

**UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION**

THE STATE OF GEORGIA; GEORGIA
DEPARTMENT OF COMMUNITY
HEALTH,

PLAINTIFFS,

v.

CHIQUITA BROOKS-LASURE, in her official
capacity as Administrator of the Centers for
Medicare and Medicaid Services; et al.,
DEFENDANTS.

CIVIL ACTION NO. 2:22-cv-6-LGW-BWC

ORAL HEARING REQUESTED

Plaintiffs' Motion for Summary Judgment and Memorandum in Support

The Centers for Medicare and Medicaid Services (CMS) has attempted a bait and switch of unprecedented magnitude on the State of Georgia that would eviscerate the terms at the heart of a carefully negotiated federal-state program. In the wake of the enactment of the Patient Protection and Affordable Care Act (ACA) and the Supreme Court's holding in *NFIB v. Sebelius*, States have a choice whether to expand their Medicaid programs to "low-income adults who did not previously qualify." *Gresham v. Azar*, 950 F.3d 93, 96 (D.C. Cir. 2020) (citing 42 U.S.C. §1396a(a)(10)(A)(i)(VIII); *NFIB v. Sebelius*, 567 U.S. 519, 583 (2012)). Georgia has not fully expanded Medicaid.

In 2019, however, Georgia decided to pursue a first-of-its-kind demonstration project under Section 1115 of the Social Security Act. After exhaustive negotiations with the federal government and multiple public comment periods, Georgia and CMS agreed to launch Georgia Pathways to Coverage. Pathways is an innovative program to provide Medicaid coverage to tens of thousands of otherwise-ineligible, low-income Georgians while also ensuring that those individuals take steps to benefit themselves and their communities through a minimum number of "qualifying hours" that can include work, job training, education, volunteering, or other similar activities. In short, Georgia agreed to a limited expansion of Medicaid coverage *only upon the express condition* that it could use qualifying

hours and activities, and a nominal premium requirement, as the pathway to coverage for the newly eligible population. CMS fully agreed with this approach in a comprehensive approval letter and the Special Terms and Conditions that govern the program.

Then CMS pulled the rug out. After the change of administration in 2021, CMS informed Georgia that it was rescinding its approval of the terms at the heart of the demonstration project, including the qualifying hours and activities requirement and a requirement that beneficiaries pay a small premium. But CMS said that the remaining part of the demonstration expanding coverage was still in place. In other words, CMS has tried to foist on Georgia unconditional Medicaid expansion.

CMS's actions flout bedrock principles of administrative law and should be set aside as arbitrary and capricious and contrary to law. CMS's actions violate *NFIB* because Georgia never voluntarily agreed to unconditional Medicaid expansion without the qualifying hours and premium payment requirements. CMS violated multiple provisions of the Social Security Act that carefully define the parameters of a Section 1115 demonstration program. And CMS's attempted bait-and-switch reflects paradigmatic arbitrary and capricious decisionmaking: it eviscerates the agreement at the core of a carefully negotiated federal-state program; uses the wrong baseline to measure the impact of the rescission; wastes years of work and millions of dollars that Georgia invested in reliance on CMS's approval; and relies on factual findings that directly contradict CMS's prior findings. The Court should enter judgment for Georgia and set aside CMS's attempted rescission.

STATEMENT

I. Overview of Medicaid.

Since 1965, the federal government and the States have worked together to provide medical assistance to certain vulnerable populations under Title XIX of the Social Security Act, commonly known as Medicaid. *See* 42 U.S.C. §1396a et seq.; *see also Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985) (Congress designed Medicaid to “subsidize []” States in “funding ... medical services for the

needy”). Medicaid is the quintessential “cooperative federalism” program. *King v. Smith*, 392 U.S. 309, 316 (1968). It is “financed largely by the federal government” but “administered by the States.” *Id.*; see also *Georgia Hosp. Ass’n v. Dep’t of Med. Assistance*, 528 F. Supp. 1348, 1351 n.1 (N.D. Ga. 1982) (“Title XIX ... provides for the establishment of cooperative Federal-State programs, commonly called ‘Medicaid,’ to provide payments for “necessary medical services” rendered to qualified ‘needy individuals whose income and resources are insufficient to meet the costs of these services.’”).

The Social Security Act charges the Secretary of Health and Human Services with administering the Medicaid program. See 42 U.S.C. §301 et seq. States that elect to participate in Medicaid must propose comprehensive State plans that meet federal requirements. See 42 U.S.C. §1396a; 42 C.F.R. §§430.10-25. “Once each plan is approved, the States ‘administer Medicaid with little to no oversight, but the federal government pays a large portion of state administrative expenses.’” *Texas v. Brooks-LaSure*, 2021 WL 5154219, at *1 (E.D. Tex. Aug. 20, 2021); see also *Georgia Hosp. Ass’n*, 528 F. Supp. at 1351 (“The various Medicaid programs, once approved, are administered by the respective States.”).

“The current Medicaid program requires States to cover only certain discrete categories of needy individuals—pregnant women, children, needy families, the blind, the elderly, and the disabled.” *NFIB*, 567 U.S. at 575. In the Patient Protection and Affordable Care Act, Congress authorized the expansion of Medicaid beyond the discrete categories originally authorized by the Social Security Act. Although expansion was mandatory under the ACA, in *NFIB v. Sebelius*, the Supreme Court held that States must have a voluntary choice whether to “expand medical coverage to low-income adults who did not previously qualify” for Medicaid. *Gresham v. Azar*, 950 F.3d 93, 96 (D.C. Cir. 2020) (citing §1396a(a)(10)(A)(i)(VIII); *NFIB*, 567 U.S. at 583).

II. Section 1115 Demonstration Projects.

Section 1115 of the Social Security Act allows States and the federal government to work collaboratively to implement innovative Medicaid programs. Although Medicaid establishes certain minimum requirements, Section 1115 allows States to deviate from them in the form of “experimental, pilot, or demonstration project[s].” 42 U.S.C. §1315(a). Section 1115 promotes the development of “experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients.” S. Rep. No. 87-1589, at 19 (1962), *reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. To this end, Section 1115 authorizes the Secretary to approve a demonstration project “which, in the judgment of the Secretary, is likely to assist in promoting the objectives” of Medicaid. *Id.*; *see also Crane v. Mathews*, 417 F. Supp. 532, 536 (N.D. Ga. 1976). The Secretary has largely delegated this authority to CMS’s Administrator. 42 C.F.R. §430.25(f)(2).

The Section 1115 application process is collaborative, exhaustive, and transparent. Section 1115 allows a State to propose an alternative plan that varies from the Social Security Act’s default requirements and serves the goals of Medicaid beneficiaries within the State. *See Forrest Gen. Hosp. v. Azar*, 926 F.3d 221, 224 (5th Cir. 2019). Such demonstration projects “provide benefits to people who wouldn’t otherwise be eligible for Medicaid benefits; and the costs of these benefits are treated as if they are matchable Medicaid expenditures.” *Id.* The application process includes separate state- and federal-level public comment periods. *Texas*, 2021 WL 5154219, at *1 (citing 42 C.F.R. §§431.408, 431.416). The Secretary must then approve or deny the demonstration application. 42 U.S.C. §1315(d); 42 C.F.R. §431.412. Only after this exhaustive process—often including extensive negotiation and compromise between CMS and the State—can a State implement a Section 1115 demonstration project.

III. Negotiation of Georgia Pathways.

Under the Supreme Court’s ruling in *NFIB*, States may choose to expand Medicaid, reject expansion altogether, or implement hybrid expansion through Section 1115 programs. Georgia has not fully expanded Medicaid. In 2019, however, Georgia decided to pursue a Section 1115 waiver for an innovative new program that would deliver coverage to tens of thousands of additional participants while also ensuring that the participants were taking steps to better themselves and their communities. *See* O.C.G.A. §49-4-142.3 (authorizing Section 1115 waiver request).

Georgia officials held meetings with CMS officials beginning in late 2019 to develop the waiver, which would include a requirement that newly eligible participants complete a minimum number of qualifying hours of work, education, job training, community service, or other similar activities to receive and maintain coverage. Starting in February 2020, CMS and the State began engaging in weekly negotiation calls to discuss various elements of Georgia’s application. Ex. 10.¹ In these exhaustive give-and-take negotiations, CMS made several recommendations to improve Georgia’s proposal. For example, CMS asked Georgia to modify its proposal to ensure that there would be coverage for participants affected by COVID-19. *Id.* at 38. Georgia responded by agreeing to excuse compliance with the qualifying hours requirement for “good cause” when a “beneficiary is quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, exposure to COVID-19, or because of a closure of the place(s) where the beneficiary was meeting the hours requirement related to COVID-19 and as a result, is unable to fulfill the hours and activities requirement.” Ex. 1 at 17-18.

These exhaustive negotiations resulted in a comprehensive plan that benefitted all stakeholders. CMS advanced its goal of expanding Medicaid coverage to individuals in Georgia who were not otherwise eligible, as Georgians with income up to 100% of the federal poverty level became

¹ All Exhibits cited in this motion are Exhibits to the declaration of Attorney Daniel Shapiro.

eligible for Medicaid benefits for the first time. And Georgia advanced its goal of sustainably increasing coverage while promoting activities to help individuals attain independence and self-reliance. In short, even though Georgia had no obligation to expand eligibility, the State worked with CMS in good faith to adopt an innovative program—including qualifying activities and a small premium payment—to deliver coverage to a new category of individuals while helping them build important skills and become more independent and self-reliant. As required by Section 1115, Georgia Pathways was subjected to two public comment periods at both the federal and state levels. Ex. 2 at 11-12.

IV. Georgia Pathways.

The compromise plan that emerged from this exhaustive negotiation, analysis, and public input is called “Georgia Pathways to Coverage.” Pathways provides Medicaid coverage to low-income adults ages 19-64 with incomes up to 95 percent of the federal poverty line (FPL) (effectively 100 percent with the 5 percent income disregard), who are not otherwise eligible for Medicaid coverage. Ex. 1 at 4.

The central component of Pathways is its pathway to Medicaid coverage for those otherwise ineligible. This pathway—the eligibility mechanism—requires that to qualify for coverage, applicants must complete a minimum of 80 hours of qualifying activities in the month prior to approval. *Id.* at 15-16. Pathways participants must then complete 80 hours of qualifying activities per month to maintain eligibility. *Id.* A wide range of activities can be used to satisfy the 80-hour requirement 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. *Id.* at 16.

Georgia agreed to provide reasonable accommodations to enable individuals with disabilities (who are not otherwise eligible for Medicaid on the basis of disability) to meet the qualifying hours

requirement. *Id.* at 18-19. Such reasonable accommodations may include an assessment to determine eligibility for another category of Medicaid assistance; referral to a State vocational rehabilitation program for assessment to determine the appropriate accommodation, which may include a reduction in the number of hours required to participate in a qualifying activity; or an alternate way to report compliance with the qualifying activities requirement. *Id.*

Georgia further agreed to allow participants who had been compliant with the qualifying hours requirement but become unable to comply for good cause to have a maximum of 120 hours of noncompliance during the benefit year. *Id.* at 17-18. Good cause includes, but is not limited to: the participant or an immediate family member is hospitalized; the participant or an immediate family member experiences a serious illness; the participant experiences a short-term injury or illness; the participant experiences the birth, adoption, or death, of an immediate family member; the participant accepts a foster child or kin-ship care placement; the participant experiences a natural or human-caused disaster (including a public health emergency); the participant has a family emergency or other life event (*e.g.*, divorce, civil legal matter, or is a victim of domestic violence); the participant is temporarily homeless; or other good cause reasons as defined and approved by the State. *Id.*

Individuals admitted to Pathways must report compliance with the qualifying hours requirement through methods including in-person confirmation, online reporting, or reporting by mail. *Id.* at 9. Georgia agreed that participants who have reported compliance for six consecutive months will be exempt from monthly reporting until they are reevaluated for eligibility during the annual redetermination period. *Id.* at 16.

Another component of the pathway to coverage is the premium payment. Most applicants with incomes between 50 and 95 percent of the FPL are required to make small initial and ongoing premium payments of up to \$11 per month. *Id.* at 12. Such applicants will have 90 days following their eligibility determination to make the initial monthly payment before their coverage begins. *Id.* at 12-

13. The premium payment helps participants build personal responsibility through contributions to their health and prepares them for transition into commercial insurance. Failure to make the initial payment results in closure of the individual's application, but the individual may reapply at any time. *Id.* at 13. The premium is on a sliding scale based on family income and is calculated to not exceed two percent of household income. *Id.* at 12. Not all Pathways participants must pay a premium, as participants with incomes below 50 percent of the FPL are exempt from this requirement. *Id.*

V. CMS's Approval of Georgia Pathways.

On October 15, 2020, CMS formally approved Pathways as a Section 1115 demonstration project. The approval letter (hereinafter "Approval") provides a comprehensive analysis of Pathways with several express factual findings explaining why the demonstration will further the objectives of the Medicaid program. Ex. 2. CMS began by identifying the objectives of the Medicaid program: "[t]o enable states to 'furnish ... medical assistance'—i.e., healthcare services—to certain vulnerable populations and to furnish those populations with rehabilitation and other services to help them 'attain or retain capability for independence or self-care.'" *Id.* at 2 (quoting 42 U.S.C. §1396-1).

CMS made several specific findings that Pathways would further the objectives of Medicaid. *First*, CMS found that "the only impacts on eligibility or enrollment will be to expand" Medicaid eligibility and coverage because Pathways "applies only to beneficiaries who previously were not eligible for Medicaid." *Id.* at 3. Thus, the demonstration "expands the Medicaid eligible population in Georgia" and "is expected to result in a significant coverage expansion in Georgia" with estimates that "approximately 64,336 individuals will enroll in Medicaid throughout the life of this demonstration." *Id.* at 8. *Second*, CMS found that the demonstration "would promote the sustainability of Georgia's Medicaid program." *Id.* at 9. By promoting such fiscal sustainability, Pathways "will provide greater access to coverage for low-income beneficiaries than would be available absent the demonstration." *Id.* *Third*, CMS found that Pathways would further Medicaid's objective of "attain[ing] or retain[ing]

capability for independence or self-care.” *Id.* at 2, 10-11 (quoting 42 U.S.C. §1396-1). CMS also found that it expects the demonstration “will result in greater financial independence for the demonstration population as well as improved health status.” *Id.* at 10.

