020 to 60.2 percent in April 2020 only to recover somewhat to 61.8

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<sup>105</sup> Stavem K., Ghanima W., Olsen M.K., Gilboe, H.M., & Einvik, G. (2021). Persistent symptoms 1.5–6 months after COVID-19 in non-hospitalised subjects: a population-based cohort study. *Thorax*;76. <http://dx.doi.org/10.1136/thoraxjnl-2020-216377>. Retrieved from <https://thorax.bmj.com/content/76/4/405>; see also Berger et al. (2021).

<sup>106</sup> Panchal, N., Kamal, R., Cox, C. & Garfield, R. (2021). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>.

<sup>107</sup> Kaiser Family Foundation. (2019). State Health Facts: Adults Who Report Not Having a Personal Doctor/Health Care Provider by Race/Ethnicity. Retrieved from <https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-raceethnicity/?state=GA>.

<sup>108</sup> Kaiser Family Foundation. (2019). State Health Facts: Adults Who Report Not Seeing a Doctor in the Past 12 Months Because of Cost by Race/Ethnicity.

percent in November 2021.<sup>109</sup> Compared to pre-pandemic conditions, these data suggest that the labor force is still down in November 2021 by approximately 2.5 million individuals.<sup>110</sup>

Evidence shows that losing a job can have significant long-term effects on an individual's future earnings. Studies have found that workers who lose their jobs in mass layoffs still earn 20 percent less than similar workers who kept their jobs, 15 to 20 years after the layoff, and the impacts are greater for individuals who lose their jobs during a recession. On average, men lost 2.8 years of pre-layoff earnings when the mass layoff occurred in a time when the unemployment rate was above eight percent.<sup>111</sup>

Layoffs can also impact an individual's mortality and morbidity risks.<sup>112</sup> For example, one study found that male workers experienced mortality rates that were 50-100 percent higher than expected in the year after a layoff occurred, and 20 years later, mortality rates remained 10-15 percent higher for these individuals.<sup>113</sup> Furthermore, workers experiencing layoffs have reductions in health care utilization, especially among those who lose coverage, which suggests that access to coverage, and continuity of care, could be important in alleviating the long-term ill effects of layoffs on mortality.<sup>114</sup> For Georgians living with long COVID symptoms who also experienced layoffs, health care access could be especially important in the aftermath of the pandemic.

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<sup>109</sup> U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from <https://www.bls.gov/cps/> and <https://www.bls.gov/charts/employment-situation/civilian-labor-force-participation-rate.htm>; The numerator of the labor force participation rate, i.e., the total labor force, consists of those employed and unemployed, where the unemployed are individuals without a job but actively looking for work during the past month. The labor force does not include individuals who would like to and are available for work but may have given up looking for work altogether (known as discouraged workers, or more broadly as, marginally attached workers), usually because they believe that there are no jobs available for them or there are none for which they would qualify. Recessions, such as the one that resulted as a consequence of the COVID-19 pandemic, often lead to a sharp rise in the number of discouraged workers, and therefore, the size of the labor force shrinks resulting in a sharp decline in labor force participation rates. These individuals who leave the labor force *discouraged* are not represented either in the employment or unemployment rates. Therefore, in addition to the employment and unemployment rates, the labor force participation rate is another important measure of the labor market, particularly during times of economic shocks. For more information, for example, see: <https://fred.stlouisfed.org/series/LNU05026645>, <https://www.bls.gov/charts/employment-situation/civilian-labor-force-participation-rate.htm>, and <https://www.bls.gov/opub/btn/archive/ranks-of-discouraged-workers-and-others-marginally-attached-to-the-labor-force-rise-during-recession.pdf>.

<sup>110</sup> For November 2021 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved on December 13, 2021 from <https://www.bls.gov/web/empsit/cpseea08b.pdf>; or February 2020 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (March, 2020). The Employment Situation – February 2020. News Release.

<sup>111</sup> Davis, S.J. & von Wachter, T. (2011). Recessions and the Costs of Job Loss. Brookings Papers on Economic Activity. Retrieved from [https://www.brookings.edu/wp-content/uploads/2011/09/2011b\\_bpea\\_davis.pdf](https://www.brookings.edu/wp-content/uploads/2011/09/2011b_bpea_davis.pdf).

<sup>112</sup> Banks, J., Karjalainen, H. & Propper, C. (2020). Recessions and Health: The Long-Term Health Consequences of Responses to the Coronavirus. Journal of Applied Public Economics. DOI: 10.1111/1475-5890.12230. Retrieved from <https://onlinelibrary.wiley.com/doi/full/10.1111/1475-5890.12230>.

<sup>113</sup> Sullivan, D. & von Wachter, T. (2009). Job Displacement and Mortality: An Analysis Using Administrative Data. Quarterly Journal of Economics. Retrieved from [http://www.econ.ucla.edu/tvwachter/papers/sullivan\\_vonwachter\\_qje.pdf](http://www.econ.ucla.edu/tvwachter/papers/sullivan_vonwachter_qje.pdf).

<sup>114</sup> Schaller, J. & Stevens, A. (2015). Short-Run Effects of Job Loss on Health Conditions, Health Insurance, and Health Care Utilization. Journal of Health Economics, 43, 190-203. DOI: 0.1016/j.jhealeco.2015.07.003. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0167629615000788>.

In summary, the short-to-long-term adverse implications of the COVID-19 pandemic on the economic opportunities for Medicaid beneficiaries, potential beneficiaries, and other low-income individuals amplifies the risks of attaching a work requirement to eligibility for coverage. In addition, the uncertainty regarding the emergence of new variants of the virus that causes COVID-19 and lingering health complications of COVID-19 infections may continue to affect Georgians.<sup>115</sup> Continued transmission of infections and long COVID are likely to limit the ability of individuals to start and continue meeting the work requirement.

The potential long-term adverse health effects resulting from the economic and non-economic consequences of the pandemic also exacerbate the risk of denial or loss of coverage for the intended beneficiaries of the Georgia Pathways to Coverage demonstration. The likely ramifications of denial or loss of timely access to necessary health care also can be long lasting. As such, CMS believes that the potential for denial or loss of coverage among beneficiaries and potential beneficiaries of Georgia Pathways to Coverage—especially from requirements that are administratively complex, difficult for beneficiaries and potential beneficiaries to understand, and likely to exacerbate health disparities—would be particularly harmful in the aftermath of the pandemic.

Additionally, as discussed above, CMS has determined that premium requirements beyond those permitted under the statute are not likely to promote the objectives of Medicaid. Evidence from other states that imposed premium requirements beyond those authorized under the statute in their demonstrations showed that these policies were associated with decreased initial enrollment rates, shortened enrollment spells, and increased likelihood of disenrollment from the demonstrations. Therefore, CMS has determined that premium requirements beyond those authorized under the statute, like those approved in Georgia Pathways to Coverage, are not likely to directly or indirectly promote coverage. While we have reached this conclusion independently of the COVID-19 pandemic and its likely aftermath, we note that the pandemic-related challenges discussed in this letter in connection with the work requirement could also make it even more difficult for intended demonstration beneficiaries to make initial and ongoing premium payments; additionally, the health consequences of being unable to initially access or to maintain coverage due to inability to meet a premium payment requirement could be exacerbated.

### **Evidence Submitted by Georgia on the Work Requirement**

On March 12, 2021, Georgia submitted a response to CMS's letter of February 12, 2021. As noted above, the February 12, 2021 letter informed Georgia that CMS had preliminarily determined that allowing the work requirement to take effect in Georgia would not promote the objectives of the Medicaid program. The February 12, 2021 letter explained that the potential impact of the COVID-19 public health emergency on economic opportunities, as well as on access to transportation and affordable child care, has increased the risk that it would be unreasonably difficult or impossible for Georgians who could otherwise be eligible for demonstration benefits to meet the state's work requirement. While the demonstration was approved in the midst of the public health emergency, evidence of the full gravity and likely duration and long-term effects of the pandemic was not available at the time of the approval.

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<sup>115</sup> Berard, Y. (2021).

Taking into consideration the evidence we have available now, and as discussed throughout this letter, CMS no longer believes that the work requirement in the Georgia Pathways to Coverage demonstration is feasible or likely to promote the objectives of the Medicaid statute.

Neither the state's March 12, 2021 letter to CMS nor any other information that has become available in the time since that letter resolves the concerns we raised in the February 12, 2021 letter. There is significant uncertainty as to whether there will be sufficient employment or other community engagement opportunities for individuals who are not already working, or otherwise meeting the work requirement, to become eligible or to maintain eligibility for coverage that Georgia Pathways to Coverage is intended to make available, even once the public health emergency has ended.