CMS directly responded to comments asserting that participants would lose coverage, emphasizing that the demonstration’s only effect is to expand coverage and will not affect current beneficiaries: “If an applicant meets the qualifying hours and activities requirement at the time of application and thereafter, this demonstration provides a pathway to ‘opt-in’ to Medicaid coverage for an individual who, absent this demonstration, has no such pathway.” *Id.* at 12. CMS also addressed comments regarding the potential for disparate impacts by noting that the State must “identify any disparate impact” and report it to CMS as part of its ongoing monitoring activities. *Id.*

CMS responded to comments attacking the premium requirement by noting that the premiums were on a sliding scale (up to \$11 per month) and the neediest segment of participants would pay no premiums at all. *Id.* at 13. Moreover, CMS highlighted the benefits of premium payments by “provid[ing] beneficiaries with an experience similar to that of commercial insurance,” which will “build personal responsibility through financial contributions to their health.” *Id.*

CMS extensively addressed comments regarding COVID-19. CMS acknowledged the public health emergency and noted uncertainty about the future of the pandemic. *Id.* at 14. CMS explained that the demonstration specifically addresses COVID-19 by including it in the good cause exception for noncompliance with the qualifying hours requirement: “These circumstances include those that may be associated with future public health emergencies, as well as those related to beneficiaries who may be quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, or exposure to COVID-19.” *Id.* CMS also explained that Georgia will “take into account the potential closure, related to COVID-19, of the place(s) where the beneficiary was meeting the requirement and as a result, is unable to fulfill the hours and activities requirement.” *Id.* Finally, CMS noted the obvious

fact that “expanding Medicaid coverage to individuals not previously eligible will have significant positive impact on access to health care during and after a public health emergency.” *Id.*

CMS also addressed concerns regarding the reporting requirement, explaining that Pathways “provide[s] beneficiaries with multiple avenues to report their qualifying hours and activities, including an online portal, mail in or in-person.” *Id.* at 15. Moreover, CMS noted that Georgia “will also be required to accommodate beneficiaries who may have trouble reporting their hours due to a disability.” *Id.* Finally, CMS explained that “[i]f a beneficiary has a disability affecting their ability to report their required hours, the state is required to provide the beneficiary reasonable accommodations.” *Id.*

CMS extensively responded to comments alleging that Pathways suffered similar alleged flaws as other state demonstration waivers by reiterating that Pathways “only offers coverage opportunities to individuals not currently eligible for Medicaid.” *Id.* at 17. Thus “individuals who choose not to comply with the qualifying hours and activities requirement will be no worse off than they are without this demonstration.” *Id.* at 18. CMS noted the fundamental difference between Pathways, which “offers a new pathway to coverage for individuals who otherwise would not have Medicaid or other health coverage, and therefore is, by design, a significant coverage expansion” and other programs that impose work or other requirements on individuals already receiving Medicaid. *Id.*

The full parameters of the demonstration were enshrined in eighty Special Terms and Conditions (STCs) signed by Georgia and CMS. Ex. 1. On January 4, 2021, CMS and Georgia signed a supplemental agreement regarding termination or withdrawal of the demonstration. Ex. 3. The agreement begins by emphasizing that “[b]y their nature, section 1115 demonstrations represent a contract between the state and federal government.” *Id.* In this agreement, CMS and Georgia agreed to a comprehensive process affording Georgia full notice and an opportunity to be heard in the event CMS seeks to withdraw the demonstration. *Id.* Moreover, CMS promised that it “shall make the

effective date for its determination no sooner than 9 months after the date on which CMS transmits its determination to the affected State.” *Id.*

VI. Georgia’s Reliance on CMS’s Approval of Pathways.

Georgia has made earnest and good faith efforts to implement Pathways and has taken several steps in direct reliance on the Approval. *First*, the General Assembly appropriated \$65,450,836 to cover benefits for projected enrollment for the first year of the demonstration. H.B. 81 §91.9. *Second*, Georgia budgeted \$27,169,720 for fiscal year 2021 through the first quarter of 2023 for the development of the Georgia Gateway system components, improvements, and project management functions necessary for successful implementation of Pathways. Ex. 9 at 92. *Third*, Georgia hired and assigned 31 state employee personnel full-time equivalents to support Pathways implementation project activities. *Id.* at 39. *Fourth*, both before and after the Approval, Georgia had been working closely with care management organizations and vendors on program implementation activities regarding eligibility and enrollment, customer service, and general project management. *Id.* at 51.

VII. CMS’s Recission of the Pathways Approval.

In February 2021, as Georgia actively worked to implement Pathways, it received two letters from CMS. The first, on February 12, 2021, informed Georgia that CMS had “preliminarily determined that allowing work and other community engagement requirements to take effect in Georgia would not promote the objectives of the Medicaid program.” Ex. 4. The sole stated reason was COVID-19. After a one-paragraph discussion of COVID-19, CMS stated that it was “commencing a process of determining whether to withdraw the authorities approved in the Pathways to Coverage demonstration that permit the state to require work and other community engagement activities as a condition of Medicaid eligibility while leaving in place the demonstration’s ... extension of Medicaid eligibility to certain otherwise-ineligible individuals.” *Id.* The second letter, also sent on

February 12, 2021, purported to withdraw the January 4, 2021, agreement between Georgia and CMS citing “CMS’s need for flexibility to make and effectuate determinations.” Ex. 5.

On March 12, 2021, Georgia responded to these letters. Ex. 6. Georgia explained that CMS’s first letter fundamentally erred in equating Georgia’s program—which would expand eligibility to individuals not currently eligible for coverage—with other States’ work requirements for existing participants. Georgia also rebutted CMS’s reliance on COVID-19: “If anything, the COVID-19 crisis makes the qualifying hours and activities—which include work, job training, education, or volunteering—more important, not less.” *Id.* Georgia also disputed CMS’s authority to unilaterally rescind the January 4, 2021 Agreement—signed by both Georgia and CMS—because “CMS did not identify any ‘changed circumstances’ in the thirty-two days between January 4 to February 12, nor could it.” *Id.*

Pathways was set to go into effect on July 1, 2021. On June 24, in light of the uncertainty created by the preliminary determination and being concerned with the financial implication to the State by CMS’s refusal to pay its portion of the FMAP for the Pathways beneficiaries, Georgia delayed the implementation of the program. Ex. 7.

On December 23, 2021, without a public comment period, CMS sent Georgia a letter purporting to rescind Georgia’s authority to implement the qualifying activities and premium components of Pathways. Ex. 8 (“Recission”). The Recission, however, stated that it was leaving in place the part of Pathways expanding Medicaid coverage to certain able-bodied adults. Ex. 8 at 35-36. The consequence of the letter is that CMS would allow the Medicaid expansion to proceed while stripping out the qualifying hours and premium requirements that were indispensable to the State’s decision to participate in this demonstration program in the first place. The Recission cited COVID-19 as the primary reason to withdraw the premium and qualifying activities components, based on conclusions and findings that were the exact opposite of the agency’s exhaustive findings in the

Approval. *Id.* at 2-3. Notably, CMS phrased the Recission as based on its “reevaluat[ion]” of the Approval. *Id.* at 4.

VIII. Consequences of the Recission.

CMS’s Recission will have devastating consequences for Georgia and its citizens. All of the resources expended, legislation enacted, and policies established, will have been done in vain—a monumental waste of Georgia’s resources over the past three years. It is simply impossible for Georgia to implement Pathways without the qualifying activities and premium requirements. Georgia projected when it applied for the waiver that approximately 64,336 individuals would enroll in Medicaid throughout the duration of the Pathways program. Ex. 2 at 8. Sheared of the qualifying activities and premium components, however, CMS has estimated that approximately 269,000 individuals would qualify in the first year alone. Ex. 8 at 12. That is, CMS itself has estimated that its actions in the Recission would *more than quadruple* the number of individuals likely to receive coverage under Pathways. And CMS has further acknowledged that the Recission would likely “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. *Id.* at 12 n.31. As noted above, the Georgia General Assembly has appropriated only \$65,460,836 for the implementation of Pathways. H.B. 81 §91.9. Given that the Recission dramatically expands both the enrollment and cost of Pathways by multiples of the initial projections—and far in excess of the existing appropriations—Georgia would have no choice but to terminate the program altogether if the Recission is allowed to stand.

ARGUMENT

In a challenge to agency action under the APA, the question for the court on summary judgment is whether the challenging party has established that the agency’s action is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.” 5 U.S.C. §706(2)(A); *see Pres. Endangered Areas of Cobb’s History, Inc. v. U.S. Army Corps of Eng’rs*, 87 F.3d 1242, 1246 (11th Cir.

1996); 10B Charles Alan Wright et al., *Federal Practice and Procedure* 2733 (4th ed. 2013) (“Summary judgment is particularly appropriate in cases in which the court is asked to review or enforce a decision of a federal administrative agency.”).

I. The Recission Is Contrary To Law.

A. Georgia Did Not Voluntarily Consent to Medicaid Expansion Absent the Qualifying Activities and Premium Payment Requirements.

Under *NFIB*, the “legitimacy” of any Medicaid expansion program requires that Georgia “voluntarily and knowingly accepts the terms of the contract.” *NFIB*, 567 U.S. at 77 (Roberts, C.J., joined by Breyer & Kagan, JJ.). “Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system.” *Id.*; *accord id.* at 675-79 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting).

CMS’s attempt to excise the qualifying activities and premium components of Pathways flouts the holding of *NFIB*. Georgia agreed to expand coverage to a new category of individuals *only* under the carefully negotiated terms set forth in the Special Terms and Conditions. Georgia would never have agreed to unconditional expansion of Medicaid without the qualifying activities and premium requirements, and Georgia has neither the appropriations nor the staff necessary to effectuate such an expansion. *See supra* at 13. Indeed, the demonstration is nonsensical without the qualifying hours requirement as it provides the “pathway” to obtain coverage in the first place. By removing the qualifying activities and premium components, the demonstration ceases to be a Section 1115 demonstration at all and effectively becomes a condition-free expansion of Medicaid up to 100% FPL. This is not what Georgia “voluntarily and knowingly” accepted when it signed the STCs. *NFIB*, 567 U.S. at 77. Because the Recission transforms the Pathways program into an entirely different form of expansion that Georgia did not voluntarily accept, it is contrary to law and must be vacated.

B. The Act Does Not Authorize CMS to Reconsider and Rescind Approved Waivers.

CMS has only the powers conferred on it by *statute*. *La. Pub. Serv. Comm’n v. F.C.C.*, 476 U.S. 355, 374 (1986) (“[A]n agency literally has no power to act ... unless and until Congress confers power upon it.”). And CMS cannot expand those powers by *regulation*. *See, e.g., id.* (“An agency may not confer power upon itself.”); *see also Civil Aeronautics Bd. v. Delta Airlines, Inc.*, 367 U.S. 316, 334 (1961). This rule applies with special force when an agency seeks to disrupt the balance between federal and State power. *See, e.g., La. Pub. Serv. Comm’n*, 476 U.S. at 368-67. Section 1115 provides CMS with no authority whatsoever to rescind, withdraw, or reconsider an approved demonstration. It only authorizes CMS to “waive compliance with” Medicaid requirements, 42 U.S.C. §1315(a)(1), to promulgate regulations relating to demonstration projects, *id.* §1315(d)(1), (2), and to approve or disapprove extensions of demonstration projects, *id.* §1315(f). Because Section 1115 expressly authorizes approval or disapproval of a demonstration, but not the power to rescind or reconsider an existing approval, CMS lacks such power. As the Fifth Circuit has observed, “[o]nce the [Administrator] authorizes a demonstration project, no take-backs.” *Forrest Gen. Hosp.*, 926 F.3d at 233. This makes perfect sense—a demonstration project is typically a massive and expensive undertaking in the nature of a contract, and it would be profoundly inequitable to allow CMS to change the rules of a carefully negotiated program after it has already been approved.

By its own terms, the Recission is an attempt to reconsider CMS’s prior approval of Pathways. *See, e.g., Ex. 8* at 4 (“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.”). Because Congress conferred no such

reconsideration authority and precludes CMS from reopening an already approved demonstration, the Recission is beyond its statutory authority and contrary to law.

Absent statutory authorization, CMS could rely only on its “inherent authority to reconsider its decisions.” *Texas*, 2021 WL 5154219, at *8.² “Any such reconsideration must (1) be made within a reasonable time after the original decision; (2) be preceded by notice to the parties of the agency’s intent to reconsider; and (3) not be arbitrary, capricious, or an abuse of discretion.” *Id.* The Recission fails the first and third prong. *First*, the time lapse between the Approval (October 15, 2020) and the Recission (December 23, 2021) is significantly greater than a year—well beyond the reconsideration periods generally considered reasonable. *See id.* (collecting time lapse cases). Moreover, “the time lapse here is not short and reasonable from a functionalist perspective due to the intervening, reasonable reliance on the [October 2020] final approval” that “resulted from a complex negotiation process between CMS and [Georgia] and thus reasonably led [Georgia] to immediately begin intense preparation efforts for implementing the program.” *Id.* *Second*, as discussed extensively below, *infra* Sec. II, the Recission is arbitrary and capricious. Accordingly, CMS failed to carry its heavy burden of establishing the Recission is permissible under any inherent reconsideration power it may have.

C. The Recission Is Contrary To Law Because It Violates Section 1115 of the Act.

The Recission is also contrary to the text and express purposes of Section 1115 and the Social Security Act. Section 1115 authorizes the Secretary to approve “any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives” of Medicaid. *Id.* Congress enacted Section 1115 to ensure that Medicaid requirements do not “stand in the way of experimental projects designed to test out new ideas and ways of dealing with

² Because Section 1115 provides no authority for reconsideration, Georgia does not concede that CMS has inherent authority to reconsider its Approval. This argument is presented in the alternative.

the problems of public welfare recipients.” S. Rep. No. 87-1589, at 19 (1962), *reprinted in* 1962 U.S.C.C.A.N. 1943, 1961; *see also Crane*, 417 F. Supp. at 536.

In the Recission, rather than employing a no-expansion baseline, CMS analyzed Pathways against a theoretical world in which Georgia had fully expanded Medicaid. *See, e.g., Ex. 8* at 16. Moreover, CMS measured the impact of the qualifying hours requirement in Pathways against States that have fully expanded Medicaid. *Id.* at 14-16. Under that methodology, no demonstration that did not unconditionally expand Medicaid to the full eligible expansion population would *ever* pass muster because, by definition, any such demonstration program would provide less coverage than a full expansion baseline. The Recission thus eviscerates Section 1115, which—particularly in the wake of the Supreme Court’s holding in *NFIB v. Sebelius*—is designed to allow States to experiment with expansion to less than the full possible eligible population. Because CMS’s analysis in the Recission effectively imposes a full-expansion-or-no-expansion dichotomy, it is contrary to the text and purpose of Section 1115, which allows States to experiment with a middle ground such as the Pathways program.

The Recission also conflicts with any discernable purpose of the Social Security Act. Congress designed Medicaid to “subsidize[]” States in “funding ... medical services for the needy.” *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985). And the Medicaid program is designed “[t]o enable states to ‘furnish ... medical assistance’—i.e., healthcare services—to certain vulnerable populations and to furnish those populations with rehabilitation and other services to help them ‘attain or retain capability for independence or self-care.’” Approval at 2 (quoting 42 U.S.C. §1396-1). Georgia’s decision to *expand* coverage to previously ineligible populations obviously furthers these purposes.

At bottom, far from promoting the purposes of the Medicaid statutes, the Recission will ultimately result in *less* coverage. Tens of thousands of Georgians who would have become eligible under Pathways will now lose their pathway to coverage due to the Recission. And, as discussed above,

supra at 13, Georgia does not have anywhere close to the resources in its budget to implement full expansion without the qualifying hours requirement. Accordingly, the Recission will directly result in fewer Georgians receiving medical assistance under Medicaid. Moreover, the Recission undermines Georgia's efforts through the qualifying activities and premium requirements to help its citizens "attain" and "retain capability for independence [and] self-care." 42 U.S.C. §1396-1. Accordingly, the Recission is contrary to the text and purpose of the Social Security Act and Section 1115.

Finally, CMS asserted in the Recission that the Families First Coronavirus Response Act (FFCRA), Pub. L. 116-127, somehow mandates the elimination of the qualifying hours requirement. Ex. 8 at 2-3. But that argument misreads the FFCRA. That statute imposes two relevant limitations on States that accepted a temporary increase in Medicaid funding during the COVID-19 pandemic. First, the State cannot impose "more restrictive" "eligibility standards, methodologies, or procedures" than it had in place on January 1, 2020, during a quarter it receives the additional funding. *Id.* §6008(b)(1). Pathways does no such thing. As of January 1, 2020, the individuals who became eligible for coverage under Pathways were not entitled to Medicaid benefits *at all*. Thus, far from imposing "more restrictive" eligibility standards compared to January 1, 2020, Pathways would only serve to *expand* coverage to individuals not currently eligible. Second, the FFCRA requires States to ensure that a person who enrolls during the "emergency period" "shall be treated as eligible" for Medicaid "through the end of the month in which such emergency period ends." *Id.* §6008(b)(3). This provision may temporarily limit the State's ability to disenroll existing beneficiaries but imposes no limitations whatsoever on the use of a qualifying hours requirement as the pathway to initial coverage. The FFCRA is irrelevant here.

II. The Recission is Arbitrary and Capricious.

Although arbitrary and capricious review is deferential, courts are "not a rubber stamp," *In re Gateway Radiology Consultants, P.A.*, 983 F.3d 1239, 1263 (11th Cir. 2020), and are "not required to

exhibit a naiveté from which ordinary citizens are free,” *Dep’t of Com. v. New York*, 139 S. Ct. 2551, 2575 (2019). The Recission is arbitrary and capricious for several independent reasons.

First, the Recission will ultimately result in less Medicaid coverage for Georgians. In the absence of the qualifying hours and premium requirements, Georgia has neither the appropriations nor the staff to implement the expansion contained in Pathways. That means that tens of thousands of Georgians would be deprived of coverage due to the Recission. The Recission never even considers this obvious and predictable result of revoking the core components of Pathways. Because the Recission never grapples with the fact that it will ultimately result in less Medicaid coverage in Georgia and deprive tens of thousands of individuals of potential coverage, it is arbitrary and capricious. *Georgia Dep’t of Educ. v. United States Dep’t of Educ.*, 883 F.3d 1311, 1314 (11th Cir. 2018) (agency action arbitrary and capricious when it “entirely failed to consider an important aspect of the problem”).

Second, the Recission is arbitrary because it renders the demonstration nonsensical and unadministrable. The revocation of the qualifying activities component makes it impossible to effectuate the expansion because the qualifying activities requirement is the core of the waiver—it is the “pathway” to coverage in the first place. Implementing Pathways absent this requirement would eliminate the mechanism for enrolling individuals in Medicaid and, ultimately, defeat the purpose of the demonstration waiver. Simply put, without the qualifying hours and activities requirement, no one currently ineligible for Medicaid would be able to enroll in Medicaid in Georgia. *See* Ex. 6 at 3 (Georgia informing CMS that “any attempt to excise the qualifying hours and activities would make it impossible to effectuate the expansion”).

Third, the Recission relies upon factors not authorized by the Social Security Act. As noted above, the Act directs the Secretary to consider whether a demonstration would expand coverage and increase self-sufficiency and whether the demonstration would be a useful experiment in testing innovative ways to provide health insurance. But the Recission elevates a myriad of nonstatutory

factors. For example, CMS stated that the premium requirement conflicted with its “priority in advancing health equity.” Ex. 2 at 11-12. But health equity is not a statutory factor. By elevating the nonstatutory health equity concern above the statutory concern of facilitating independence—which CMS does not contest is furthered by the premium requirement—CMS has arbitrarily ignored statutory factors to further nonstatutory policy interests. *See Alabama-Tombigbee Rivers Coal. v. Kempthorne*, 477 F.3d 1250, 1254 (11th Cir. 2007) (action arbitrary and capricious when “the agency has relied on factors which Congress has not intended it to consider”); *see also Qwest Corp. v. F.C.C.*, 258 F.3d 1191, 1200 (10th Cir. 2001) (agency may not “depart from” statutory principles “altogether to achieve some other goal”).

Fourth, CMS’s removal of the qualifying hours and premium requirements is an arbitrary bait-and-switch. Under *NFIB*, Georgia had *no obligation* to expand Medicaid to individuals with incomes below 133% of the poverty line. Nonetheless, Georgia worked closely with CMS and relevant stakeholders to develop an innovative program to voluntarily expand coverage to tens of thousands of otherwise-ineligible, low-income Georgians while ensuring that those individuals were taking steps to build skills, find work, complete additional education, or volunteer in their communities. Any attempt to excise the qualifying hours requirement would arbitrarily upend the policy choices at the heart of this program. As the Supreme Court explained in *NFIB*, the “legitimacy” of any expansion of the Medicaid program requires that the State “voluntarily and knowingly accepts the terms of the contract.” 567 U.S. at 77 (Roberts, C.J., joined by Breyer & Kagan, JJ.). And “[r]especting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system.” *Id.*; *see also id.* at 675-79 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) (same). Georgia unequivocally did not “voluntarily and knowingly” agree to expand coverage absent the qualifying hours and activities and premium requirements.

Fifth, CMS’s references to the COVID-19 pandemic provide no basis to excise the qualifying hours and activities and premium requirements. Unlike programs in some other states, Georgia’s waiver does not impose any requirements on *existing* Medicaid recipients. Rather, Georgia provides a pathway for otherwise-ineligible individuals to obtain Medicaid coverage through participation in a wide range of possible activities. Thus, as CMS itself previously recognized, “expanding Medicaid coverage to individuals not previously eligible will have a significant positive impact on access to health care during and after a public health emergency.” Ex. 2 at 14.

CMS makes no attempt to explain in the Recission how *expanding* coverage in a pandemic would fail to “promote the objectives of the Medicaid program.” Ex. 8 at 7. Moreover, the COVID-19 pandemic was ongoing when CMS approved Pathways in October 2020. CMS raised specific concerns about the pandemic’s impact on potential participants throughout the waiver negotiations, and Georgia specifically addressed those concerns to CMS’ satisfaction in the STCs (by, for example, confirming that quarantining due to a COVID diagnosis or exposure would qualify as good cause for noncompliance with the qualifying hours requirement). *See* Ex. 2 at 14. CMS fails to explain why it has suddenly changed its position about the adequacy of these measures.

If anything, the COVID-19 pandemic makes the qualifying hours and activities more important, not less. In approving Pathways, CMS highlighted that “recent research during the COVID-19 pandemic indicates that factors such as a lack of economic participation, social isolation, and other economic stressors have negative impacts on mental and physical health” Ex. 2 at 1 n.1. Therefore, “incentives and requirements that increase such participation may have a positive effect on beneficiary health and economic mobility.” *Id.* Even for individuals facing economic disruption or job losses, the qualifying hours and activities requirement contains significant flexibility for participants to choose activities that will help them learn new skills and move toward independence and self-sufficiency. *See* Ex. 1, STC ¶33 (documenting seven different categories of qualifying activities). New

participants can qualify through public or private employment, including self-employment and employment as an independent contractor. They can also qualify for coverage with a variety of other pursuits. On-the-job training counts. So does participation in job readiness activities related to the preparation for employment, including GED programs, rehabilitation activities, or vocational educational training. Ex. 1 at 16. Enrollment in an institution of higher education qualifies as well. Participants can also volunteer with “public or non-profit organizations participating in projects that serve the community.” *Id.* Additionally, a participant does not even need to do any of these activities full time. Pathways requires only eighty hours per month. *See id.* at 16-17.

The program also contains a “good cause” exception for individuals enrolled in Pathways who subsequently become unable to meet their qualifying hours due to injury or illness, including illness of a family member; the birth or adoption of a child; a family emergency, such as domestic violence; the loss of housing; and several other reasons. *See id.* STC ¶36. Moreover, the “good cause” exception expressly covers Pathways participants who are quarantining due to COVID-19 exposure or unable to meet the qualifying hours and activities due to a public health emergency. *See id.* STC ¶36(h). This robust “good cause” exception directly refutes CMS’s suggestion that COVID-19 has somehow made it “infeasible” to implement the qualifying hours and activities requirement. The program’s current terms—adopted in close coordination with CMS officials—contain more than ample flexibility for individuals affected by the pandemic.

Sixth, CMS ignored the specific factual findings in the Approval and the State’s massive reliance interests. Because the Recission “rests upon factual findings that contradict those which underlay its prior policy,” and destroys the State’s reliance interests in implementing the approved program, CMS was required to provide a “more detailed justification” than the initial finding. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). But CMS does not engage with its prior factual findings at all. Indeed, CMS identifies no intervening change in the relevant facts that could justify so

extreme a change in position. Its sole reliance is on COVID-19. *See, e.g.*, Ex. 8 at 2. But the pandemic was at its height when the demonstration project was developed, negotiated, and approved. Moreover, it is flagrantly arbitrary to suggest that *expanding* healthcare coverage would be harmful in the midst of a pandemic. And, as noted, there is significant flexibility in meeting the qualifying hours requirement and numerous exceptions for individuals who cannot meet the requirement due to extenuating circumstances. Given these facts, there is a “significant mismatch” between CMS’s stated rationale and the administrative record. *Dep’t of Com. v. New York*, 139 S. Ct. 2551, 2575 (2019).

Seventh, CMS used an arbitrary and capricious baseline in evaluating the qualifying hours requirement. Because Pathways applies only to a new population not currently eligible for coverage, the appropriate point of comparison to determine if it furthered the objectives of Medicaid was a world without Pathways (*i.e.*, no expansion at all), not a hypothetical world of condition-free expansion. This error infects each of CMS’s findings in the Recission. Pathways obviously *expands* coverage to tens of thousands of otherwise-ineligible individuals—that is its very purpose. It was only by drawing a false comparison with a world that does not exist—full expansion in Georgia—that CMS could reach the counterintuitive conclusion that the qualifying hours requirement would somehow contract coverage. *Cf. Leather Indus. of Am., Inc. v. EPA*, 40 F.3d 392, 405 (D.C. Cir. 1994) (decision based on erroneous baseline arbitrary and capricious).

Eighth, and relatedly, the Recission draws a false equivalence between Pathways and other demonstration programs that attempted to impose work requirements on existing Medicaid beneficiaries. Ex. 8 at 14-16. Unlike demonstrations in the States cited by CMS, Georgia’s waiver does not impose any requirements on existing Medicaid recipients. Rather, Georgia provides a pathway for individuals to newly obtain Medicaid coverage through participation in a wide range of possible activities. CMS arbitrarily ignores the fundamental difference between Pathways and the other demonstrations.

Ninth, the Recission fails to once mention the significant resources Georgia expended and actions it took in reliance upon the Approval. Georgia's reliance interests are significant. The State has reasonably relied upon CMS's final approval to make substantial investments of time, money, and manpower in preparation to implement Pathways—all of which will be unrecoverable if the Recission is allowed to stand. *See supra* Sec. VI. Far from meeting its duty to thoroughly consider and explain why these reliance interests should be brushed aside, CMS just ignored them. *See Texas*, 2021 WL 5154219, at *8 (“In short, given the complex nature of a Medicaid plan, the State’s and third parties’ reliance on the January final approval was immediate, extensive, and reasonably so.”).

Finally, the Recission is arbitrary and capricious because its discussion of the Social Security Act serves as mere pretext for achieving the Administration’s policy goal of full, unconditional Medicaid expansion. As described above, there is a “significant mismatch” between CMS’s stated reason for rescinding the Approval—expanding Medicaid coverage—and the record, which demonstrates beyond a shadow of a doubt that it was the Approval that would expand coverage and the Recission that contracts coverage. Courts “cannot ignore the disconnect between the decision made and the explanation given.” *New York*, 139 S. Ct. at 2575. Accepting CMS’s flagrantly “contrived reasons would defeat the purpose” of judicial review. *Id.*

III. The Recission Violates the APA’s Notice and Comment Requirement.

An agency must use the same process to rescind an action as it employed to enact it in the first place. *See, e.g., Clean Water Action v. United States Envtl. Prot. Agency*, 936 F.3d 308, 312 (5th Cir. 2019) (agency must “follow the same process to revise a rule as it used to promulgate it”) (citing *Perez v. Mortg. Bankers Ass’n*, 575 U.S. 92, 100 (2015)). Indeed, where—as here, *see supra*—significant reliance interests are implicated, notice and comment is required even where an initial action was not taken with notice-and-comment procedures. *Dep’t of Homeland Sec. v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1913-14 (2020).

CMS's approval of Pathways came after two full public comment periods. Ex. 2 at 11-12. The Recission received no public comment whatsoever. The failure to provide public notice and comment is even more harmful for a Recission than Approval because both Georgia and private entities have already expended considerable time and resources in reliance on the Approval. Although Georgia was given a chance to respond to the preliminary recission determination, private parties were not. Accordingly, the Recission was made without the process required by law. *See* 5 U.S.C. §706(2)(D).

IV. The Recission Is Arbitrary and Capricious and Contrary To Law Because It Violates the Agreement of January 4, 2021, Between Georgia and CMS.

In a letter dated January 4, 2021, CMS reaffirmed its commitment to Georgia Pathways. That letter emphasized that programs like Georgia Pathways “have proven to be a cornerstone of state innovation from which new best practices can emerge and next generation program design be fostered.” Ex. 3 at 1. And the letter further affirmed that “[b]y their nature, section 1115 demonstrations represent a contract between state and federal government.” *Id.* For that reason, the letter outlined the terms and conditions through which CMS could withdraw approval of the Georgia Pathways waiver. Among other provisions, those terms outlined that “CMS shall make the effective date for its determination no sooner than 9 months after the date on which CMS transmits its determination.” *Id.* at 2. Georgia agreed to CMS's terms shortly thereafter.

Because agreements between States and CMS in the Section 1115 context are contractual in nature, CMS lacked unilateral authority to rescind the January 4 Agreement. CMS's proffered reason for that attempt is no different than its proffered reason for eliminating the qualifying activities requirement: “The current COVID-19 pandemic and economic environment ... necessitate that CMS maintain the regulatory flexibility to respond appropriately to the current or changed circumstances.” Ex. 5 at 1. Yet, CMS did not identify any “changed circumstances” in the thirty-two days between January 4 to February 12, nor could it for the reasons discussed above. Because CMS's Recission flouts the January 4 Agreement, it is contrary to law and must be set aside.

CONCLUSION

For the foregoing reasons, the Court should grant Georgia's Motion for Summary Judgment and set aside the Recission as arbitrary and capricious and contrary to law.

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Dated: March 16, 2022

CERTIFICATE OF SERVICE

I hereby certify that the foregoing motion was electronically filed with the Clerk of Court using the CM/ECF system on March 16, 2022. This motion has also been sent by electronic mail to Vinita Andrapalliyal (vinita.b.andrapalliyal@usdoj.gov) and Hannah Solomon-Strauss (Hannah.m.solomon-s Strauss@usdoj.gov) who have notified Plaintiffs' counsel that they will be representing Defendants.

/s/ Jeffrey M. Harris
Jeffrey M. Harris

**UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION**

THE STATE OF GEORGIA; GEORGIA
DEPARTMENT OF COMMUNITY
HEALTH,

PLAINTIFFS,

v.

CHIQUITA BROOKS-LASURE, in her official
capacity as Administrator of the Centers for
Medicare and Medicaid Services; et al.,
DEFENDANTS.

CIVIL ACTION NO. 2:22-cv-6-LGW-BWC

Statement of Undisputed Material Facts

Rule 56.1 of this Court's Local Rules requires a party moving for summary judgment to submit a statement of undisputed material facts. This case involves claims of unlawful agency action under the Administrative Procedure Act. Because cases brought under the Administrative Procedure Act are resolved as a matter of law based on the administrative record, this Court "is not required to resolve any facts." *Fla. Keys Citizens Coal, Inc. v. U.S. Army Corps of Eng'rs*, 374 F. Supp. 2d 1116, 1126 (S.D. Fla. 2005). Instead, "[t]he focal point for judicial review of an administrative agency's action should be the administrative record" and "the 'task of the reviewing court is to apply the appropriate ... standard of review ... to the agency decision based on the record the agency presents to the reviewing court.'" *Pres. Endangered Areas of Cobb's Hist., Inc. v. U.S. Army Corps of Engineers*, 87 F.3d 1242, 1246 (11th Cir. 1996). Plaintiffs identify below the portions of the administrative record that are material to the resolution of this case on summary judgment.