The state did not respond satisfactorily to how low-income Georgians will overcome the pandemic's detrimental impact on economic opportunities. The state indicated that there would be a good cause exception available to enrolled beneficiaries who might be quarantining for reasons related to COVID-19, as well as for an inability to meet the work requirement due to COVID-19-related closure of the place(s) where the beneficiary was meeting the requirement. However, notwithstanding the gradual reopening of businesses across the state, these exceptions highlighted by Georgia in the letter would only apply to individuals who would have already met the work requirement and would have become enrolled under the demonstration after implementation. In order to become eligible for demonstration coverage, applicants would first need to complete a minimum of 80 hours of qualifying activities in a month, as specified in Special Terms and Conditions ¶ 32 and 33. The state does not address how beneficiaries who have been unable to find or maintain employment or other opportunities to complete qualifying activities, due to all the challenges described above, would be able to access demonstration coverage in the first place. Moreover, even for beneficiaries who would be able to enroll in demonstration coverage, a good cause exception would only be available for a maximum of 120 required hours in a 12-month benefit period. The state has not addressed how our concerns related to the challenges of meeting the required number of hours, exacerbated by the COVID-19 pandemic and its likely aftermath, could be addressed for beneficiaries who would be unable to complete more than 120 hours of qualifying activities in a benefit year, which is the maximum number of hours a beneficiary can miss due to reasons giving rise to a good cause exception. Therefore, implementation of the work requirement would unduly burden otherwise eligible individuals in their efforts to qualify for demonstration coverage, at a time when individuals are already struggling to cope with the physical, mental and economic ill effects of the pandemic, and impediments to access to coverage and care may have particularly deleterious effects.

Furthermore, the state claimed that the COVID-19 pandemic did not present a barrier for individuals to complete the work requirement, which at the time of the state's March 12, 2021 letter was planned for implementation beginning July 1, 2021. The state noted that the number of COVID-19 cases, hospitalizations, and deaths were decreasing, both in Georgia and nationwide. However, as noted above, Georgia ranks higher than the national average in terms of the overall number of COVID-19 cases and COVID-19 deaths per one million population<sup>116</sup> while COVID-19 vaccination rates in Georgia are currently below the national average. As of

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<sup>116</sup> Worldometer. (2021). United States Coronavirus Cases. Retrieved from <https://www.worldometers.info/coronavirus/country/us/>.

December 13, 2021, the proportion of vaccine-eligible Georgians who are fully vaccinated against COVID-19 (49.9 percent) is 11.1 percentage points lower than the proportion of vaccine-eligible Americans who are fully vaccinated (61 percent) nationally.<sup>117</sup> Evidence suggests that low-wage work is associated with the spread of COVID-19 due to unsafe work conditions.<sup>118</sup> Additionally, low-wage earners are more likely than higher-paid earners to live with many people, but less likely to have adequate health care coverage. These workers are less likely to have savings, or sick leave to cope with economic shocks from lost days of work or potential catastrophic health expenditures.<sup>119</sup> Therefore, the low vaccination rate in Georgia could place its low-wage workers, such as those potentially subject to the work requirement, at higher risk of COVID-19 morbidity and mortality, and increase the likelihood of experiencing long COVID, particularly since low-wage workers also have higher prevalence of preexisting conditions like diabetes, asthma, and heart disease, which can increase the likelihood of serious and long-term illness from COVID-19.<sup>120</sup>

Research on potential beneficiary coverage loss from community engagement requirements indicates that most of those losing coverage from disenrollment would be individuals who are already working or should be otherwise exempt under the design of most states' approved community engagement requirements,<sup>121</sup> but would lose coverage because of the inherently complex reporting requirements.<sup>122</sup> The Kaiser Family Foundation, for example, estimated that if community engagement requirements were implemented nationwide, coverage losses due to non-reporting of qualifying activities or exemptions would account for 62–91 percent of total Medicaid disenrollments due to such a requirement, with the rest potentially attributable to not participating in sufficient hours of qualifying activities to meet work or community engagement requirements.<sup>123</sup> Similar coverage losses could occur among Georgia Pathways to Coverage beneficiaries who are able to understand, meet, document, and successfully report compliance with the work requirement to become initially enrolled, but who are unable to continue meeting the requirement. In Georgia's case, however, the same obstacles to continued enrollment also could prevent potential demonstration beneficiaries from enrolling in coverage in the first place, since the state's demonstration requires individuals to be already in compliance with the work requirement before becoming eligible for coverage. Thus, the challenges of successfully reporting compliance with community engagement requirements estimated and observed in other

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<sup>117</sup> The Mayo Clinic. (2021). U.S. COVID-19 vaccine tracker.

<sup>118</sup> Padilla, A. & Orozco, E. (2020). Hidden Threat: California COVID-19 Surges and Worker Distress. Community and Labor Center at the University of California Merced. Retrieved from [https://clc.ucmerced.edu.672elmp01.blackmesh.com/sites/clc.ucmerced.edu/files/page/documents/hidden\\_threat\\_july\\_12.pdf](https://clc.ucmerced.edu.672elmp01.blackmesh.com/sites/clc.ucmerced.edu/files/page/documents/hidden_threat_july_12.pdf); see also Wolfe, Harknett, and Schneider (2021).

<sup>119</sup> Wolfe, Harknett, and Schneider (2021).

<sup>120</sup> Koma, W., Artiga, S., Neuman, T., Claxton, G., Rae, M., Kates, J. & Michaud, J. (2020). Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/>; see also Berger et al. (2021).

<sup>121</sup> Georgia's demonstration does not provide any exemption from the work requirement; a maximum of 120 hours may be available for verified good cause exceptions during a 12-month benefit year for beneficiaries who have already met the requirements and been enrolled under the demonstration. See Georgia Department of Community Health. (2020). "Pathways to Coverage" Section 1115 demonstration Special Terms and Conditions.

<sup>122</sup> See Solomon, J. (2019), Wagner, J. & Schubel, J. (2020), and Garfield et al. (2018). Implications of a Medicaid Work Requirement.

<sup>123</sup> Garfield et al. (2018). Implications of a Medicaid Work Requirement.

states to lead to coverage losses could lead to large numbers of intended beneficiaries of Georgia Pathways to Coverage never gaining coverage at all.

As described earlier, lack of beneficiary awareness about community engagement requirements in other states has caused beneficiaries to lose coverage when they were not aware of the requirements, did not understand reporting requirements, or were otherwise unable to complete timely reporting, including for good cause exceptions.<sup>124</sup> Based on the draft Implementation Plan and the demonstration monitoring reports that the state submitted to CMS, we do not believe we have adequate information to establish that the state’s plans to educate beneficiaries are sufficiently robust, or whether any such outreach has been conducted to-date to reach potential demonstration beneficiaries.<sup>125</sup>

Georgia’s demonstration would require beneficiaries to report on a monthly basis their compliance with the work requirement for six consecutive months. Beneficiaries would then be exempt from the monthly reporting requirement for the remainder of the beneficiary’s 12-month benefit year. However, the state would still perform periodic and random audits to verify their documentation and compliance with the work requirement. Additionally, beneficiaries who no longer had to report compliance monthly still would be required to report changes in circumstances, such as regarding income, employment, or other qualifying activities, that could impact eligibility. These reporting requirements would be burdensome, as beneficiaries may find it difficult to report work hours due to documentation requirements, such as paystubs and timesheets, possibly from multiple employers, and other bureaucratic hurdles.<sup>126</sup> This would be more challenging for individuals who are self-employed and therefore may not have such documentation readily available.<sup>127</sup> Furthermore, with increased administrative requirements, and burdens on the state agency, it is possible that a backlog in processing paperwork could develop and result in delays or mistakes affecting coverage of individuals subject to the work requirement.<sup>128</sup>

The state notes that “even for individuals facing economic disruption or job losses, the qualifying hours and activities contain significant flexibility for beneficiaries to choose activities that will help them learn new skills and move toward independence and self-sufficiency.” However, low-wage workers with a stated preference for full-time work are also often working irregular hours as many of their employers expect them to be on-call and available on short notice, making it potentially difficult for these workers to secure a second job or to take advantage of education and training opportunities that may require scheduled attendance.<sup>129</sup> In addition, the nuances of

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<sup>124</sup> Solomon, J. (2019).

<sup>125</sup> Georgia Department of Community Health. (2021). Georgia Pathways to Coverage Section 1115 demonstration Implementation Plan. Submitted on February 12, 2021. Under CMS Review. As of December 1, 2021, CMS has received from the Georgia Department of Community Health, three quarterly and one annual monitoring reports covering the period from October 1, 2020 through September 30, 2021. The reports are under review by CMS.