1. Starting in February 2020, CMS and the State began engaging in weekly negotiation calls to discuss various elements of Georgia's waiver application. Ex. 10.¹ In these exhaustive give-and-take

¹ All Exhibits cited in this Statement are Exhibits to the declaration of Attorney Daniel Shapiro.

negotiations, CMS asked Georgia to modify its proposal to ensure that there would be coverage for participants affected by COVID-19. *Id.* at 38. Georgia responded by agreeing to excuse compliance with the qualifying hours requirement for “good cause” when a “beneficiary is quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, exposure to COVID-19, or because of a closure of the place(s) where the beneficiary was meeting the hours requirement related to COVID-19 and as a result, is unable to fulfill the hours and activities requirement.” Ex. 1 at 17-18.

2. As required by Section 1115, Georgia Pathways was subjected to two public comment periods at both the federal and state levels. Ex. 2 at 11-12.

3. Pathways provides Medicaid coverage to low-income adults ages 19-64 with incomes up to 95 percent of the federal poverty line (FPL) (effectively 100 percent with the 5 percent income disregard), who are not otherwise eligible for Medicaid coverage. Ex. 1 at 4.

4. The central component of Pathways is its pathway to Medicaid coverage for those otherwise ineligible. This pathway—the eligibility mechanism—requires that to qualify for coverage, applicants must complete a minimum of 80 hours of qualifying activities in the month prior to approval. *Id.* at 15-16. Pathways participants must then complete 80 hours of qualifying activities per month to maintain eligibility. *Id.* A wide range of activities can be used to satisfy the 80-hour requirement 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. *Id.* at 16.

5. Georgia agreed to provide reasonable accommodations to enable individuals with disabilities (who are not otherwise eligible for Medicaid on the basis of disability) to meet the qualifying hours requirement. *Id.* at 18-19. Such reasonable accommodations may include an assessment to determine eligibility for another category of Medicaid assistance; referral to a State vocational rehabilitation

program for assessment to determine the appropriate accommodation, which may include a reduction in the number of hours required to participate in a qualifying activity; or an alternate way to report compliance with the qualifying activities requirement. *Id.*

6. Georgia further agreed to allow participants who had been compliant with the qualifying hours requirement but become unable to comply for good cause to have a maximum of 120 hours of noncompliance during the benefit year. *Id.* at 17-18. Good cause includes, but is not limited to: the participant or an immediate family member is hospitalized; the participant or an immediate family member experiences a serious illness; the participant experiences a short-term injury or illness; the participant experiences the birth, adoption, or death, of an immediate family member; the participant accepts a foster child or kin-ship care placement; the participant experiences a natural or human-caused disaster (including a public health emergency); the participant has a family emergency or other life event (*e.g.*, divorce, civil legal matter, or is a victim of domestic violence); the participant is temporarily homeless; or other good cause reasons as defined and approved by the State. *Id.*

7. Individuals admitted to Pathways must report compliance with the qualifying hours requirement through methods including in-person confirmation, online reporting, or reporting by mail. *Id.* at 9. Georgia agreed that participants who have reported compliance for six consecutive months will be exempt from monthly reporting until they are reevaluated for eligibility during the annual redetermination period. *Id.* at 16.

8. Most applicants with incomes between 50 and 95 percent of the FPL are required to make small initial and ongoing premium payments of up to \$11 per month. *Id.* at 12. Such applicants will have 90 days following their eligibility determination to make the initial monthly payment before their coverage begins. *Id.* at 12-13. Failure to make the initial payment results in closure of the individual's application, but the individual may reapply at any time. *Id.* at 13. The premium is on a sliding scale based on family income and is calculated to not exceed two percent of household income. *Id.* at 12.

Not all Pathways participants must pay a premium, as participants with incomes below 50 percent of the FPL are exempt from this requirement. *Id.*

9. On October 15, 2020, CMS formally approved Pathways as a Section 1115 demonstration project. The approval letter (hereinafter “Approval”) provides a comprehensive analysis of Pathways with several express factual findings explaining why the demonstration will further the objectives of the Medicaid program. Ex. 2. CMS began by identifying the objectives of the Medicaid program: “[t]o enable states to ‘furnish ... medical assistance’—i.e., healthcare services—to certain vulnerable populations and to furnish those populations with rehabilitation and other services to help them ‘attain or retain capability for independence or self-care.’” *Id.* at 2 (quoting 42 U.S.C. §1396-1).

10. CMS made several specific findings that Pathways would further the objectives of Medicaid. *First*, CMS found that “the only impacts on eligibility or enrollment will be to expand” Medicaid eligibility and coverage because Pathways “applies only to beneficiaries who previously were not eligible for Medicaid.” *Id.* at 3. Thus, the demonstration “expands the Medicaid eligible population in Georgia” and “is expected to result in a significant coverage expansion in Georgia” with estimates that “approximately 64,336 individuals will enroll in Medicaid throughout the life of this demonstration.” *Id.* at 8. *Second*, CMS found that the demonstration “would promote the sustainability of Georgia’s Medicaid program.” *Id.* at 9. By promoting such fiscal sustainability, Pathways “will provide greater access to coverage for low-income beneficiaries than would be available absent the demonstration.” *Id.* *Third*, CMS found that Pathways would further Medicaid’s objective of “attain[ing] or retain[ing] capability for independence or self-care.” *Id.* at 2, 10-11 (quoting 42 U.S.C. §1396-1). CMS also found that it expects the demonstration “will result in greater financial independence for the demonstration population as well as improved health status.” *Id.* at 10.

11. CMS directly responded to comments asserting that participants would lose coverage, emphasizing that the demonstration’s only effect is to expand coverage and will not affect current

beneficiaries: “If an applicant meets the qualifying hours and activities requirement at the time of application and thereafter, this demonstration provides a pathway to ‘opt-in’ to Medicaid coverage for an individual who, absent this demonstration, has no such pathway.” *Id.* at 12. CMS also addressed comments regarding the potential for disparate impacts by noting that the State must “identify any disparate impact” and report it to CMS as part of its ongoing monitoring activities. *Id.*

12. CMS responded to comments attacking the premium requirement by noting that the premiums were on a sliding scale (up to \$11 per month) and the neediest segment of participants would pay no premiums at all. *Id.* at 13. Moreover, CMS highlighted the benefits of premium payments by “provid[ing] beneficiaries with an experience similar to that of commercial insurance,” which will “build personal responsibility through financial contributions to their health.” *Id.*

13. CMS acknowledged the public health emergency regarding COVID-19 and noted uncertainty about the future of the pandemic. *Id.* at 14. CMS explained that the demonstration specifically addresses COVID-19 by including it in the good cause exception for noncompliance with the qualifying hours requirement: “These circumstances include those that may be associated with future public health emergencies, as well as those related to beneficiaries who may be quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, or exposure to COVID-19.” *Id.* CMS also explained that Georgia will “take into account the potential closure, related to COVID-19, of the place(s) where the beneficiary was meeting the requirement and as a result, is unable to fulfill the hours and activities requirement.” *Id.* Finally, CMS noted the obvious fact that “expanding Medicaid coverage to individuals not previously eligible will have significant positive impact on access to health care during and after a public health emergency.” *Id.*

14. CMS also addressed concerns regarding the reporting requirement, explaining that Pathways “provide[s] beneficiaries with multiple avenues to report their qualifying hours and activities, including an online portal, mail in or in-person.” *Id.* at 15. Moreover, CMS noted that Georgia “will also be

required to accommodate beneficiaries who may have trouble reporting their hours due to a disability.” *Id.* Finally, CMS explained that “[i]f a beneficiary has a disability affecting their ability to report their required hours, the state is required to provide the beneficiary reasonable accommodations.” *Id.*

15. CMS extensively responded to comments alleging that Pathways suffered similar alleged flaws as other state demonstration waivers by reiterating that Pathways “only offers coverage opportunities to individuals not currently eligible for Medicaid.” *Id.* at 17. Thus “individuals who choose not to comply with the qualifying hours and activities requirement will be no worse off than they are without this demonstration.” *Id.* at 18. CMS noted the fundamental difference between Pathways, which “offers a new pathway to coverage for individuals who otherwise would not have Medicaid or other health coverage, and therefore is, by design, a significant coverage expansion” and other programs that impose work or other requirements on individuals already receiving Medicaid. *Id.*

16. The full parameters of the demonstration were enshrined in eighty Special Terms and Conditions (STCs) signed by Georgia and CMS. Ex. 1. On January 4, 2021, CMS and Georgia signed a supplemental agreement regarding termination or withdrawal of the demonstration. Ex. 3. The agreement begins by emphasizing that “[b]y their nature, section 1115 demonstrations represent a contract between the state and federal government.” *Id.* In this agreement, CMS and Georgia agreed to a comprehensive process affording Georgia full notice and an opportunity to be heard in the event CMS seeks to withdraw the demonstration. *Id.* Moreover, CMS promised that it “shall make the effective date for its determination no sooner than 9 months after the date on which CMS transmits its determination to the affected State.” *Id.*

17. Georgia has made earnest and good faith efforts to implement Pathways and has taken several steps in direct reliance on the Approval. *First*, the General Assembly appropriated \$65,450,836 to cover benefits for projected enrollment for the first year of the demonstration. H.B. 81 §91.9. *Second*, Georgia budgeted \$27,169,720 for fiscal year 2021 through the first quarter of 2023 for the

development of the Georgia Gateway system components, improvements, and project management functions necessary for successful implementation of Pathways. Ex. 9 at 92. *Third*, Georgia hired and assigned 31 state employee personnel full-time equivalents to support Pathways implementation project activities. *Id.* at 39. *Fourth*, both before and after the Approval, Georgia had been working closely with care management organizations and vendors on program implementation activities regarding eligibility and enrollment, customer service, and general project management. *Id.* at 51.

18. In February 2021, as Georgia actively worked to implement Pathways, it received two letters from CMS. The first, on February 12, 2021, informed Georgia that CMS had “preliminarily determined that allowing work and other community engagement requirements to take effect in Georgia would not promote the objectives of the Medicaid program.” Ex. 4. The sole stated reason was COVID-19. After a one-paragraph discussion of COVID-19, CMS stated that it was “commencing a process of determining whether to withdraw the authorities approved in the Pathways to Coverage demonstration that permit the state to require work and other community engagement activities as a condition of Medicaid eligibility while leaving in place the demonstration’s ... extension of Medicaid eligibility to certain otherwise-ineligible individuals.” *Id.* The second letter, also sent on February 12, 2021, purported to withdraw the January 4, 2021, agreement between Georgia and CMS citing “CMS’s need for flexibility to make and effectuate determinations.” Ex. 5.

19. On March 12, 2021, Georgia responded to these letters. Ex. 6. Georgia explained that CMS’s first letter fundamentally erred in equating Georgia’s program—which would expand eligibility to individuals not currently eligible for coverage—with other States’ work requirements for existing participants. Georgia also rebutted CMS’s reliance on COVID-19: “If anything, the COVID-19 crisis makes the qualifying hours and activities—which include work, job training, education, or volunteering—more important, not less.” *Id.* Georgia also disputed CMS’s authority to unilaterally rescind the January 4, 2021 Agreement—signed by both Georgia and CMS—because “CMS did not

identify any ‘changed circumstances’ in the thirty-two days between January 4 to February 12, nor could it.” *Id.*

20. Pathways was set to go into effect on July 1, 2021. On June 24, in light of the uncertainty created by the preliminary determination and being concerned with the financial implication to the State by CMS’s refusal to pay its portion of the FMAP for the Pathways beneficiaries, Georgia delayed the implementation of the program. Ex. 7.

21. On December 23, 2021, without a public comment period, CMS sent Georgia a letter purporting to rescind Georgia’s authority to implement the qualifying activities and premium components of Pathways. Ex. 8 (“Recission”). The Recission, however, stated that it was leaving in place the part of Pathways expanding Medicaid coverage to certain able-bodied adults. Ex. 8 at 35-36. The Recission cited COVID-19 as the primary reason to withdraw the premium and qualifying activities components, based on conclusions and findings that were the exact opposite of the agency’s exhaustive findings in the Approval. *Id.* at 2-3. Notably, CMS phrased the Recission as based on its “reevaluat[ion]” of the Approval. *Id.* at 4.

22. It is impossible for Georgia to implement Pathways without the qualifying activities and premium requirements. *See* Ex. 6 at 3. Georgia projected when it applied for the waiver that approximately 64,336 individuals would enroll in Medicaid throughout the duration of the Pathways program. Ex. 2 at 8. Sheared of the qualifying activities and premium components, however, CMS has estimated that approximately 269,000 individuals would qualify in the first year alone. Ex. 8 at 12. CMS has further acknowledged that the Recission would likely “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. *Id.* at 12 n.31.

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Dated: March 16, 2022

**UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION**

THE STATE OF GEORGIA; GEORGIA
DEPARTMENT OF COMMUNITY
HEALTH,

PLAINTIFFS,

v.

CHIQUITA BROOKS-LASURE, in her official
capacity as Administrator of the Centers for
Medicare and Medicaid Services; THE
CENTERS FOR MEDICARE AND
MEDICAID SERVICES; XAVIER
BECERRA, in his official capacity as Secretary
of Health and Human Services; THE UNITED
STATES DEPARTMENT OF HEALTH AND
HUMAN SERVICES; THE UNITED STATES
OF AMERICA,

DEFENDANTS.

CIVIL ACTION NO. 2:22-cv-6-LGW-BWC

Declaration of Attorney Daniel Shapiro

I, Daniel Shapiro, pursuant to 28 U.S.C. §1746, declare the following:

1. I am over the age of eighteen, have personal knowledge of these facts, and if called, could and would testify to them. I make this declaration in support of Plaintiffs' Motion for Summary Judgment.
2. Attached as Exhibit 1 is a true and accurate copy of the Expenditure Authority for Georgia Pathways to Coverage and Special Terms and Conditions, 11-W-00342/4.
3. Attached as Exhibit 2 is a true and accurate copy of CMS's Approval Letter of October 15, 2020.
4. Attached as Exhibit 3 is the January 4, 2021, Letter from CMS to Lynnette Rhodes and attached Procedures for Withdrawing or Modifying a Section 1115 Demonstration.

5. Attached as Exhibit 4 is a true and accurate copy of the February 12, 2021, Letter from CMS to Frank W. Berry.

6. Attached as Exhibit 5 is a true and accurate copy of the February 12, 2021, Letter from CMS to Lynnette Rhodes.

7. Attached as Exhibit 6 is a true and accurate copy of the March 12, 2021, Letter from the Georgia Department of Community Health to CMS.

8. Attached as Exhibit 7 is a true and accurate copy of the June 24, 2021, Letter from the Georgia Department of Community Health to CMS.

9. Attached as Exhibit 8 is a true and accurate copy of the CMS Recission Letter dated December 23, 2021.

10. Attached as Exhibit 9 is a true and accurate copy of the August 25, 2021, Patients First Act Implementation Advance Planning Document sent from the Georgia Department of Community Health to CMS.

11. Attached as Exhibit 10 is a true and accurate copy of email exchanges between Georgia staff and CMS staff between February 7, 2020, and July 31, 2020.

12. Attached as Exhibit 11 is a true and accurate copy of the Georgia Department of Community Health's Application for a Section 1115 Demonstration Waiver dated December 23, 2019.

I declare under penalty of perjury that the above is true and correct to the best of my knowledge.

Executed on this 16th day of March, 2022

/s/ Daniel J. Shapiro

Exhibit 1

**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. Eligibility and Reasonable Promptness

**Section 1902(a)(8)
and 1902(a)(10)(A)**

To the extent necessary to enable the state to require qualifying hours and activities and premium payments as a condition of eligibility as described in the STCs.