<sup>126</sup> Hahn, H., Sullivan, L., Tran, V., Blount, D. & Waxman, E. (2019). SNAP Work Requirements in Arkansas for Adults without Dependents or Disabilities. Urban Institute. Retrieved from [https://www.urban.org/sites/default/files/publication/101112/snap\\_work\\_requirements\\_in\\_arkansas\\_for\\_adults\\_with\\_out\\_dependents\\_or\\_disabilities\\_5.pdf](https://www.urban.org/sites/default/files/publication/101112/snap_work_requirements_in_arkansas_for_adults_with_out_dependents_or_disabilities_5.pdf); see also Katch, H., Wagner, J. & Aron-Dine, A. (2018).

<sup>127</sup> Katch, H., Wagner, J. & Aron-Dine, A. (2018).

<sup>128</sup> Katch, H., Wagner, J. & Aron-Dine, A. (2018).

<sup>129</sup> Smith, V. & Halpin, B. (2014). Low-Wage Work Uncertainty Often Traps Low-Wage Workers. Policy Brief, Volume 2, Number 9. Center for Poverty Research, University of California-Davis. Retrieved from

the good cause exceptions and qualifying activities, and the reporting obligations, may be demanding and difficult to comply with in terms of documenting employment or exception status, filling out forms, and responding to bureaucratic directives. All of these can potentially limit access to coverage and health care.<sup>130</sup> Furthermore, the work requirement is likely to aggravate the psychological costs, including the stigma, stress, frustration, anxiety, and loss of autonomy, which can arise from interacting with administratively burdensome public programs, potentially adversely impacting the health of beneficiaries and potential beneficiaries.<sup>131</sup> Moreover, the mental stress and negative health implications of administratively burdensome programs may be more pronounced among populations of racial minorities.<sup>132</sup>

The state also noted that incentives and requirements that increase “... participation [in the work requirement] may have a positive effect on beneficiary health and economic mobility.”<sup>133</sup> While unemployment and job losses have been shown to adversely affect health,<sup>134</sup> it is also widely understood that individuals must be healthy to work, and consistent access to health coverage is vital to being healthy enough to work.<sup>135</sup> Furthermore, there is no evidence of a causal effect of employment on health outcomes, particularly for the population likely to be subject to the work requirement. More importantly, social interactions, as well as participation in economic

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[https://poverty.ucdavis.edu/sites/main/files/file-attachments/smith\\_cpr\\_policy\\_brief\\_employability.pdf](https://poverty.ucdavis.edu/sites/main/files/file-attachments/smith_cpr_policy_brief_employability.pdf); Walther, A. (2018-2019). Poverty Fact Sheet: Unstable Jobs, Unstable Lives: Low-Wage Work in the United States. Institute for Research on Poverty; University of Wisconsin-Madison. Retrieved from <https://www.irp.wisc.edu/wp/wp-content/uploads/2018/12/Fact-Sheet-16-2018-UnstableJobs-UnstableLives.pdf>.

<sup>130</sup> Herd P. & Moynihan, D. (2020). How Administrative Burdens Can Harm Health. Health Affairs: Health Policy Brief. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hpb20200904.405159/full/>.

<sup>131</sup> Herd & Moynihan (2020).

<sup>132</sup> Schram, S., Soss, J., Fording, R., & Houser, L. (2009). Deciding to Discipline: Race, Choice, and Punishment at the Frontlines of Welfare Reform. *American Sociological Review*, 74(3): 398-422. Retrieved from <https://journals.sagepub.com/doi/pdf/10.1177/000312240907400304>.

<sup>133</sup> In its approval of the Georgia Pathways to Coverage demonstration, CMS cited a study that found an association between job losses during the COVID-19 pandemic and increased rates of anxiety and/or depressive disorders. CMS mentioned in the demonstration’s approval letter that, if structured properly, measures that could reduce social isolation and enhance greater economic participation during the pandemic might help lessen the ill effects of the pandemic on stress and anxiety. However, neither CMS nor the cited study made any suggestion that requiring individuals to participate in a work requirement in order to obtain health coverage would reduce rates of anxiety or depression among individuals, especially those who might not have the capacity, or the opportunities available to them, to engage in such activities. See The Centers for Medicare & Medicaid Services. (2020). Georgia Pathways to Coverage Section 1115 Demonstration Special Terms and Conditions; and Panchal et al. (2021).

<sup>134</sup> Centers for Disease Control and Prevention. (2003). CDC Health Disparities and Inequalities Report — United States, 2013. Retrieved from [https://www.researchgate.net/profile/David-Freedman-7/publication/262045348\\_Obesity\\_-\\_United\\_States\\_1999-2010/links/5d14048c299bf1547c821db0/Obesity-United-States-1999-2010.pdf#page=29](https://www.researchgate.net/profile/David-Freedman-7/publication/262045348_Obesity_-_United_States_1999-2010/links/5d14048c299bf1547c821db0/Obesity-United-States-1999-2010.pdf#page=29); Jin, R., Shah, C. & Svoboda, T. (1997). The Impact of Unemployment on Health: A Review of the Evidence. *Journal of Public Health Policy*. 18, 275–301 (1997). Retrieved from <https://doi.org/10.2307/3343311>; Strully, K.W. (2009). Job Loss and Health in the U.S. Labor Market. *Demography*. 46, 221–246. Retrieved from <https://link.springer.com/content/pdf/10.1353/dem.0.0050.pdf>; Burgard, S.A., Brand, J.E., & House, J.S. (2007). Toward a Better Estimation of the Effect of Job Loss on Health. *Journal of Health and Social Behavior*, 48(4), 369–384. Retrieved from <https://doi.org/10.1177/002214650704800403>; Schaller, J. & Stevens, A.H. (2015).

<sup>135</sup> The Ohio Department of Medicaid. (2018). 2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment. Retrieved from <https://www.medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf>. Beneficiaries participating in substance use disorder treatment are exempt from the community engagement requirement; see also Gehr & Wickle (2017), Tipirneniet al. (2017), and Musumeci, Rudowitz & Lyons (2018).

activities, only have the potential to improve the mental health of individuals who have the capacity to engage in them, and who have those opportunities available to them. As we have discussed throughout this letter, employment opportunities and economic recovery—especially for low-income workers—are still sluggish during the pandemic, and may remain so for the foreseeable future. Additionally, 61 percent of adults with children reported difficulty paying for household expenses in September and October 2021, compared to 52 percent the overall population.<sup>136</sup> Pandemic-related complications, such as limited access to transportation and accessible and affordable child care,<sup>137</sup> still restrict individuals from fully participating in the workforce and may cause difficulty meeting the work requirement. Given those circumstances, it is not clear how the state’s work requirement would succeed in promoting coverage gains through expanding engagement in such activities for Georgians who could otherwise be eligible under the demonstration.

Parents may experience additional obstacles to meeting the work requirement in Georgia due to shortages in affordable child care centers in the state. Data from Georgia show that 39 percent of the state’s children live in single-parent families, and one-third of single-parent families live below the FPL.<sup>138</sup> Moreover, about half of Georgian children under 13 in a working family are from a low-income working family.<sup>139</sup> Additionally, nine percent of licensed child care programs in the state closed permanently since the beginning of the pandemic.<sup>140</sup> Also, according to an interactive cost calculator, the costs of center-based child care in Georgia were estimated to have had increased by 115 percent during the pandemic compared to the pre-pandemic scenario.<sup>141</sup> A survey conducted in the summer of 2021 indicated that 34 percent of Georgia respondents said that they or a family member had quit a job, not taken a job, or made a big job change in the past year due to a lack of child care,<sup>142</sup> and lack of child care was one of the most frequently cited reasons for not working at the end of 2020.<sup>143</sup> Furthermore, informal child care support systems, such as neighbors or grandparents, may no longer be available to help, given the increased risk of spreading COVID-19.<sup>144</sup> Because Georgia Pathways to Coverage would not provide child care exemptions, good cause exceptions, or credit toward qualifying

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<sup>136</sup> Orgera, K., Garfield, R., & Rudowitz, R. (2021). Tracking Social Determinants of Health During the COVID-19 Pandemic. KFF. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/tracking-social-determinants-of-health-during-the-covid-19-pandemic/>.

<sup>137</sup> As noted above, unlike the community engagement requirements in other states, Georgia’s demonstration does not include any qualifying exemptions, good cause exceptions, or credits toward required hours to accommodate caregiving activities for individuals who may not be able to meet the work requirements because they are taking care of children or have other family caregiving obligations.

<sup>138</sup> Spotlight on Poverty. (2021). Georgia. Retrieved from <https://spotlightonpoverty.org/states/georgia/>.

<sup>139</sup> Johnson, M. (2014). At the Bottom of a Broken Ladder: A Profile of Georgia’s Low-Income Working Families. Georgia Budget & Policy Institute. Retrieved from <http://www.workingpoorfamilies.org/wp-content/uploads/2014/07/GA-At-the-Bottom-of-a-Broken-Ladder.pdf>.

<sup>140</sup> Ho, S. and Boak, J. (2021). Worsened by pandemic, child care crisis hampers broader economy. PBS. Retrieved from <https://www.pbs.org/newshour/economy/worsened-by-pandemic-child-care-crisis-hampers-broader-economy>.

<sup>141</sup> Choi, A. (2021). How Much Child Care Went Up in Your State. Politico Nightly. Retrieved from <https://www.politico.com/newsletters/politico-nightly/2021/05/26/how-much-child-care-went-up-in-your-state-493017>.

<sup>142</sup> Tagami, T. (2021).

<sup>143</sup> McGrath, J. (2021).

<sup>144</sup> Wolfe, R., Harknett, K., and Schneider, D. (2021). Inequalities at Work and the Toll of COVID-19. Health Affairs. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hpb20210428.863621/full/>.

hours required under the demonstration,<sup>145</sup> low-income parents and caregivers would need to meet the work requirement before becoming eligible for coverage. Therefore, availability of and access to child care may be an especially important factor in meeting the work requirement in Georgia.

The state's draft Implementation Plan described that it would arrange for child care support services through the Department of Early Care and Learning.<sup>146</sup> Although Georgia recently announced its plan to use funds available from the American Rescue Plan Act of 2021 (Pub. L. 117-2; ARP) to provide much-needed subsidies for child care, the subsidies are temporary and are not expected to cover the full costs for parents.<sup>147</sup> The state also indicated in the draft Implementation Plan that it would assess the availability of child care supports across regions and the methods it would use to address gaps, but the state has not provided further updates on such an availability assessment of child care supports.<sup>148</sup> Child care provider shortages and the ongoing risks of contracting different variants of the virus that causes COVID-19 continue to make it challenging for parents to secure stable child care arrangements, which may inhibit parents' ability to obtain and keep employment.<sup>149</sup> Overall, with the COVID-19 pandemic increasing caregiving responsibilities and burden across families, especially for women, it is likely to be unreasonably difficult for low-income parents and other caregivers to complete and/or maintain compliance with the requirement and thereby access and remain enrolled in demonstration coverage.

As mentioned above, the work requirement is estimated to potentially affect only a small percentage of the state's population because few Georgians with incomes under 100 percent of the FPL are not otherwise eligible for Medicaid and not already working at least part-time.<sup>150</sup> Limited employment and other community engagement opportunities, especially for the demonstration's intended beneficiary population; insufficient outreach to potential demonstration beneficiaries to educate them about the work requirement and its reporting obligations; and a lack of affordable childcare and access to transportation may further limit the number of individuals who could qualify for coverage or maintain coverage under the demonstration.<sup>151</sup> Meanwhile, suspending eligibility for beneficiaries initially enrolled in the demonstration but who become unable to meet the work requirement for continued coverage, or denying initial

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<sup>145</sup> Georgia Department of Community Health. (2020). "Pathways to Coverage" Section 1115 demonstration Special Terms and Conditions.

<sup>146</sup> Georgia Department of Community Health. (2021). Georgia Pathways to Coverage Section 1115 Demonstration Implementation Plan. Submitted on February 12, 2021. Under CMS Review.

<sup>147</sup> Tagami, T. (2021).

<sup>148</sup> As of December 1, 2021, CMS has received from the Georgia Department of Community Health, three quarterly and one annual monitoring reports covering the period from October 1, 2020 through September 30, 2021. The monitoring reports provide information about state's activities toward planned implementation of the demonstration. The reports are under review by CMS.

<sup>149</sup> Ho and Boak (2021).

<sup>150</sup> Georgia Department of Community Health. (2019). Georgia "Pathways to Coverage" Section 1115 Demonstration Waiver Application.

<sup>151</sup> Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from [www.tracktherecovery.org](https://www.tracktherecovery.org); and Tagami, T. (2021). Even with federal aid, Georgia's child care centers face staffing woes. The Atlanta Journal-Constitution. Retrieved from <https://www.ajc.com/education/even-with-federal-aid-georgias-child-care-centers-face-staffing-woes/BB3U4MUHZBA7JMISSIONVA3TKLI/>.

eligibility for individuals who otherwise qualify, poses a significant risk to individuals who need access to health care services in the midst of the COVID-19 pandemic and even after the public health emergency has ended, particularly for those experiencing long COVID symptoms.

Georgia stated in its March 12, 2021 letter that its program “is essential to helping beneficiaries build new skills” and “become more independent and self-reliant.” However, the state does not offer any evidence on how the work requirement will result in greater independence or self-reliance, especially during and in the aftermath of the COVID-19 pandemic when there may be a dearth of employment opportunities and other opportunities to perform and satisfy the minimum hours or qualifying activities for low-income beneficiaries and potential beneficiaries in the state. Additionally, there is no evidence offered by the state suggesting that its work requirement would be likely to succeed in generating greater levels of employment.

Overall, the state has not offered sufficient evidence to support the idea that conditioning initial and continued eligibility on compliance with the work requirement is likely to be effective in positively influencing employment, independence or self-reliance. Meanwhile, it is clear that this requirement would risk denying or suspending eligibility for individuals who could otherwise be eligible for demonstration coverage. The state also has not presented information to suggest that withholding safety net benefits, such as demonstration coverage, from otherwise eligible beneficiaries would lead to increased employment or other positive outcomes for low-income and vulnerable individuals. Thus, we do not have information before us that suggests that the design and approach of Georgia’s work requirement is likely to reduce the risks that this component of the state’s demonstration project would result in eligibility denials, suspensions and disenrollments at a time when being denied or losing access to health care coverage would cause significant harm to the individuals intended to benefit from the demonstration.

#### **Withdrawal of the Work and Premium Requirements in the Georgia Pathways to Coverage Section 1115 Demonstration**

Based on the foregoing, and pursuant to our obligation under section 1115 of the Act to review demonstration projects and ensure they remain likely to promote the objectives of Medicaid, CMS has determined that, on balance, the approval authorizing Georgia to implement a work requirement as a condition of initial and continued eligibility under the Georgia Pathways to Coverage demonstration is not likely to promote the objectives of the Medicaid program. At a minimum, in light of the significant risks and uncertainties described above about the adverse effects of the pandemic and its aftermath, the information available to CMS does not provide an adequate basis to support an affirmative judgment that the work requirement is likely to assist in promoting the objectives of Medicaid. As indicated in CMS’s February 12, 2021 letter, CMS also reviewed the other authorities that were previously approved in the Georgia Pathways to Coverage demonstration. Since the demonstration’s approval, CMS has determined that charging beneficiaries premiums beyond those authorized under the Medicaid statute can present a barrier to coverage. Therefore, upon further review, and for the reasons outlined in detail above, CMS has determined that authority to require premiums beyond those specifically permitted under the Medicaid statute, as previously approved in Georgia’s Pathways to Coverage demonstration, is not likely to promote the objectives of Medicaid.

Accordingly, pursuant to our authority and responsibility under applicable statutes and regulations to maintain ongoing oversight of whether demonstration projects are currently likely to promote Medicaid objectives, CMS is hereby withdrawing the portion of the October 15, 2020 Georgia Pathways to Coverage demonstration approval and the accompanying expenditure authorities and Special Terms and Conditions that authorize the state to require and implement the work and premium requirements as conditions of initial and continued eligibility. The withdrawal of these authorities is effective on the date that is thirty days after the date of this letter, unless the state timely appeals, as discussed below.

We understand that, on March 27, 2019, the Governor of Georgia signed the Patients First Act (S.B. 106), which authorizes the state to submit a section 1115 demonstration request that includes an increase in the Medicaid income eligibility threshold of up to 100 percent of the FPL.<sup>152</sup> This action preserves Georgia's authorization to provide health coverage through the Pathways to Coverage demonstration, without the work requirement or the demonstration-authorized premium requirement. On June 24, 2021, Georgia submitted a letter to inform CMS of the state's intent to postpone the demonstration implementation date until at least August 1, 2021. On July 27, 2021, the state informed CMS that it would further defer implementation of the demonstration until the end of 2021. Georgia had been working with CMS to find a mutually agreeable path forward to increase access to health coverage in Georgia. The state has not submitted such a proposal to CMS at this time. We stand ready to work with the state to explore other options. We are also willing and able to work with the state on making any necessary changes to the state's mechanism for enrolling beneficiaries in Medicaid, such that withdrawal of the work requirement and premium requirement are not a barrier to the state's expansion of the Medicaid income eligibility threshold.