To the extent necessary to enable the state to begin Medicaid coverage on the first day of the month following receipt of a beneficiary’s initial premium payment and verification of compliance with the qualifying hours and activities requirement as described in the STCs.

2. 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.

3. Provision of Medical Assistance

Section 1902(a)(8)

To the extent necessary to suspend and terminate eligibility for individuals who fail to comply with the qualifying hours and activities requirement as described in the STCs.

4. 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.

5. Premiums

**Section 1902(a)(14)
insofar as it
incorporates
Sections 1916 and
1916A**

To the extent necessary to enable the state to require monthly premium payments, as described in the STCs.

6. Comparability

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

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

7. Retroactive Eligibility

Section 1902(a)(34)

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

8. 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. Qualifying Hours and Activities Requirement
- X. General Reporting Requirements
- XI. General Financial Requirements
- XII. Monitoring Budget Neutrality
- XIII. 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.

As a condition of eligibility, individuals must complete a minimum of 80 hours of qualifying activities monthly unless they require a reasonable accommodation due to a disability or experience a circumstance that gives rise to good cause for non-compliance after enrollment. Applicants and beneficiaries may satisfy the qualifying hours and activities requirement through a variety of qualifying activities described in these STCs. Certain applicants will also be required to make a premium payment within 90 days of the eligibility determination before Medicaid coverage will begin, unless they meet the criteria for an exemption from the premium payment requirement as described in these STCs.

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. At the point of application, individuals must report and provide documentation for meeting the qualifying hours and activities requirement for the month prior to application unless the individual self-attests to having a disability in their Medicaid application, in which case they would be considered for a reasonable accommodation. Applicants and beneficiaries can report compliance with the qualifying hours and activities requirement for the month prior to application by self-attestation, accompanied by the submission of supporting documentation online or in-person. Eligible individuals will receive an approval notice and an initial premium packet and must also pay their initial monthly premium (if applicable) as set forth in STC 25 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.
- a. Beneficiaries with household income from 0 up to 50 percent of the FPL do not have an initial and monthly premium payment requirement and their Medicaid coverage will begin the first day of the month following the state's eligibility determination.
 - b. Beneficiaries with income at 50 percent up to 95 percent (effectively 100 percent with the 5 percent income disregard) of the FPL are required to make an initial and ongoing sliding scale monthly premium payments based on their household income as described in STC 25. Individuals will have ninety (90) days following their initial eligibility determination to make their first premium payment. Failure to make a payment during the ninety (90) day payment period will result in closure of the beneficiary's application as specified in STC 28. Individuals may reapply at any time. For individuals who make an initial premium payment, Medicaid coverage will begin the first day of the month following the initial premium payment. Beneficiaries must continue to make ongoing monthly premium payments as described in STCs 25-28, for continued Medicaid coverage.

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 HIPPP 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 HIPPP) will be provided with a Member Rewards Account (MRA). The MRA is an educational tool used to “deduct” beneficiary copayments, reflect accrued premium payment amounts (if applicable), 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 premium payments or 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, premium credits, 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 premium payments (if applicable) or 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 \$1.00 for rentals and supplies
Pharmacy – Copayment varies based on the cost to the state.	\$10.00 or less: \$0.50 \$10.01 to \$25.00: \$1.00 \$25.01 to \$50.00: \$2.00 \$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 42

CFR 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. Premiums.** All beneficiaries, except beneficiaries described in Table 2 and beneficiaries exempt from premiums as described in 42 CFR 447.56, will be required to make initial and ongoing premium payments based on household income as described in Table 3 below. Premiums rates will not exceed two percent of the beneficiary's household income. Premium payments will be reflected in the beneficiary's MRA and a premium surcharge will apply to beneficiaries who use tobacco as described in STC 26(a).

Table 2. Populations Exempt from Premium Payments
Beneficiaries with employer-sponsored insurance enrolled in HIPP.
Beneficiaries enrolled in vocational education programs of highly sought-after trades through the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant programs. Beneficiaries are also exempt from premiums for two months after graduation.
Beneficiaries with income less than 50 percent of the FPL.

- 26. Eligibility.** Beneficiaries must meet the eligibility requirements specified in these STCs and pay the first monthly premium (unless they are exempt from premium payments) in order for Medicaid coverage to begin. Individuals will have ninety (90) days following the initial eligibility determination to make their first premium payment, if applicable. Failure to make the initial payment within ninety (90) days will result in closure of the individual's case. Individuals required to pay premiums will not be enrolled in Medicaid until the initial premium payment has been made. Table 3 provides the monthly premium and tobacco surcharge amounts based on income. The state will determine the beneficiary's monthly premium amount based on the beneficiary's modified adjusted gross income.
- a. **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 3 below. This surcharge is a separate deduction from the beneficiary's MRA and is not assessed with the monthly premium payment. 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 3. Premium and Tobacco Surcharge Amounts		
Income	Monthly Single Premium	Tobacco Surcharge
From 50 percent up to 85 percent FPL	\$7.00	\$3.00
From 85% and up to 95 percent FPL (effectively 100 percent)	\$11.00	\$5.00

with the 5 percent income disregard)		

27. Premium Notices. The state must notify applicants of the premium payment requirement at the time of their eligibility determination. Applicants will receive an initial premium packet with information about premium payment due dates; how to report changes in income; the time period over which income is calculated (e.g., monthly income); the deadline for reporting a change in circumstances; the consequences of non-payment (including the date of termination for failure to pay) and the consequences of failing to report changes in circumstance that could affect eligibility. Applicants will also be informed that once the premium payment is made the beneficiary may only change MCOs for cause, except during the beneficiary's annual enrollment opportunity. If a beneficiary misses a monthly premium payment deadline, they will receive a reminder notice outlining the missed payment, the deadline for the late payment, and the consequences of non-payment, including the date of suspension or disenrollment for failure to pay. The state will provide beneficiaries with advance notice of any adverse action prior to the date of action, consistent with 42 CFR 435.917 and 42 CFR part 431 subpart E.

28. Missed Premium Payments. Beneficiaries who miss one or two subsequent premium payments after making the initial premium payment will be granted a maximum of two grace period months in a benefit year. Beneficiaries will be given the following opportunities to avoid suspension and disenrollment and to prospectively reinstate coverage as described below:

- a. Grace Period. Beneficiaries who miss a premium payment will be given a two-month grace period and coverage will continue. There is a maximum of two grace period months in a benefit year. Payments made during the grace period will be applied to the following month. All missed premiums during a beneficiary's grace period will be forgiven at redetermination and the beneficiary's grace period will reset for the new certification year.
- b. Suspension. Beneficiaries who miss a total of three premium payments in a benefit year will have coverage suspended for up to ninety (90) days if they fail to make a payment before the next due date, except for beneficiaries who are in a grace period at the time of redetermination as described in STC 28(c). Beneficiaries will have ninety (90) days from the date of suspension to submit a payment in order to prospectively reinstate coverage. Beneficiaries who fail to make a payment within ninety (90) days of the suspension date will be disenrolled from Medicaid and will need to reapply for coverage.
- c. Redetermination. If at any time, including at redetermination, the state is made aware of a change in the beneficiary's income during the current enrollment period, the state will evaluate whether the beneficiary's premium amount should be adjusted. Outstanding premium payments from the prior benefit year will be forgiven.

29. Beneficiary and State Contributions: State Assurances. Prior to the implementation of the premium requirement as a condition of eligibility at the time of application and for continued eligibility, the state shall make the general assurance that it is in compliance with protections for beneficiaries related to STC 28, and will:

- a. Permit the state or the MCO to attempt to collect the unpaid premiums from the beneficiary, but the state or the MCO will not report the premium amount owed to credit reporting agencies, place a lien on a beneficiary's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the beneficiary's earnings for enrollees at any income level. The state will not "sell" the obligation for collection by a third-party. Further, while the amount is collectible by the state, re-enrollment is not conditioned upon repayment.
- b. Monitor that beneficiaries do not incur household cost sharing and premiums that, when combined, exceed 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, and the premium amount will be reduced for the remainder of the quarter to retain access to the My Rewards Account.
- c. Charge copayment amounts, if applicable, that do not exceed Medicaid cost sharing permitted by federal law and regulation and the terms of this demonstration.
- d. 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.
- e. Ensure that all payments from the beneficiary, or on behalf of the beneficiary, are accurately credited toward unpaid premiums in a timely manner, and provide the beneficiary an opportunity to review and seek correction of the payment history.
- f. Ensure that the state has a process to refund any premiums paid for a month in which the beneficiary is ineligible for Medicaid services for that month.
- g. Ensure that a beneficiary will not be charged a higher premium the following month due to nonpayment or underpayment of a premium in the previous month(s), except that amounts outstanding and due from the previous month/s may be reflected separately on subsequent invoices.
- h. Ensure the state notifies beneficiaries whose eligibility has been suspended for failure to meet the qualifying hours and activities requirement, and provide written notice to prevent overpayment of premiums.
- i. Conduct outreach and education to beneficiaries to ensure that they understand the program policies regarding qualifying hours and activities, good cause, premiums and associated consequences for nonpayment. Beneficiaries must be informed of how premium payments should be made; the potential impact of a change in income on premium payments owed; the consequences of failure to report a change in income or circumstances that affect eligibility; the time period over which income is calculated (e.g., monthly income); the deadline for reporting changes in circumstances; and how to reenroll if disenrolled for non-payment of premiums.
- j. Provide all applicants timely determinations of eligibility in accordance with 42 CFR 435.912.
- k. 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.

- l. 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.
- m. Provide all applicants and beneficiaries with fair hearing rights consistent with 42 CFR part 431, subpart E.
- n. Ensure program information is available, and accessible in accordance with 42 CFR 435.901 and 435.905.
- o. Provide beneficiaries written notice of requirements to qualify for reactivation of Medicaid coverage following suspension or disenrollment due to non-payment of premiums described in STC 33.
- p. Provide notice (consistent with 42 CFR 435.917 and 431.206-214) in advance of any adverse action, including information about the suspension period with an explanation of what the status means, including but not limited to: the right to appeal; the right to apply for Medicaid on a basis not affected by this status; what the suspension status means with respect to the ability to access other coverage (such as coverage in a qualified health plan through the Exchange, or access to premium tax credits through the Exchange); 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.
- q. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable accommodations related to premium payments.
- r. Maintain a system that identifies, confirms, and provides reasonable accommodations related to the obligation to pay premiums to beneficiaries with disabilities protected by the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Patient Protection and Affordable Care Act.
- s. 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

30. 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.

31. 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. QUALIFYING HOURS AND ACTIVITIES REQUIREMENT

32. Overview. As a requirement for eligibility, applicants must complete a minimum of 80 hours of qualifying activities, as described in STC 33 before Medicaid coverage will begin. As a condition of maintaining Medicaid eligibility, beneficiaries will be required to continue

meeting the qualifying hours and activities requirement and report compliance, as specified in STC 34, unless they require a reasonable accommodation due to a disability as described in STC 37, or experience a circumstance that gives rise to good cause for non-compliance after enrollment, as described in STC 36.

- 33. Qualifying Activities.** Beneficiaries may satisfy their qualifying hours and activities requirement through participation in one or more of the following activities:
- a. Subsidized or unsubsidized public or private sector employment, including self-employment and employment as an independent contractor;
 - b. On-the-job-training in the public or private sector;
 - c. Participation in job readiness activities directly related to the preparation for employment, including habilitation and rehabilitation activities and GED programs;
 - d. Community service with public or non-profit organizations participating in projects that serve the community;
 - e. Vocational Educational Training limited to 12 months in a beneficiary's lifetime, unless a beneficiary is enrolled in vocational education for a highly sought-after trade through the Technical College System of Georgia High Demand Career Initiative (in this instance, vocational education training may count as a qualifying activity for the duration of the vocational education program);
 - f. Enrollment in an institution of higher education, (qualifying activity hours earned will vary based on course load); and
 - g. Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program, as long as the beneficiary has been determined eligible for GVRA services based upon a documented disability and remains in compliance with the terms of the GVRA program.

34. Hour Requirements and Reporting. All applicants must be in compliance with the 80 hour qualifying activities and income eligibility requirements for the month prior to the application to be enrolled. Applications of individuals not in compliance with the qualifying hours and activities requirement at the time of application will be denied if the individual is not eligible for any other category of assistance. The individual may reapply at any time. Applicants and beneficiaries who report a disability at the point of application, or after initial eligibility, and who are not eligible for any other category of assistance based on their disability, may request a reasonable accommodation to assist with meeting the qualifying hours and activities as described in STC 37. An individual whose application is denied will receive information regarding other resources or activities to assist in meeting the hours and activities requirements and may reapply at any time. Beneficiaries must report their qualifying hours and activities monthly, except as specified below. Beneficiaries who report their qualifying hours and activities, and demonstrate that they meet these requirements, for six (6) consecutive months will be exempt from the monthly reporting requirement for the remainder of the beneficiary's 12-month benefit year. The state will perform periodic and random audits to verify documentation and compliance with qualifying hours and activities. Beneficiaries who no longer have to report compliance monthly are still required to report changes in circumstance such as income, employment or other qualifying activities that impact eligibility.

- 35. Non-Compliance.** Applicants who do not comply with the qualifying hours and activities requirement as described in STCs 32-34, and who do not have a reasonable accommodation due to a disability reported at the time of application as described in STC 37, will have their application denied if they do not qualify for any other category of assistance. Beneficiaries who are enrolled in the demonstration and fail to meet the qualifying hours and activities requirement, and who do not have a reasonable accommodation due to a disability, or do not have a circumstance that gives rise to good cause, will have their eligibility suspended.
- a. Suspension Effective Date. Beneficiaries who fail to comply with the qualifying hours and activities requirement as described in STCs 32-34 and who do not have a circumstance that gives rise to good cause, will have eligibility suspended on the first day of the month following notification to the beneficiary of his or her non-compliance, consistent with the requirements in 42 CFR 431.211 and will have ninety (90) days from the notice of suspension to meet the qualifying hours and activities requirement for the suspension to be lifted.
 - b. Reinstatement Following Non-Compliance. Beneficiaries may have coverage prospectively reinstated after a suspension if the beneficiary provides verification of compliance with the qualifying hours and activities requirement for one month. Coverage will be prospectively reinstated in the month immediately following the month in which a beneficiary meets the qualifying hours and activities requirements.
 - c. Disenrollment and Re-enrollment Following Non-Compliance. Beneficiaries who do not meet the qualifying hours and activities requirements within the ninety (90) day suspension period will be disenrolled and can reapply for coverage at any time.
- 36. Good Cause.** The state will consider a beneficiary who has been compliant with the qualifying hours and activities requirement for good cause if the beneficiary demonstrates a need for the good cause as a result for failing to meet or report the qualifying hours and activities requirement for that month. Beneficiaries may request a good cause from the qualifying hours and activities requirement up to a maximum of 120 hours during a 12 month benefit year. The circumstances constituting good cause must have occurred during the month for which the beneficiary is seeking a good cause exception. The circumstances that may give rise to good cause include, but are not limited to, the following verified circumstances:
- a. The beneficiary or an immediate family member experiences a hospitalization or a serious illness and as a result, is unable to fulfill the qualifying hours and activities;
 - b. The beneficiary experiences a short-term injury or illness and as a result, is unable to fulfill the qualifying hours and activities;
 - c. The beneficiary experiences the birth, adoption, or death, of an immediate family member;
 - d. The beneficiary accepts a foster child placement, including those in kinship care;
 - e. The beneficiary experiences a natural or human-caused disaster (including a public health emergency declared by the state in the county the person resides) and as a result, is unable to meet the requirements;
 - f. The beneficiary has a family emergency or other life event (e.g., divorce, civil legal matter, or is a victim of domestic violence) and as a result, is unable to fulfill the hours and activities requirements;

- g. The beneficiary is temporarily homeless and as a result, is unable to fulfill the hours and activities requirements;
- h. The beneficiary is quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, or exposure to COVID-19, or because of a closure of the place(s) where the beneficiary was meeting the hours requirement related to COVID-19 and as a result, is unable to fulfill the hours and activities requirement; or
- i. Other good cause reason(s) as defined and approved by the state.

37. Reasonable Accommodations. The state must provide reasonable accommodations to individuals with disabilities protected by the ADA, Section 504 of the Rehabilitation Act and Section 1557 of the Patient Protection and Affordable Care Act, who are unable to meet the qualifying hours and activities requirement either at the time of application, or after enrollment in the demonstration.

- a. Reasonable accommodations may include:
 - i. Modified activities hours when a beneficiary or applicant is unable to participate due to the otherwise-required number of hours if agreed upon by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity;
 - ii. Other accommodations that have been agreed upon by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity;
 - iii. Alternative mechanisms to report compliance; and
 - iv. Support services necessary to participate; including, referrals to state programs currently providing rehabilitation services for individuals with disabilities
- b. The state must also provide reasonable accommodations and protections for program procedures, including but not limited to: understanding notices and program rules related to the qualifying hours and activities requirement; documenting qualifying hours and activities; assistance with demonstrating eligibility; circumstances that give rise to good cause; appealing disenrollments; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable accommodations.
- c. Disability Reported at Application. If an individual has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and is unable to meet the qualifying hours and activities requirement for reasons related to that disability at the time of application, the state will determine if the individual is eligible for another eligibility category. If the individual is not eligible for another eligibility category, the beneficiary will be referred to a state rehabilitation services program for individuals with disabilities. If the individual accepts the referral and meets the program requirements set by the referral agency within (90) days, the individual will be determined eligible for the demonstration.
- d. Disability Reported After Enrollment. If beneficiary becomes unable to meet the qualifying hours and activities requirement after enrollment due to a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act, or due to having to care for a family member with a disability defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act, the state will:

- i. Modify the number of hours of required for participation if agreed upon by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity;
 - ii. Provide other accommodations that have been agreed to by the beneficiary and their employer, supervisor, or other representative of the organization that is providing the qualifying activity, alternative mechanisms to report compliance; and/or
 - iii. Provide support services, including referrals to state programs currently providing rehabilitation services for individuals with disabilities.
- e. Beneficiary Compliance with Reasonable Accommodation. If a beneficiary participates in a qualifying program that provides rehabilitation services and meets the activities requirements determined by the program, the beneficiary will continue to receive Medicaid enrollment under the demonstration.
- f. Beneficiary Non-Compliance with Reasonable Accommodation. Beneficiaries who are offered a reasonable accommodation and are unwilling to comply with the qualifying hours and activities requirement with the reasonable accommodation provided by the state, their employer, supervisor, or representative of the organization that provides the qualifying activity, will be reevaluated by the state to determine eligibility for another Medicaid eligibility. If the beneficiary declines the states proposed accommodation, the beneficiary's Medicaid coverage will be terminated, subject to the beneficiary's appeal rights.

38. Qualifying Hours and Activities: State Assurances. Prior to implementing the qualifying hours and activities requirement as a condition of eligibility at the time of application and for continued eligibility after enrollment, the state shall:

- a. Ensure that there are processes and procedures in place to stop or recoup payments to an MCO when a beneficiary is suspended for failure to comply with program requirements and to trigger payment when eligibility is reinstated.
- b. Ensure, to the maximum extent practicable, that there are processes and procedures in place to seek data from other sources, including SNAP and TANF, regarding a beneficiary's potential satisfaction of the qualifying hours and activities requirement and systems to permit beneficiaries to efficiently report qualifying hours and activities or demonstrate circumstances that give rise to good cause, in accordance with 42 CFR 435.907(a), 435.916(c), and 435.945, and to permit the state to monitor compliance.
- c. Ensure that activities that may be used to satisfy qualifying hours and activities requirement are available during a range of times and through a variety of means (e.g., online, mail, in person, by telephone) at no cost to the beneficiary.
- d. Ensure that beneficiaries have been screened and determined ineligible for all other bases of Medicaid eligibility prior to disenrollment or denial of eligibility and reviewed for eligibility for insurance affordability programs in accordance with 42 CFR 435.916(f).
- e. Maintain system capabilities to operationalize both the suspension of eligibility and the prospective reinstatement of eligibility once the qualifying hours and activities requirement is met as described in STC 36.
- f. Provide outreach and education to inform new applicants about the qualifying hours and activities requirement and how the requirement must be satisfied beginning at the time of

application.

- g. Ensure that there are timely and adequate beneficiary notices provided in writing consistent with 42 CFR 435.917(a), 435.905(b), and 431.206-214, including but not limited to:
 - i. The specific number of qualifying hours per month that a beneficiary is required to complete, and when and how the beneficiary must report participation or request a good cause exception;
 - ii. A list of the specific qualifying activities that must be used to satisfy the qualifying hours and activities requirement and a list of the specific activities that beneficiaries can engage in;
 - iii. Information about resources that help connect beneficiaries to opportunities for activities that would meet the qualifying activities and information about the community supports that are available to assist beneficiaries in meeting their qualifying hours and activities;
 - iv. Information about how qualifying hours will be counted and documented;
 - v. Information about what gives rise to a suspension of eligibility, what suspension of eligibility would mean for the beneficiary, including how it could affect redetermination, and how to avoid suspension, including how to apply for good cause exception and what kinds of circumstances might give rise to good cause;
 - vi. If a beneficiary has sought to demonstrate good cause, that the good cause has been approved or denied with an explanation of the basis for the decision and how to appeal a denial;
 - vii. If a beneficiary is not in compliance, that the beneficiary is out of compliance, and, if applicable, how the beneficiary can resume compliance in the month immediately following in order to avoid suspension of eligibility;
 - viii. If a beneficiary is suspended, information on how to appeal that decision and/or how to demonstrate compliance so that coverage can be reinstated or reapply for Medicaid benefits if the beneficiary has been disenrolled; and
 - ix. The right of individuals with disabilities to establish reasonable accommodations of their qualifying hours and activities with examples of the reasonable accommodations in those requirements to which individuals may be entitled, including, assistance with documenting participation, referrals for vocational rehabilitation services or accommodations through a state program, good cause exceptions if after initial eligibility an individual becomes unable to participate for a disability-related reason, and if applicable, reductions in hours of required participation if an individual is unable to participate in the otherwise required numbers of hours.
- h. Provide full fair hearing rights as required under 42 CFR part 431 subpart E prior to suspension or dis-enrollment, and observe all requirements for due process for beneficiaries whose eligibility will be suspended, denied, or terminated for failing to meet the qualifying hours and activities requirements, including allowing beneficiaries the opportunity to raise additional issues in a hearing, including whether the beneficiary should be subject to the suspension or disenrollment, and provide additional documentation through the appeals process.
- i. Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the

state, consistent with all applicable Medicaid requirements.

- j. Develop and implement an outreach strategy to inform applicants and beneficiaries about the qualifying hours and activities requirement, how to report compliance with or request good cause exceptions from the qualifying hours and activities requirements and how to report changes in circumstances. Notices provided at enrollment, and suspension will provide information on resources available to beneficiaries who may require assistance reporting compliance with qualifying activities, requesting good cause exceptions, or reporting changes in circumstances.
- k. Establish beneficiary protections, including assuring to the maximum extent practicable, that beneficiaries do not have to duplicate requirements, if applicable, to maintain access to all public assistance programs that require employment or another form of qualifying hours and activities.
- l. Make good faith efforts to connect beneficiaries to existing community supports that are available to assist beneficiaries in meeting their qualifying hours and activities, including available non-Medicaid assistance with transportation, child care, language access services and other supports.
- m. Ensure the state assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with a lack of public transportation to determine whether there should be further good cause exceptions from the qualifying hours and activities requirement and/or additional mitigation strategies, so that the qualifying hours and activities requirement will not be unreasonably burdensome for applicants and beneficiaries to meet.
- n. Develop and maintain an ongoing partnership with the Georgia Department of Community Health and other state entities such as the Georgia Department of Labor, the Department of Behavioral Health and Developmental Disabilities, and the Georgia Vocational Rehabilitation Agency, to assist recipients with identifying and accessing opportunities for workforce training, complying with qualifying hours and activities, and moving toward independence and self-sufficiency.
- o. Provide each beneficiary who has been disenrolled from Medicaid with information on how to access primary care and preventative care services at low or no cost to the beneficiary. This material will include information about free health clinics and community health centers including clinics that provide behavioral health and substance use disorder services. Georgia shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries who have lost coverage.
- p. Make the general assurance that the state is in compliance with protections for beneficiaries related to STC 37 and:
 - i. Make good faith efforts to connect beneficiaries with disabilities as defined above with services and supports necessary to enable them to meet their qualifying hours and activities;
 - ii. Maintain a system that provides reasonable accommodations related to meeting the qualifying hours and activities to beneficiaries with disabilities as defined above;
 - iii. Ensure the state will assess whether people with disabilities have limited job or other opportunities for reasons related to their disabilities. If these barriers exist

- for people with disabilities, the state will consider further good cause exceptions from the qualifying hours and activities requirement;
- iv. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable accommodations related to meeting the qualifying hours and activities requirements; and
- v. 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.

X. GENERAL REPORTING REQUIREMENTS

39. 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.

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

41. 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.

42. 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 qualifying hours and activities requirements, premiums, and 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.

43. 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 47 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 qualifying hours and activities requirements, premiums and 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 47 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.

44. 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 qualifying hours and activities, premiums, including 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, participation in the qualifying hours and activities requirement, 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 how they were addressed.

45. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. 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.

46. 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 39.

47. 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.

48. 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.

XI. GENERAL FINANCIAL REQUIREMENTS

49. 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.

50. 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.

- 51. 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.
- 52. 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.
- 53. 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.

54. 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.

55. 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

56. 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.

- a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the DY will be offset against expenditures incurred in the DY for determination of the state's compliance with the budget neutrality limits.
- c. 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.
- d. 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.
- e. 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.

- f. 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 OR Other	MAP	Y	October 15, 2020	September 30, 2025

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

Table 6: Demonstration Years

Demonstration Year	Demonstration Period	Duration
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

58. 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.¹

¹ 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

59. 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.

60. 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.

XII. MONITORING BUDGET NEUTRALITY

61. 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

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.

- 62. 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.
- 63. 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.
- 64. 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.

65. 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 or Agg*	WOW Only, WW Only, or Both	BASE YEAR [define]	TREND	DY 1	DY 2	DY 3	DY 4	DY 5
Low Income Adults	PC	Both	\$556.98	4.5 %	\$608.24	\$625.74	\$632.49	\$658.08	\$684.41

66. 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.

67. 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.

68. 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.

Table 9: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
	Cumulative Target Definition	Percentage
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

XIII. EVALUATION OF THE DEMONSTRATION

69. 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 39.

70. 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.

71. 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.

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

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

- a. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing CE Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.
- b. All applicable evaluation design guidance, including guidance about qualifying hours and activities requirements, premiums, the non-applicability of NEMT, copayment for non-emergent use of emergency department, the non-applicability of retroactive eligibility, and the overall demonstration sustainability.

72. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as 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.

73. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS's measure sets for eligibility and coverage (including qualifying hours and activities requirements), 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 qualifying hours and activities requirements must relate to (but are not limited to) the following outcomes: employment levels, income, transitions to commercial health insurance, and health status. Hypotheses for premiums and beneficiary account payments must relate to (but are not limited to) the following outcomes: beneficiary familiarity with premiums as a feature of commercial coverage, efficient use of health services (applicable to states with beneficiary accounts only), and likelihood of enrollment and enrollment continuity. Evaluation of premiums must also account for 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.

74. 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.

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

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

receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

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

76. 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.

77. 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.

78. 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.

79. 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.

80. 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

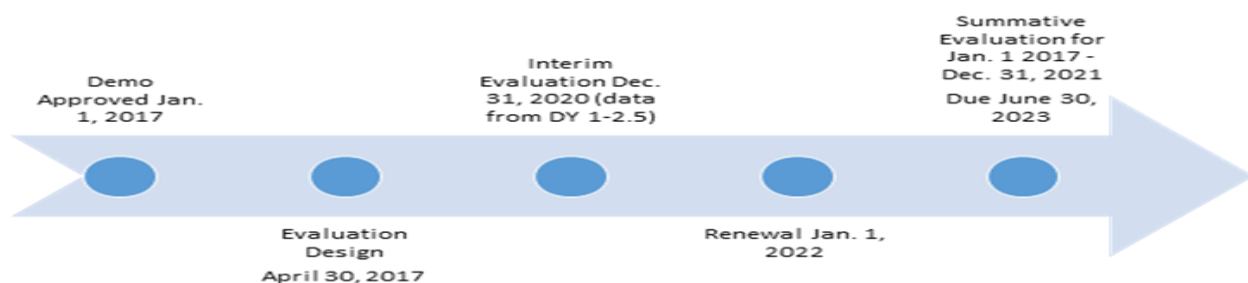
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, 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
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

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

- 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.

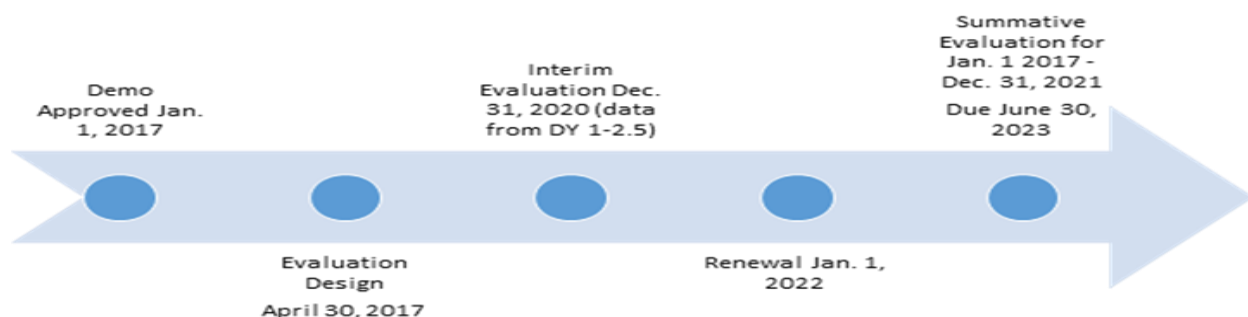
The format for the Interim and Summative Evaluation reports is as follows:

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)

Exhibit 2



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

October 15, 2020

Frank W. Berry
Commissioner
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, Georgia 30303-3159

Dear Mr. Berry:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services 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, including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not “stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients.” S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. As relevant here, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Georgia’s request to expand Medicaid coverage to individuals who meet specified additional requirements beyond those described in the state plan through a section 1115 demonstration project entitled, “Georgia Pathways to Coverage” (Project Number 11-W-00342/4), in accordance with section 1115(a) of the Act.

This approval is effective October 15, 2020, through September 30, 2025, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS’s approval of this section 1115(a) demonstration is subject to the limitations specified in the attached expenditure authorities, Special Terms and Conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may implement the demonstration effective July 1, 2021.¹ The state may

¹ While it cannot be known what the status of the current public health emergency for COVID-19 will be when the demonstration is implemented in 2021, it is worth noting that recent research during the COVID-19 pandemic indicates that factors such as a lack of economic participation, social isolation, and other economic stressors have negative impacts on mental and physical health. Structured properly, incentives and requirements that increase such participation may have a positive effect on beneficiary health and economic mobility. See, e.g., Nirmita Panchal et al., *The Implications of COVID-19 for Mental Health and Substance Use*, Kaiser Family Found. (Apr. 21, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures under the demonstration.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the demonstration is likely to assist in promoting the objectives of title XIX. Under section 1901 of the Act, the Medicaid program provides federal funding to participating states, “[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” Act § 1901. As this statutory text makes clear, two Medicaid objectives are to enable states to “furnish ... medical assistance” – i.e., healthcare services – to certain vulnerable populations and to furnish those populations with rehabilitation and other services to help them “attain or retain capability for independence or self-care.” Section 1901 of the Act. Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better “enabling each [s]tate, as far as practicable under the conditions in such [s]tate”, to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need.