Additionally, Georgia submitted a state plan amendment (SPA) request (SPA 21-0001) to effectuate changes needed to implement eligibility provisions of the Georgia Pathways to Coverage demonstration, including collection of information needed to determine if applicants meet the work requirement to have completed 80 hours of qualifying activities in the month prior to application as a condition of eligibility for potential demonstration beneficiaries. Because the state had not implemented the Georgia Pathways to Coverage demonstration at the time Georgia SPA 21-0001 was approved, those portions of the SPA that revise the application to include questions needed to implement the Georgia Pathways to Coverage demonstration were approved with a prospective effective date contingent upon implementation of the Georgia Pathways to Coverage demonstration (and not the June 1, 2021 effective date that was approved for the other application changes in Georgia SPA 21-0001 that are not associated with the Georgia Pathways to Coverage demonstration). As such, the state may not implement the prospectively approved application changes until such time as the state implements the Georgia Pathways to Coverage demonstration, in accordance with the demonstration's Expenditure Authorities and Special Terms and Conditions as revised to reflect the CMS action described in this letter.

We anticipate that the state will be fully able to implement the other authorized components of the Georgia Pathways to Coverage demonstration. We welcome the opportunity to continue to work with you on approaches to health care coverage for Medicaid beneficiaries and uninsured

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<sup>152</sup> Georgia Senate Bill 106. "Patients First Act". Available at <https://www.legis.ga.gov/api/legislation/document/20192020/185957>.

individuals in Georgia that are likely to promote the objectives of Medicaid. The state and CMS will work together to develop and update the demonstration's Monitoring Protocol and Evaluation Design to reflect all the key policies that are implemented during the approval period. The current established timeline for the quarterly and annual monitoring reports as well as the Interim and Summative Evaluation Reports will remain in effect. CMS looks forward to continuing to work with the state on the monitoring deliverables, as well as the Evaluation Design, and the Interim and Summative Evaluation Reports.

### **Procedure to Appeal This Decision**

In accordance with Special Terms and Conditions ¶ 10 and Medicaid regulations at 42 C.F.R. § 430.3, the state may request a hearing to challenge CMS's determination prior to the above-referenced effective date by appealing this decision to the Departmental Appeals Board (DAB or Board), following the procedures set forth at 45 C.F.R. part 16. This decision shall be the final decision of the Department unless, within 30 calendar days after the state receives this decision, the state delivers or mails (the state should use registered or certified mail to establish the date) a written notice of appeal to the DAB.

A notice of appeal may be submitted to the DAB by mail, by facsimile (fax) if under 10 pages, or electronically using the DAB's electronic filing system (DAB E-File). Submissions are considered made on the date they are postmarked, sent by certified or registered mail, deposited with a commercial mail delivery service, faxed (where permitted), or successfully submitted via DAB E-File. The Board will notify the state of further procedures. If the state faxes its notice of appeal (permitted only if the notice of appeal is under 10 pages), the state should use the Appellate Division's fax number, (202) 565-0238.

To use DAB E-File to submit your notice of appeal, the state's Medicaid Director or its representative must first become a registered user by clicking "Register" at the bottom of the DAB E-File homepage, <https://dab/efile.hhs.gov/>; entering the information requested on the "Register New Account" form; and clicking the "Register Account" button. Once registered, the state's Medicaid Director or its representative should login to DAB E-File using the e-mail address and password provided during registration; click "File New Appeal" on the menu; click the "Appellate" button; and provide and upload the requested information and documents on the "File New Appeal-Appellate Division" form. Detailed instructions can be found on the DAB E-File homepage.

Due to the COVID-19 public health emergency, the DAB is experiencing delays in processing documents received by mail. To avoid delay, the DAB strongly encourages the filing of materials through the DAB E-File system. However, should the state so choose, written requests for appeal should be delivered or mailed to U.S. Department of Health and Human Services, Departmental Appeals Board MS 6127, Appellate Division, 330 Independence Ave., S.W., Cohen Building Room G-644, Washington, DC 20201. Refer to 45 C.F.R. Part 16 for procedures of the Departmental Appeals Board.

The state must attach to the appeal request, a copy of this decision, a note of its intention to appeal the decision, a statement that there is no dollar amount in dispute but that the state disputes CMS's withdrawal of certain section 1115 demonstration authorities, and a brief statement of why the decision is wrong. The Board will notify the state of further procedures. If the state chooses to appeal this decision, a copy of the notice of appeal should be mailed or delivered (the state should use registered or certified mail to establish the date) to Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services at 7500 Security Blvd, Baltimore, MD 21244.

Medicaid is a federal-state partnership and we look forward to continuing to work together. If you have any questions, please contact Judith Cash, Director, CMS State Demonstrations Group, at (410) 786-9686.

Sincerely,

A black rectangular box redacting the signature of Chiquita Brooks-LaSure.

Chiquita Brooks-LaSure

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

**NUMBER:** 11-W-00342/4

**TITLE:** Georgia Pathways to Coverage

**AWARDEE:** Georgia Department of Community Health

**Title XIX Costs Not Otherwise Matchable Authority**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Georgia for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from October 15, 2020 – September 30, 2025, unless otherwise specified, be regarded as expenditures under the state’s title XIX plan. The demonstration will be implemented effective July 1, 2021.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Georgia to operate the above-identified section 1115(a) demonstration.

- 1. Low Income Adults.** Expenditures to provide medical assistance to individuals ages 19 – 64 with income up to 95 percent (effectively 100 percent with the 5 percent income disregard) of the federal poverty level (FPL), who are not otherwise eligible for Medicaid, as described in the STCs.
- 2. Mandatory Employer-Sponsored Insurance.** Expenditures to the extent necessary to provide premium assistance and assistance for associated cost sharing to subsidize the employee’s share of the costs of insurance premiums for employer-sponsored health insurance, as described in the STCs.

**Title XIX Requirements Not Applicable to the Demonstration Eligible Populations**

All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly identified as not applicable to these expenditure authorities shall apply to the demonstration for the period of this demonstration.

**1. Methods of Administration**

**Section 1902(a)(4)  
insofar as it  
incorporates 42 CFR  
431.53**

To the extent necessary to enable the state to not provide non-emergency medical transportation services (NEMT), except for individuals eligible for early periodic screening, diagnostic and treatment (EPSDT) services as described in the STCs.

**2. Amount, Duration, Scope of Services and Comparability**

**Sections  
1902(a)(10)(B) and  
1902(a)(17)**

To the extent necessary to enable the state to allow beneficiaries to receive benefits provided through an ESI plan without wrap-around benefits.

**3. Comparability**

**Sections  
1902(a)(10)(B) and  
1902(a)(17)**

To the extent necessary to enable the state to vary cost sharing requirements for different beneficiaries based on income and other factors as described in the STCs.

**4. Retroactive Eligibility**

**Section 1902(a)(34)**

To permit the state not to provide retroactive eligibility to individuals in the demonstration.

**5. Hospital Presumptive Eligibility**

**Section  
1902(a)(47)(B)**

To permit the state not to provide hospital presumptive eligibility to individuals in the demonstration.

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

**NUMBER:** 11-W-00342/4

**TITLE:** Georgia Pathways to Coverage

**AWARDEE:** Georgia Department of Community Health

**I. PREFACE**

The following are the STCs for the “Georgia Pathways to Coverage” section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Georgia Department of Community Health (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the state expenditure authorities 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 related to this demonstration. The Georgia Pathways to Coverage demonstration will operate statewide and is approved for a 5-year period from October 15, 2020 – September 30, 2025. The state will implement the demonstration effective July 1, 2021.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility
- V. Benefits
- VI. Member Rewards Accounts
- VII. Cost Sharing
- VIII. Delivery System
- IX. General Reporting Requirements
- X. General Financial Requirements
- XI. Monitoring Budget Neutrality
- XII. Evaluation of the Demonstration

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

## II. PROGRAM DESCRIPTION AND OBJECTIVES

With this approval, Georgia's Pathways to Coverage demonstration will provide Medicaid coverage to individuals ages 19 through 64 who have household incomes up to 95 percent of the federal poverty level (FPL) (effectively 100 percent with the 5 percent income disregard) who are not otherwise eligible for Medicaid coverage and who meet the eligibility criteria and requirements.