We are committed to supporting states that seek to test measures that are likely to increase coverage and improve the health of beneficiaries, and make them more financially independent, which in turn supports the fiscal sustainability of states’ Medicaid programs. We expect that such demonstration policies will improve beneficiaries’ physical and mental health, resulting in these beneficiaries consuming fewer health care services and resources while they are enrolled in Medicaid, which will preserve Medicaid program resources, make the Medicaid program more efficient, and potentially reduce the program’s national average annual cost per beneficiary of \$7871.² Such measures can promote the objectives of the Medicaid statute by enabling states to make improvements and investments “as far as practicable under the conditions in such state[s],” SSA Section 1901, in the broader Medicaid program. These measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.³ By the same token, such measures may also preserve states’ ability to continue to provide the optional services and coverage they already have in place. To the extent that either or both of these trends results in lower costs for the state over the long-term, it may allow the state to

² U.S. Department of Health and Human Services 2018 Actuarial Report on the Financial Outlook for Medicaid.

³ States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom their Medicaid programs will cover. Certain eligibility groups must be covered under a state’s program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

maintain the long-term fiscal sustainability of its Medicaid program and provide medical services to more Medicaid beneficiaries. Individuals who qualify for the Georgia demonstration may become healthier and more financially independent.

The measures being tested with this demonstration approval may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may “result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing.” Act § 1115(d)(1). Here, however, we anticipate that the only impacts on eligibility or enrollment will be to expand eligibility and enrollment. The Georgia Pathways to Coverage demonstration applies only to beneficiaries who previously were not eligible for Medicaid, and thus it expands the Medicaid eligible population in Georgia. In the long term, the measures set out in the demonstration may also help many beneficiaries enjoy the numerous personal benefits that come with improved health and financial independence and allow the state to more sustainably cover its vulnerable populations.

To create an effective incentive for beneficiaries to engage in behaviors that improve health and promote financial independence, it may be necessary for states to attach those incentives to eligibility for coverage, including conditioning eligibility for Medicaid coverage on compliance with conditions designed to improve beneficiary health, promote financial independence, and safeguard the fiscal sustainability of the Medicaid program. The Georgia Pathways to Coverage demonstration, however, only makes such incentives a condition of eligibility for individuals who previously were not eligible for Medicaid at all, and who became eligible only by virtue of the demonstration. This may mean that beneficiaries who fail to comply will not be eligible for Medicaid coverage, which is consistent with the consequences for failing to meet other conditions of eligibility. But, as we discuss more fully below, these measures have been designed to help beneficiaries who, if they choose to “opt-in” to new Medicaid coverage, are successfully able to do so. In addition, section 1115 gives CMS the authority to offer states more flexibility in experimenting with different ways of improving health outcomes and strengthening the financial independence of beneficiaries.

The Georgia Pathways to Coverage section 1115 demonstration is designed to extend Medicaid coverage (with limited exceptions described below) to individuals with incomes up to 95 percent of the federal poverty level (FPL) (effectively 100 percent with the 5 percent income disregard), who meet the qualifying hours and activities and premium payment requirements as a condition of initial and continued eligibility.

Background of Medicaid Coverage in Georgia

As of December 2019, Georgia’s Medicaid program has enrolled over 1 million individuals through its Georgia Families Medicaid managed care program, which provides healthcare to non-disabled adults and children. An additional 470,500 aged, blind, and disabled, low-income individuals are enrolled in the state’s fee-for-service Medicaid program. At this time, the state has elected not to implement the Patient Protection and Affordable Care Act (ACA) expansion to provide Medicaid coverage to adults with income up to 133 percent of the FPL.

Extent and Scope of the Demonstration***New Coverage and Qualifying Hours and Activities Requirements***

The Georgia Pathways to Coverage demonstration will provide Medicaid coverage to low income adults ages 19 through 64, with incomes up to 95 percent of the FPL (effectively 100 percent with the 5 percent income disregard), who are not otherwise eligible for Medicaid coverage. As a condition of eligibility, applicants and beneficiaries must complete a minimum of 80 hours of qualifying activities, unless they require a reasonable accommodation due to a disability or, for beneficiaries already enrolled, experience a circumstance that gives rise to good cause for non-compliance. Applicants and beneficiaries may satisfy these eligibility requirements through a variety of qualifying activities described in the STCs, 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 qualifying hours and activities requirement at application, is not eligible for a reasonable accommodation, and is not eligible for Medicaid under another eligibility category, the application will be denied and the individual may reapply at any time.

Most applicants with incomes at 50 percent up to 95 percent of the FPL (effectively 100 percent with the 5 percent income disregard) are required to make initial and ongoing monthly premium payments. These applicants will have 90 days following the eligibility determination to make an initial monthly premium payment before Medicaid coverage will begin. Failure to make the initial premium payment within 90 days of the eligibility determination will result in closure of the individual's application and the individual may reapply at any time.

As part of this new coverage, the state will not provide hospital presumptive eligibility or retroactive eligibility for any month prior to the month of application and premium payment (if applicable) for individuals who apply for Medicaid coverage through the demonstration.

Reasonable Accommodations

Georgia will 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 qualifying hours and activities 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 qualifying hours and activities requirement as a result of this disability, will be assessed to determine eligibility for another Medicaid category of assistance. Individuals or beneficiaries who are ineligible for other categories of assistance may request a reasonable accommodation to assist in meeting the qualifying hours and activities requirement. Medicaid coverage will not begin until the individual completes the program requirements and makes the initial premium payment (if applicable), as described below. Reasonable accommodations may include: a referral to a state vocational rehabilitation program for an assessment to determine the appropriate reasonable

accommodation, which may include a reduction in the number of hours required to participate in a qualifying activity; or an alternate way to report compliance with the qualifying hours and activities requirement. Individuals referred to a qualifying vocational rehabilitation program must engage in the qualifying hours and activities requirement specified by the vocational rehabilitation program within 90 days of the referral in order to enroll in the demonstration.

Applicants who fail to complete the qualifying hours and activities requirement specified by vocational rehabilitation program within 90 days of the referral will be determined ineligible for the demonstration and may reapply at any time. Beneficiaries who are enrolled at the time of requesting a reasonable accommodation, who fail to meet the qualifying hours and activities requirement specified by the vocational rehabilitation program, will have their coverage suspended and will have 90 days from the date of suspension to meet the qualifying hours and activities in order for the suspension to be lifted. Beneficiaries who fail to meet the qualifying hours and activities within the 90-day suspension period will be disenrolled and may reapply at any time. Any individual whose coverage is suspended or terminated for failure to meet the requirements, or who experiences any other adverse action, will have the right to appeal the state's decision, consistent with all existing appeal and fair hearing protections.

Good Cause Circumstances

Georgia will also allow beneficiaries enrolled in the demonstration who have been compliant with the qualifying hours and activities, but become unable to comply with the requirements due to circumstances that give rise to good cause for non-compliance, a maximum of 120 hours of non-compliance during the 12-month benefit year. These good cause circumstances include, but are not limited to: the beneficiary or immediate family member is hospitalized; the beneficiary or an immediate family member experiences a serious illness; the beneficiary experiences a short-term injury or illness; the beneficiary experiences the birth, adoption, or death, of an immediate family member; the beneficiary accepts a foster child or kin-ship care placement; the beneficiary experiences a natural or human-caused disaster (including a public health emergency); the beneficiary has a family emergency or other life event (e.g., divorce, civil legal matter, or is a victim of domestic violence); the beneficiary is temporarily homeless; or other good cause reasons as defined and approved by the state.

Qualifying Hours and Activities Reporting Requirement

The state will notify individuals who have met the qualifying hours and activities requirement and who have been determined eligible for the demonstration of the premium payment requirements (as applicable) and the need to continue to participate in the qualifying hours and activities in order to continue receiving Medicaid coverage. Beneficiaries will be required to report compliance with qualifying hours and activities on a monthly basis through methods consistent with the requirements in 42 CFR 435.907(a), such as: in-person, over the phone, online, or by mail. The state will allow beneficiaries who have reported compliance with the qualifying hours and activities requirement for six consecutive months an exemption from the monthly reporting requirement until they are reevaluated for eligibility during the annual redetermination period. Beneficiaries exempt from the reporting requirements are required to report changes in employment or other qualifying activities that may affect their eligibility.

Scope of Benefits and Employer-Sponsored Insurance (ESI)

Most beneficiaries enrolled in the demonstration will receive benefits consistent with the Medicaid state plan, with the exception of non-emergency medical transportation (NEMT). Beneficiaries ages 19 and 20 will receive early and periodic screening, diagnostic, and treatment (EPSDT) services, which include NEMT. Beneficiaries enrolled in the demonstration who are employed will be required to enroll in employer-sponsored insurance (ESI) if it is cost-efficient to the state and will receive premium and cost sharing assistance through Georgia's health insurance premium program (HIPPP). The state will not provide wrap-around services, and beneficiaries enrolled in ESI will have a benefit package limited to the services covered by the ESI plan. The state will determine cost-effectiveness using the state plan methodology, which considers the amount paid under the managed care organization (MCO) capitation versus what it would pay to cover the cost of premiums and associated cost sharing expenses. Beneficiaries will not be required to enroll in an ESI plan if the state determines the ESI plan is no longer cost-effective and the beneficiary can receive Medicaid coverage through the demonstration. Beneficiaries who disenroll from ESI while it is available and cost effective to the state, will no longer be eligible for Medicaid coverage through the demonstration.

Cost Sharing

All beneficiaries enrolled in Medicaid under this demonstration (except beneficiaries enrolled in ESI) will be provided with a Member Rewards Account (MRA). The MRA is an educational tool used to "deduct" beneficiary copayments, reflect accrued premium payment amounts (if applicable) and deposit incentive points that have a dollar-value equivalent for completing healthy behavior activities, such as attending smoking cessation classes and annual well visits. Funds in the MRA are non-monetary credits and any deduction does not result in actual charges to the beneficiary. Beneficiaries may use their MRA to access dental services, glasses, contacts, and over the counter drugs not covered by Medicaid. If there are insufficient funds in the beneficiary's MRA to cover applicable copayments, the state will continue to deduct copayment amounts from the MRA and will apply any future premium payments (if applicable) or healthy incentive points to the negative balance. Beneficiaries will not incur any out of pocket expenses due to a negative MRA balance.

All demonstration eligible beneficiaries will be required to pay copayments that mirror the state plan and are consistent with Medicaid cost sharing rules. Copayments will not be collected from the beneficiary at the point-of-service but will be reduced from the MRA, retroactively. The state will also reduce a beneficiary's MRA by \$30.00 for each non-emergent use of the emergency department (ED). The charge will be waived for beneficiaries who contact their MCO 24-hour nurse hotline prior to seeking services in an ED. A beneficiary must receive an appropriate medical screening examination under section 1867 – the Emergency Medical Treatment and Labor Act, or EMTALA, provision of the Act, before they can be charged. The STCs also require the state to ensure that hospitals provide beneficiary education about appropriate alternative settings before the state charges the beneficiary for non-emergent use of the ED, as described in 42 CFR 447.54(d)(2).

Beneficiaries with income at 50 percent up to 95 percent of the FPL (effectively 100 percent with the 5 percent income disregard), are required to make premium payments based on household income. Total cost sharing (copayments and premiums) will not exceed 5 percent of the beneficiary's household income. Beneficiaries enrolled in vocational education programs through the Georgia Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant programs are exempt from premium payments and will have a two-month grace period after graduation before they are required to make their initial monthly premium payment. Beneficiaries with a premium requirement will also be assessed an additional \$3.00 or \$5.00 tobacco premium surcharge through the MRA, based on income, if they self-attest to using tobacco. The state will remove the surcharge if a beneficiary completes a smoking cessation program and attests to no longer using tobacco. The tobacco surcharge is appealable for beneficiaries who believe they should not be subject to a surcharge. The surcharge is not appealable for beneficiaries who attest to using tobacco, but do not participate in a smoking cessation program.

The state will notify individuals who meet the qualifying hours and activities requirement and are eligible to enroll in the demonstration of the premium payment requirements. Notices will include: information about the premium due date; how to report changes in income; the time period over which income is calculated (e.g., monthly income); the deadline for reporting changes in circumstance; the consequences of non-payment; the consequences of failure to report changes in eligibility circumstances; and the criteria for changing MCOs. The state will provide beneficiaries with advance notice of any adverse action prior to the date of the eligibility action, consistent with 42 CFR 435.917 and 42 CFR 431 subpart E.

Beneficiaries who fail to make monthly premium payments will receive a reminder notice with information regarding the deadline for the submitting the late payment and the consequences of non-payment. Beneficiaries who fail to make one or two premium payments after making the initial premium payment, will be granted a 60-day grace period for each missed premium payment and coverage will continue as long as the beneficiary makes subsequent premium payments. Beneficiaries who accumulate three missed payments will be suspended from the demonstration in the month immediately following the date of the third missed premium payment. Beneficiaries who are suspended will have 90 days from the date of suspension to make a minimum of one payment in order to regain coverage. A suspended beneficiary who fails to make a premium payment within 90 days will be disenrolled and may reapply at any time. The state will forgive the outstanding premium payments of beneficiaries who are in a grace period at the time of redetermination.

CMS is requiring that the state's evaluation of the demonstration's premiums policy assess beneficiary knowledge of monthly payment requirements, consequences of nonpayment and the likelihood of making regular payments among beneficiaries with payment obligations.

Elements of the Demonstration Request that CMS is Not Approving at This Time

In its application, Georgia requested authority to allow individuals who are disenrolled from Medicaid because their income exceeds 95 percent of the FPL (effectively 100 percent with the 5 percent income disregard) to access the remaining balance in their MRA to pay for future

qualified health related expenses, up to 90 days after disenrollment. CMS is continuing to work with Georgia on this request, but is not approving it at this time.

Additionally, in its application, the state requested to receive enhanced Federal Medical Assistance Percentage (FMAP) available under section 1905(y)(1) of the Act for coverage of the low-income adult population with incomes up to 95 percent of the FPL (effectively 100 percent with the 5 percent income disregard) covered under this demonstration. CMS is not authorizing the enhanced federal match for this demonstration population, and will continue the existing policy of providing the enhanced federal match rate when the state covers the entire adult expansion group, those adults with income up to 133 percent of the FPL.

Determination that the demonstration is likely to assist in promoting Medicaid's objectives

For the reasons discussed below, the Secretary has determined the Georgia Pathways to Coverage demonstration is likely to assist in promoting the objectives of the Medicaid program.

The demonstration will expand coverage.

Approval of the Georgia Pathways to Coverage demonstration will allow certain individuals who are not otherwise eligible for Medicaid to receive Medicaid coverage. This demonstration will test an approach of offering certain currently non-eligible individuals a pathway to “opt-in” to coverage by meeting the qualifying hours and activities and premium requirements at application and thereafter. This demonstration is likely to assist in promoting the objectives of the Medicaid program because it is expected to result in a significant coverage expansion in Georgia. The state estimates approximately 64,336 individuals will enroll in Medicaid throughout the life of this demonstration.