The monitoring and evaluation sections in the STCs specify that CMS has the authority to require the state to submit a corrective action plan if monitoring or evaluation data indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid. The STCs further specify that any such corrective action plan, submitted by the state, could include a temporary suspension of implementation of demonstration programs in circumstances where data indicate substantial, sustained, directional change, inconsistent with state targets (such as substantial, sustained trends indicating increased difficulty accessing services by those attempting to opt-in). These updates will aid the state in measuring and tracking the demonstration's impact on Georgians affected by it, and give CMS additional tools to protect applicants and beneficiaries, if necessary. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

## III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Laws.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable accommodations to individuals with disabilities under the ADA, Section 504, and Section 1557, with eligibility and documentation requirements, understanding program rules and notices, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits.
- 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in federal law, regulation, and written policy, not expressly

waived 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 Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid 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 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
  - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as well as a modified allotment neutrality worksheet as necessary, as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
  - b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.
- 5. State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plans governs.
- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or service-based expenditures, will be available for changes to the

demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval 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 viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
  - a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
  - b. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;
  - c. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
  - d. An up-to-date CHIP allotment worksheet, if necessary; and
  - e. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.
8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs, must submit a transition and phase-out plan consistent with the requirements of STC 9.
9. **Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:
  - a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct

tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised transition and phase-out plan.

- b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan, the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities, including community resources that are available.
- c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.
- d. Transition and Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR part 431 subpart E. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.
- e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
- f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.
- g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

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

**11. Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and

enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

- 12. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

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

- 14. Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, 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.

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

#### **IV. ELIGIBILITY**

- 16. Eligibility.** Only adults ages 19 through 64 with income up to 95 percent of the FPL (effectively 100 percent with the 5 percent income disregard) are eligible to opt into Medicaid coverage under the Georgia Pathways to Coverage demonstration by meeting the requirements specified in these STCs. Individuals must also meet non-financial eligibility requirements (e.g., residency, citizenship or satisfactory immigration status) and other

eligibility requirements as described in these STCs. This demonstration eligible population is not otherwise eligible for Medicaid through the state plan and can only be covered under Medicaid through this demonstration.

**17. Demonstration Enrollment.** Eligibility under this demonstration is prospective only. Eligible individuals will receive an approval notice and select a managed care organization (MCO) or be auto-assigned before they are enrolled in the Medicaid program.

**18. Effective Date of Coverage.** The state is not obligated to provide retroactive eligibility in accordance with section 1902(a)(34) for beneficiaries eligible for or enrolled in Medicaid under the Pathways to Coverage demonstration. Beneficiary coverage will begin the first day of the month following the state's eligibility determination.

## **V. BENEFITS**

**19. Georgia Pathways to Coverage Program Benefits.** Beneficiaries enrolled in the demonstration will receive Medicaid state plan benefits with the exception of non-emergency medical transportation (NEMT). Beneficiaries ages 19 and 20 who receive Medicaid benefits under the demonstration will receive early and periodic screening, diagnostic, and treatment (EPSDT) services.

**20. Employer Sponsored Insurance.** Beneficiaries who are eligible for Medicaid under the demonstration and who are eligible for employer sponsored insurance (ESI) will be required to enroll in the state's Health Insurance Premium Payment Program (HIPP), if it is cost effective to the state. Beneficiaries enrolled in ESI will have a benefit package limited to the services covered by their ESI and will not receive wrap-around services. Once eligible, the HIPP will provide reimbursement for monthly premium and cost sharing expenses.

- a. ESI Cost Effectiveness. During the eligibility determination process, the state will determine if the employer-sponsored plan is cost-effective using a methodology that considers the amount paid under the MCO capitation rate versus what it would pay to cover the cost of premiums and associated cost-sharing under the demonstration. If the state determines the ESI plan is no longer cost-effective, the beneficiary will no longer be required to enroll in an ESI plan, and may receive Medicaid coverage under the demonstration, if still eligible.
- b. ESI Cost Sharing. Beneficiaries intending to obtain care from an ESI provider that does not participate with Medicaid will need to:
  - i. Submit a bill, invoice or other documentation to the state Medicaid third party liability (TPL) vendor agency demonstrating the member's liability no less than thirty (30) calendar days before payment is due. The state will pay the beneficiary prospectively for the beneficiary's cost sharing obligation when the required information is submitted timely.
  - ii. The state may, at its discretion, pay cost sharing obligations prospectively if the member submits a bill or invoice less than thirty (30) calendar days before payment is due.
  - iii. The beneficiary may file for a reimbursement of a copayment made at the point of service if they are unable to submit documentation prior to the appointment for an advanced payment.

- c. ESI Disenrollment. Beneficiaries who voluntarily disenroll from ESI coverage while such coverage is available and cost-effective to the state will no longer be eligible for Medicaid coverage through the demonstration and may reapply at any time. Beneficiaries who lose ESI coverage or such ESI coverage is no longer cost effective to the state, may receive Medicaid coverage under the demonstration, if still eligible.

## VI. MEMBER REWARDS ACCOUNTS

**21. Member Rewards Account.** All beneficiaries enrolled in Medicaid under the demonstration (except beneficiaries receiving premium assistance through the HIPP) will be provided with a Member Rewards Account (MRA). The MRA is an educational tool used to “deduct” beneficiary copayments, and deposit incentives that have a dollar-value equivalent for completing healthy behavior activities as described in STC 22. Points in the MRA are non-monetary credits, that are converted to dollars for purposes of payment and when deducted for copayments and other allowable expenses. Any deduction does not result in actual charges to the beneficiary. If there are insufficient funds in the MRA to pay a copayment or other allowable expense, copayments will continue to be deducted, and any future healthy incentive points will be applied to the negative balance. Beneficiaries will not be responsible for any copayments or other allowable expenses due to a negative MRA balance. Beneficiaries will have access to view their balance, including copayment deductions, , and healthy behavior credits consistent with the requirements in 42 CFR 435.918, and will also receive account statements that will include information about the amount used, the amount paid out of the MRA, and the remaining balance.

**22. Healthy Behavior Incentives.** The state will provide dollar-value equivalent incentive points for healthy behavior activities, including but not limited to, attending smoking cessation classes, annual well visits, or complying with a diabetes prevention or management program. Once the balance of the MRA reaches a fifty (50) dollar-value equivalent, beneficiaries may use the MRA to access items and services not covered under Georgia’s Medicaid state plan, such as dental services, glasses, contacts and over the counter drugs.

## VII. COST SHARING

**23. Cost Sharing for Participants in the Demonstration.** All demonstration eligible beneficiaries, (except beneficiaries enrolled in HIPP) will be required to pay copayments for certain services consistent with Medicaid cost sharing rules. The copayments are described in Table 1 below and are consistent with copayments in the state plan, with the exception of a copayment for non-emergency use of the emergency department, as described in STC 24. Beneficiary copayments will not be collected at the point of service and will be retroactively deducted from the MRA based on encounter data. If there are insufficient funds in the MRA, copayments will continue to be deducted without any out of pocket expense to the beneficiary, as described in STC 21. Any future beneficiary healthy incentive points earned will be applied to offset the negative balance, without any out of pocket expense to the beneficiary.

| Table 1. Copayment Amounts                                  |                                                                                                                |
|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Service                                                     | Copay                                                                                                          |
| Inpatient Hospitalization                                   | \$12.50 for entire stay                                                                                        |
| Outpatient Hospital Visit                                   | \$3.00 per visit                                                                                               |
| Non-emergency use of the emergency department               | \$30.00 per visit                                                                                              |
| Primary Care                                                | \$0.00                                                                                                         |
| Specialist                                                  | \$2.00                                                                                                         |
| Durable Medical Equipment (DME)                             | \$3.00<br>\$1.00 for rentals and supplies                                                                      |
| Pharmacy – Copayment varies based on the cost to the state. | \$10.00 or less: \$0.50<br>\$10.01 to \$25.00: \$1.00<br>\$25.01 to \$50.00: \$2.00<br>\$50.01 or more: \$3.00 |

**24. Non-Emergent Use of the Emergency Department.** A beneficiary's MRA will be reduced by thirty (30) dollars of non-monetary credits for each non-emergent visit to the emergency department. This deduction will be waived for any beneficiary who contacts their MCO's 24-hour nurse hotline prior to utilizing the emergency department. The beneficiary must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA, of the Act and have a medical professional determine that it is not an emergency using the prudent layperson standard—before their MRA balance can be reduced. Notwithstanding the fact that the MRA deduction is not cost sharing, the state must ensure that hospitals comply with the requirements described in 42CFR 447.54(d)(2) related to educating beneficiaries about appropriate alternative settings before the state deducts the amount from the MRA. Emergency services are not subject to cost sharing per 42 CFR 447.56(a)(2).

**25. Tobacco Surcharge.** Beneficiaries enrolled in Medicaid through this demonstration who self-attest as a tobacco user will be assessed a tobacco surcharge as indicated in Table 2 below. This surcharge is a separate deduction from the beneficiary's MRA. If a beneficiary completes a smoking cessation program and attests to no longer using tobacco, the surcharge will be lifted. Smoking cessation programs are covered by Medicaid if the state's conditions of coverage for smoking and tobacco cessation are met. The tobacco surcharge is appealable for beneficiaries who believe they are not subject to the surcharge. The tobacco surcharge is not appealable for beneficiaries who attest to using tobacco but do not participate in a smoking cessation, or other qualified health improvement activity.

| Table 2                                                                                         |                   |
|-------------------------------------------------------------------------------------------------|-------------------|
| Income                                                                                          | Tobacco Surcharge |
| From 50 percent up to 85 percent FPL                                                            | \$3.00            |
| From 85% and up to 95 percent FPL (effectively 100 percent with the 5 percent income disregard) | \$5.00            |

## **26. Beneficiary and State Assurances.**

- a. Monitor that beneficiaries do not incur household cost sharing that exceeds five (5) percent of the aggregate household income, in accordance with 42 CFR 447.56(f), without regard to MCO enrollment of members in the household. Once a household reaches the cap, the state assures that no further copayments can be charged to beneficiaries.
- b. Charge copayment amounts, if applicable, that do not exceed Medicaid cost sharing permitted by federal law and regulation and the terms of this demonstration.
- c. Ensure that the state, or its designee, does not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing are considered an administrative expense by the state.
- d. Provide all applicants timely determinations of eligibility in accordance with 42 CFR 435.912.
- e. Provide all applicants and beneficiaries with timely and adequate written notices of any decision affecting their eligibility, including an approval, denial, termination, or suspension of eligibility, or a denial or change in benefits and services pursuant to 42 CFR 435.917 and consistent with 42 CFR 435.905(b) and 431.206-214.
- f. The state must send a notice at least 10 days in advance of the date of action (as defined at 42 CFR 431.201 pursuant to 42 CFR 431.211-214.
- g. Provide all applicants and beneficiaries with fair hearing rights consistent with 42 CFR part 431, subpart E.
- h. Ensure program information is available, and accessible in accordance with 42 CFR 435.901 and 435.905.
- i. Provide notice (consistent with 42 CFR 435.917 and 431.206-214) in advance of any adverse action, including but not limited to: the right to appeal; the right to apply for Medicaid on a basis not affected by this status; what to do if circumstances change such that they may be eligible for coverage in another Medicaid category; as well as any implications with respect to whether they have minimum essential coverage.
- j. Ensure the state will monitor the demonstration and, using information available to the state, work to identify any disparate impact on certain beneficiaries, based on characteristics including gender, sexual orientation, race or ethnicity.

## **VIII. DELIVERY SYSTEM**

**27. Overview.** The Georgia Pathways to Coverage demonstration will use the current statewide managed care delivery system for all covered individuals under the authority of the Georgia Managed Care Organization (MCO) Program authorized in the state plan. Only eligible beneficiaries participating in ESI are exempt from mandatory managed care enrollment.

**28. Managed Care Organization.** Beneficiaries will be enrolled to receive services through one of the MCOs under contract with the state. The MCOs are subject to the federal laws and regulations as specified in 42 CFR Part 438, unless otherwise specified. Beneficiaries will be given the opportunity to select an MCO at the time of application or select to be auto-assigned.

## **IX. GENERAL REPORTING REQUIREMENTS**

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

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted 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 submission of required deliverable(s).
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state’s anticipated date of submission. Should CMS agree to the state’s request, a corresponding extension of the deferral process 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 steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
- 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.

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

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

work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
- c. Submit deliverables to the appropriate system as directed by CMS.

**32. Implementation Plan.** The state must submit a draft Implementation Plan to CMS for review and comment no later than ninety (90) calendar days after the start date of the demonstration approval period. The state must submit a revised Implementation Plan within sixty (60) calendar days after receipt of CMS' comments. The Implementation Plan must cover at least the key policies being tested under this demonstration, including the non-applicability of retroactive eligibility. Additionally, the state may be expected to provide additional details not captured in the STCs regarding implementation of the other demonstration policies, such as incentives for healthy behaviors, copayments for the non-emergent use of the emergency department, and the non-applicability of hospital presumptive eligibility, retroactive eligibility and NEMT. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment D. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the Implementation Plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

**33. Monitoring Protocol.** The state must submit to CMS a draft Monitoring Protocol no later than one hundred and fifty (150) calendar days after the start date of the demonstration approval period. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS' comments. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment E.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS's templates. Any proposed deviations from CMS's templates should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as broadly described in STC 37 below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to cost-sharing, incentives for healthy behaviors, and the non-applicability of retroactive eligibility. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates as described in STC 34 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.

**34. Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each demonstration year (DY). The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

- a. Operational Updates. The operational updates will focus on progress towards meeting the milestones identified in CMS's framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's annual goals and overall targets as will be identified in the approved Monitoring Protocol, and will cover key policies under this demonstration, including but not limited to premi tobacco surcharge, incentives for healthy behaviors, and the non- applicability of retroactive eligibility. The state is also expected to provide monitoring data on demonstration policies around ESI cost-effectiveness and cost sharing, and—if appropriate—the non-applicability of hospital presumptive eligibility. The performance metrics will also reflect all other components of the state's demonstration. For example, these metrics will cover enrollment, disenrollment or suspension by specific demographics and reason, access to care, and health outcomes. Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances, and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the CMS framework provided by CMS to support federal tracking and analysis.
- c. 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

**35. 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 sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services, or unpaid medical bills). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

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

- a. The draft report must comply with the most current guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the Close Out Report.
- c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
- d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
- e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 29.

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

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

**38. Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the

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

## **X. GENERAL FINANCIAL REQUIREMENTS**

**39. Allowable Expenditures.** This demonstration project is approved for expenditures applicable to services rendered 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.

**40. 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 for services provided 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.

**41. 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 demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section XII: Monitoring Budget Neutrality.

- 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.

**42. Sources of Non-Federal Share.** The state certifies that its match for the non-federal share of

funds for this section 1115 demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. The state acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. The state acknowledges that any amendments that impact the financial status of this section 1115 demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

**43. State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
- e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. 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.

**44. 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.

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

| Table 4: Master MEG Chart |                                   |                |               |    |                              |
|---------------------------|-----------------------------------|----------------|---------------|----|------------------------------|
| MEG                       | To Which BN Test Does This Apply? | WOW Per Capita | WOW Aggregate | WW | Brief Description            |
| Low Income Adults         | Hypo 1                            | X              |               | X  | See Expenditure Authority #1 |

**46. 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-00342/4. Separate reports must be submitted by MEG (identified by Waiver Name) and DY (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- 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. 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.
- Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.
- 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 table below, 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 IX, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita, and as also indicated in the 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, 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 5: MEG Detail for Expenditure and Member Month Reporting |                      |            |                         |                                |            |                            |                  |                    |
|----------------------------------------------------------------|----------------------|------------|-------------------------|--------------------------------|------------|----------------------------|------------------|--------------------|
| MEG (Waiver Name)                                              | Detailed Description | Exclusions | CMS-64.9 Line(s) To Use | How Expend. Are Assigned to DY | MAP or ADM | Report Member Months (Y/N) | MEG Start Date   | MEG End Date       |
| Low Income Adults                                              | Refer to STC 16      | N/A        | Low Income Adults       | Date of service<br>OR<br>Other | MAP        | Y                          | October 15, 2020 | September 30, 2025 |

**47. Demonstration Years.** The DY for this demonstration are defined in the table below.

| Table 6: Demonstration Years |                                        |           |
|------------------------------|----------------------------------------|-----------|
| Demonstration Year 1         | October 15, 2020 to September 30, 2021 | 12 months |
| Demonstration Year 2         | October 15, 2021 to September 30, 2022 | 12 months |
| Demonstration Year 3         | October 15, 2022 to September 30, 2023 | 12 months |
| Demonstration Year 4         | October 15, 2023 to September 30, 2024 | 12 months |
| Demonstration Year 5         | October 15, 2024 to September 30, 2025 | 12 months |

**48. Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member month's 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 demonstration's actual expenditures to the budget neutrality expenditure limits described in section XI. CMS will provide technical assistance, upon request.<sup>1</sup>

<sup>1</sup> 42 CFR 431.420(a)(2) provides that 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

**49. 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.

**50. 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 letters, 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 Social Security 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 federal financial participation (FFP) for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation. The changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
- c. If, after review and/or audit, the data supplied by the state to set the budget neutrality expenditure limit are if found to be inaccurate. The state certifies that the data it provided 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.

## **XI. MONITORING BUDGET NEUTRALITY**

**51. 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 may consist

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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 in states agree to use the tool as a condition of demonstration approval.

of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, 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.

**52. Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. 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 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.

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

**54. 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), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. 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 otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, 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 a 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, during negotiations. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of

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

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

| Table 8: Hypothetical Budget Neutrality Test |                  |                                           |                                 |       |          |          |          |          |          |
|----------------------------------------------|------------------|-------------------------------------------|---------------------------------|-------|----------|----------|----------|----------|----------|
| MEG                                          | PC<br>or<br>Agg* | WOW<br>Only,<br>WW<br>Only,<br>or<br>Both | BASE<br>YEAR<br><i>[define]</i> | TREND | DY 1     | DY 2     | DY 3     | DY 4     | DY 5     |
| Low Income<br>Adults                         | PC               | Both                                      | \$556.98                        | 4.5 % | \$608.24 | \$625.74 | \$632.49 | \$658.08 | \$684.41 |

**56. 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 Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

**57. Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from October 15, 2020 – September 30, 2025. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

**58. Mid-Course Correction.** 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.

| <b>Table 9: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations</b> |                                          |                   |
|----------------------------------------------------------------------------------------|------------------------------------------|-------------------|
|                                                                                        | <b>Cumulative Target Definition</b>      | <b>Percentage</b> |
| DY 1                                                                                   | Cumulative budget neutrality limit plus: | 2.0 percent       |
| DY 1 through DY 2                                                                      | Cumulative budget neutrality limit plus: | 1.5 percent       |
| DY 1 through DY 3                                                                      | Cumulative budget neutrality limit plus: | 1.0 percent       |
| DY 1 through DY 4                                                                      | Cumulative budget neutrality limit plus: | 0.5 percent       |
| DY 1 through DY 5                                                                      | Cumulative budget neutrality limit       | 0.0 percent       |

## **XII. EVALUATION OF THE DEMONSTRATION**

- 59. Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirement that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 29.
- 60. Independent Evaluator.** Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.
- 61. Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after the start date of the demonstration approval period. The draft Evaluation Design also must include a timeline for key evaluation activities, including evaluation deliverables, as outlined in STCs 65 and 66.

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

The draft Evaluation Design must be developed in accordance with:

- a. Attachment A (Developing the Evaluation Design) of these STCs;
- b. All applicable evaluation design technical assistance, including technical assistance about the non-applicability of NEMT, copayment for non-emergent use of emergency department, the non-applicability of retroactive eligibility, and the overall demonstration sustainability.

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

**63. Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS's measure sets for eligibility and coverage, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF). Hypotheses for beneficiary account payments must relate to (but are not limited to) the following outcomes: efficient use of health services (applicable to states with beneficiary accounts only), and likelihood of enrollment and enrollment continuity. Evaluation of the effectiveness of the tobacco surcharge policy. Hypotheses for suspension for non-compliance must relate to (but are not limited to) the following outcomes: beneficiary compliance with demonstration requirements, enrollment continuity, and health status (as a result of greater enrollment continuity). Hypotheses for the non-applicability of retroactive eligibility and hospital presumptive eligibility must relate to (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, enrollment when people are healthy, and health status (as a result of greater enrollment continuity). Hypotheses for the non-applicability of NEMT must relate to (but is not limited to) the following outcomes: number of provider visits per 1,000 beneficiaries—overall and by provider type, unmet needs for medical transportation, and missed appointments. Hypotheses

for copayment for non-emergent use of emergency department (ED) must relate to (but are not limited to) the following outcomes: number of ED visits per 1,000 beneficiaries for emergent as well as non-emergent conditions, number of visits per 1,000 beneficiaries to primary care, urgent care clinic, and retail clinic, and average ED waiting time. The state's evaluation must also address ESI cost-effectiveness and cost-sharing. In addition, the state must investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated costs. Finally, the state must use results of hypothesis tests and cost analyses to assess demonstration effects on Medicaid program sustainability.

**64. 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.

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

- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
- b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted, should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- d. The state must submit the final Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
- e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

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

these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
- b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

**67. Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial, sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases in disenrollment, difficulty accessing services or unpaid medical bills). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

**68. 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.

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

**70. Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

## **Attachment A: Developing the Evaluation Design**

### **Introduction**

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

Technical assistance resources for constructing comparison groups, identifying causal inferences, phasing implementation to support evaluation, and designing and administering beneficiary surveys are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demo/evaluation-reports/evaluation-designs-and-reports/index.html>.

### **Expectations for Evaluation Designs**

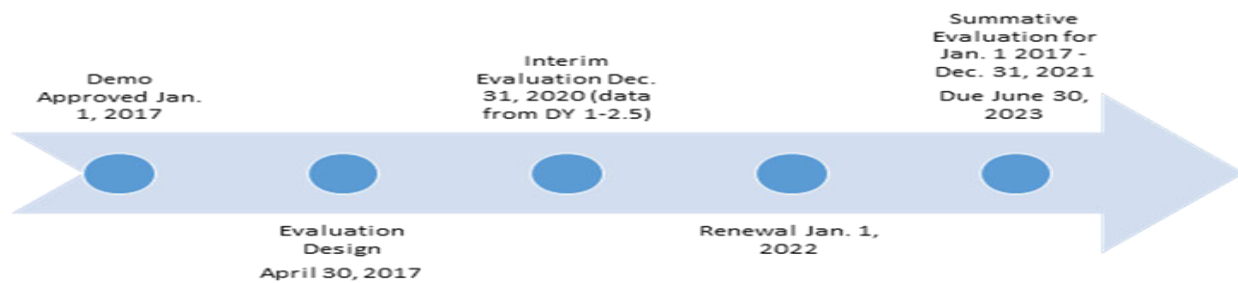
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses,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

The format for the Evaluation Design is as follows:

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

### **Submission Timelines**

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



### **Required Core Components of All Evaluation Designs**

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

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

- a. 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).
- b. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- c. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- d. 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;
- e. Describe the population groups impacted by the demonstration.

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

- a. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
- b. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended

outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams:

<https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>.

- c. Identify the state's hypotheses about the outcomes of the demonstration:
  - i. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
  - ii. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

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

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

- a. *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- b. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
- c. *Evaluation Period* – Describe the time periods for which data will be included.
- d. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
  - i. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
  - ii. Qualitative analysis methods may be used, and must be described in detail.

- a. Benchmarking and comparisons to national and state standards should be used, where appropriate.
- b. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
- c. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
- d. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- e. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources. If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).
- f. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
  - i. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
  - ii. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
  - iii. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
  - iv. The application of sensitivity analyses, as appropriate, should be considered.
- g. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

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

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

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

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

When the demonstration is:

- 1) Long-standing, non-complex, unchanged, or
- 2) Has previously been rigorously evaluated and found to be successful, or
- 3) Could now be considered standard Medicaid policy (CMS published regulations or guidance)

When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

- 1) Operating smoothly without administrative changes; and
- 2) No or minimal appeals and grievances; and

- 3) No state issues with CMS-64 reporting or budget neutrality; and
- 4) No Corrective Action Plans (CAP) for the demonstration.

#### **E. Attachments**

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

## **Attachment B: Preparing the Evaluation Report**

### **Introduction**

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

### **Expectations for Evaluation Reports**

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

### **Intent of this Attachment**

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

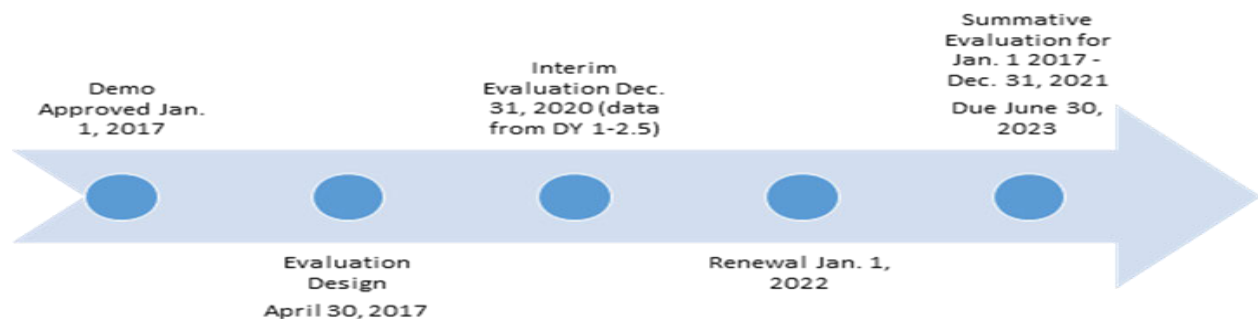
The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;

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

### Submission Timelines

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



### Required Core Components of Interim and Summative Evaluation Reports

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

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

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

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

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

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

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

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

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the

data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

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

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

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

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

- 1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
- 2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
  - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

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

judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

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

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

**J. Attachment(s)**

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

**Attachment C:**  
**Evaluation Design (reserved)**

**Attachment D:  
Implementation Plan (reserved)**

**Attachment E:**  
**Monitoring Protocol (reserved)**