The Georgia Pathways to Coverage demonstration is designed to make compliance with the qualifying hours and activities requirement attainable, and Georgia has taken steps to include protections to ensure that individuals can reasonably be expected to meet the requirements. As mentioned previously, individuals or beneficiaries who report a disability at the time of application or after enrollment in the demonstration will be assessed to determine eligibility for another Medicaid category of assistance. Applicants or beneficiaries who are ineligible for other categories of assistance, may request a reasonable accommodation to assist in meeting the qualifying hours and activities required to qualify for, or maintain Medicaid coverage through the demonstration. These reasonable accommodations may include providing applicants and beneficiaries with alternate reporting channels if they are unable to use technology as well as a reduction in the number of hours required for participation in qualifying hours and activities. This reduction would not impact the number of good cause hours available to all beneficiaries, regardless of reasonable accommodations. Additionally, any individual whose coverage is suspended or terminated for failure to meet the requirements, or who experiences any other adverse action, will have the right to appeal the state's decision, consistent with all existing appeal and fair hearing protections.

As part of ongoing monitoring of the demonstration, the state will submit enrollment data and will track the change in enrollment over time. The state will also be required to evaluate access to health care and health outcomes of individuals impacted by the demonstration, including those who do not continue to receive Medicaid coverage as a result of non-compliance with the requirements. Consistent with CMS requirements for all section 1115 demonstrations, the state will be undertaking rigorous evaluation of the demonstration policies and monitoring of a variety of metrics, including enrollment metrics. CMS also reserves the right to require the state to take corrective action, which could include suspending implementation of the qualifying hours and activities requirement, if monitoring or evaluation 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”). CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

The demonstration will furnish medical assistance in a manner that improves the sustainability of the safety net.

In addition to a significant expansion of coverage, CMS has determined that the Georgia Pathways to Coverage demonstration is likely to promote the objective of furnishing medical assistance because the demonstration, if successful, would promote the sustainability of Georgia’s Medicaid program. By making the qualifying hours and activities requirement a condition of eligibility for individuals who opt in to coverage, Georgia expects that some of these beneficiaries will gain financial security, averting their need for future, longer term public assistance as they secure employer-sponsored or other commercial coverage or otherwise transition from Medicaid eligibility.

Additionally, if participating in qualifying hours and activities, and receiving incentives to engage in healthy behaviors improves beneficiaries’ physical and mental health, as discussed below, these beneficiaries may consume fewer health care resources while they are enrolled in Medicaid and potentially reduce the need for future Medicaid enrollment. To the extent that either or both of these trends results in lower costs for the state over the long-term, it may allow the state to maintain the long-term fiscal sustainability of its Medicaid program and provide medical services to more Medicaid beneficiaries. This will help Georgia to allocate its Medicaid resources to ensure that the health care safety net is available to those Georgia residents who need it most. Accordingly, the demonstration is likely to promote the objectives of the Medicaid program.

The demonstration as a whole will provide greater access to coverage for low-income beneficiaries than would be available absent the demonstration. By providing coverage to beneficiaries in these populations who can reasonably be expected to meet the qualifying hours and activities requirement, Georgia will be able to expand coverage in a way that is economically practicable and sustainable for the state. This demonstration is likely to promote the objectives of the Medicaid program by allowing the state to experiment with innovative means of deploying its resources so it may provide coverage beyond the statutory minimum and what it currently provides. Additionally, conditioning eligibility for coverage under this demonstration on complying with requirements that have been designed to make compliance achievable and to

promote beneficiary health, beneficiary financial independence, and fiscal sustainability of the Medicaid program will further promote the objectives of the Medicaid program.

The demonstration tests reforms designed to promote financial independence, which we expect to improve continuity of coverage and lead to better health outcomes.

The qualifying hours and activities requirement for coverage is designed to encourage individuals to “opt-in” to Medicaid by obtaining employment and/or undertaking other qualifying activities. The evaluation of the demonstration will assess the effectiveness of policies that are designed to strengthen employment and earnings among individuals subject to the demonstration requirements, which we expect will lead to other health insurance coverage from employers and other commercial sources for the populations eligible for this demonstration. CMS expects that the coverage that may come from participating in this demonstration will result in greater financial independence for the demonstration population as well as improved health status. These key ideas will be captured via hypotheses and research questions in the state's evaluation design and in the subsequent interim and summative evaluation report requirements, subject to CMS approval. In evaluating and testing the hypotheses to assess the demonstration's success in achieving the key policy outcomes and objectives, the state must identify, through robust statistical methods, viable in-state or out-of-state comparison populations, or use other rigorous methodological approaches, such that the impact of the demonstration can be estimated.

The evaluation will be designed to understand whether the demonstration's offer of an “opt-in” to Medicaid promotes the goals of improving financial independence and beneficiary health. To that end, a key hypothesis that the evaluation will assess is whether the demonstration policies improve beneficiary financial independence, measured in terms of greater employment levels and earnings, and increase the likelihood that beneficiaries will transition to commercial health insurance. The evaluation will identify appropriate research questions for testing the hypotheses around employment, income and coverage that provide information about the efficacy of offering an “opt-in” to Medicaid and how such a policy impacts these outcomes. For example, the evaluation must examine whether employment, improved incomes, and employer-sponsored coverage that is conditioned on meeting the qualifying hours and activities requirement, offer coverage that is sustained over time (i.e., for a year or more, including after separating from Medicaid), since financial independence would not be assured without sustained improvements in these outcomes. The state will also examine the effect of the demonstration on take-up of commercial insurance, including ESI, and more importantly, on coverage losses (if people transition off Medicaid and do not enroll in commercial health insurance). It would also be important to understand what the barriers to maintaining enrollment in new coverage might be, if newly eligible beneficiaries fail to act to maintain coverage. It will also be important to understand the trajectories of the health status of individuals subject to the qualifying hours and activities requirement over time, including after separation from Medicaid. The evaluation will also assess whether this transition out of poverty occurs faster or at higher magnitudes than it would have otherwise without this demonstration. Furthermore, hypotheses focused on enrollment suspension for non-compliance will assess at least the following outcomes: beneficiary compliance with demonstration requirements, enrollment continuity, and health status (as a result of greater enrollment continuity).

The state also will evaluate other core policy components of the demonstration, including premiums, inclusive of tobacco surcharge, incentives for healthy behaviors, the non-applicability of retroactive eligibility and the copayment for non-emergent use of emergency department. While individually such policies may not be new to Medicaid program evaluation, when taken together as a whole, the demonstration represents a novel approach to providing opt-in coverage to a new population, not previously eligible, that tests a broad range of policies together. Where applicable, the state will be expected to adopt, with necessary adaptations, CMS's evaluation design guidance for the critical demonstration policy areas. The state must also 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 care costs. In addition, the state must use results of hypothesis tests and cost analyses to assess demonstration effects on Medicaid program sustainability. For example, it could be important to understand the demonstration's impact on program sustainability in the context of how long-term maintenance of employment, income, and commercial coverage succeed in transitioning individuals off of other public support programs like Temporary Assistance for Needy Families (TANF) and Supplemental Nutritional Assistance Program (SNAP), as well as in helping them avoid becoming eligible under a mandatory population in the future.

CMS also has included STCs in the monitoring and evaluation sections that align with CMS's current approach to monitoring and evaluation for section 1115 demonstrations. These STCs specify that CMS reserves the right to require the state to take corrective action, which could include suspending implementation of the qualifying hours and activities requirement, if monitoring or evaluation 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"). CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner. The STCs will better aid the state and CMS in measuring and tracking the demonstration's impact on Georgians affected by it, and give CMS additional tools to protect beneficiaries if necessary. Further, CMS reserves the right to withdraw expenditure authorities at any time, if it determines that continuing the expenditure authorities would no longer be in the beneficiaries' interest or promote the objectives of Medicaid.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

The ACA specified that comment periods should be "sufficient to ensure a meaningful level of public input," section 1115(d)(2)(A) & (C) of the Act, but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012

provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments. 42 CFR 431.416(d)(2).

The federal public comment period was open from January 8, 2020 through February 7, 2020. CMS received 1,729 comments during the federal comment period on the state's section 1115 demonstration application, Georgia Pathways to Coverage. Although CMS is not legally required to provide written responses to comments, CMS is addressing some of the central issues raised by the commenters and summarizing CMS's analysis of those issues for the benefit of stakeholders. After carefully reviewing the public comments submitted during the federal comment period, CMS has concluded that the demonstration project advances the objectives of Medicaid.

General Comments

The majority of comments CMS received opposed the qualifying hours and activities requirement. Specifically, many commenters asserted that the requirements may result in beneficiaries losing access to healthcare. CMS believes these comments reflect a general misunderstanding of the Georgia demonstration. This demonstration is likely to promote the objectives of Medicaid by providing an opportunity for uninsured Georgians, who previously were ineligible for Medicaid, to gain healthcare coverage. If an applicant meets the qualifying hours and activities requirement at the time of application and thereafter, this demonstration provides a pathway to "opt-in" to Medicaid coverage for an individual who, absent this demonstration, has no such pathway. This demonstration offers potential coverage gains for individuals who otherwise would not have been eligible for Medicaid. Georgia will also provide applicants and beneficiaries with disabilities reasonable accommodations to assist in meeting the qualifying hours and activities requirement, when appropriate.

CMS believes the state will implement sufficient guardrails to address concerns raised by commenters about the impact to people with health issues and to other groups like low-income families and people who are lesbian, gay, bisexual, and transgender. Not only does the demonstration require the state to comply with civil rights laws and provide for reasonable accommodations, CMS has also required the state to include specific assurances in STCs 29 and 38, which address the potential for disparate impact of the demonstration on specific populations protected by such laws, including those who are lesbian, gay, bisexual, and transgender. This assurance requires the state to monitor its program and, using information available to the state, work to identify any disparate impact not on those protected by civil rights laws and CMS will review this information with the state as part of required ongoing monitoring activities. If an adverse, disparate impact is identified, CMS reserves the right to require the state to submit a corrective action plan. The STCs further specify that any such state corrective action plan could include a temporary suspension of the 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"). CMS can also suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

Other commenters expressed concern that administering the proposed demonstration will be burdensome or costly to the state of Georgia, the federal government, and health care providers. Georgia's demonstration is projected to be budget neutral to the federal government, and the state notes that its General Fund contributions will remain below the national average. Further, Georgia is making significant efforts to reduce administrative burden at the state level by making its qualifying hours and activities requirement for Medicaid coverage similar to that of the state TANF program. To reduce administrative burden for providers, Georgia designed the benefits included in this demonstration to be consistent with those provided through the existing Medicaid state plan, with the exception of NEMT benefits, which will only be provided for individuals between the ages of 19-20 receiving EPDST services in the demonstration. Further, beneficiaries enrolled in ESI will receive a benefit package specific to the services covered by their employer-based plan. Moreover, to reduce reporting and compliance burdens on beneficiaries, Georgia will provide multiple avenues for reporting qualifying activities, such as using an online portal and reporting in person. In addition, after six consecutive months of successfully reporting their qualifying activities, beneficiaries will be exempt from the monthly reporting requirement for the remainder of the benefit year.

A number of commenters opposed certain other policies proposed in the demonstration, including the implementation of premiums for beneficiaries enrolled in demonstration coverage. It is important to note that the premiums required in this demonstration will be administered on a sliding scale based on income, with a segment of beneficiaries paying no premiums at all. The premium payment rates are designed not to exceed two percent of a beneficiary's household income. CMS believes that the inclusion of premiums in this demonstration will provide beneficiaries with an experience similar to that of commercial insurance. This is expected to help beneficiaries build personal responsibility through financial contributions to their health and prepare them for an eventual transition into commercial insurance. To that end, CMS is requiring that the state's evaluation of the demonstration's premiums policy assess beneficiary knowledge of monthly payment requirements and consequences of nonpayment, as well as likelihood of making regular payments among beneficiaries with payment obligations.

Furthermore, robust monitoring and evaluation will be required throughout the lifecycle of the demonstration approval period with regard to qualifying hours and activities, cost sharing, incentives for healthy behaviors, and the non-applicability of retroactive eligibility and hospital presumptive eligibility. For example, metrics will cover enrollment, disenrollment or suspension by specific demographics and reason, participation in qualifying activities, premium non-payment, unpaid medical bills, access to care, and health outcomes. The state is also expected to provide monitoring data on demonstration policies around the non-applicability of ESI cost-effectiveness and effects of cost sharing. CMS will gather regular monitoring data through the quarterly and annual monitoring reports as well as continue to engage with the state via regularly scheduled demonstration monitoring calls, and will work with the state to resolve any issues that arise as Georgia works to implement the demonstration.

Additionally, 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 state corrective action plan could include a temporary suspension of the 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”). CMS can also suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner. This will better aid the state in measuring and tracking the demonstration's impact on Georgians affected by it, and give CMS additional tools to protect beneficiaries, if necessary.

Finally, although the public comment period for this demonstration closed prior to the declaration of the COVID-19 public health emergency, CMS acknowledges that the public health emergency may add to the concern among stakeholders. Although CMS is approving the Georgia Pathways to Coverage demonstration today, the state does not plan to implement until July 1, 2021. It is unknown whether the public health emergency will still be in effect at that time, and how state and individual circumstances will change between now and the time at which the demonstration is actually implemented. The state has included, in the demonstration terms and conditions, specific circumstances that give rise to good cause for non-compliance with the qualifying hours and activities requirement. These circumstances include those that may be associated with future public health emergencies, as well as those related to beneficiaries who may be quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, or exposure to COVID-19. The state will also take into account the potential closure, related to COVID-19, of the place(s) where the beneficiary was meeting the requirement and as a result, is unable to fulfill the hours and activities requirement. Further, expanding Medicaid coverage to individuals not previously eligible will have significant positive impact on access to health care during and after a public health emergency.

Comments on Qualifying Hours and Activities and Reporting Requirements

Commenters who opposed the qualifying hours and activities requirement commonly asserted that they would cause Medicaid beneficiaries to lose access to healthcare – especially those individuals considered a part of vulnerable populations, such as individuals with disabilities. On the contrary, the Georgia Pathways to Coverage demonstration provides an opportunity to “opt-into” the state’s Medicaid program. This demonstration offers coverage opportunities to individuals not currently eligible for Medicaid. Specifically, this demonstration offers Medicaid coverage to Georgia residents ages 19 through 64, with a modified adjusted gross income at or below 100 percent of the FPL, who are not otherwise eligible for Medicaid in the state, should they wish to comply with the qualifying hours and activities requirement. The state estimates that approximately 64,336 Georgians would gain Medicaid coverage over the life of the demonstration.

To ensure that vulnerable individuals also have an opportunity to participate in and continue to receive coverage under the demonstration, Georgia will also provide applicants and beneficiaries with disabilities, who are not otherwise eligible for Medicaid on the basis of disability, reasonable accommodations related to meeting the qualifying hours and activities requirement to enable them to have an equal opportunity to participate in, and benefit from the program. For example, if an individual reports having a disability, as defined by the ADA, Section 504 of the Rehabilitation Act, or Section 1557 of the Patient Protection and Affordable Care Act, at the time of application or while enrolled in the demonstration, and is unable to meet the qualifying

hours and activities requirement for reasons related to that disability, the state will first determine if the individual is eligible for another Medicaid eligibility category. If deemed eligible, the individual will be enrolled in that Medicaid eligibility category instead of the demonstration. If the individual is not eligible for another eligibility category and does not have the necessary qualifying hours and activities to be eligible for, or continue participation in the demonstration, the individual will be referred to state programs currently providing rehabilitation services for individuals with disabilities.

If the individual participates in a qualifying program that is providing rehabilitation services and meets the hours and activities requirement, as determined by the qualifying program, the individual will be determined eligible for coverage under the demonstration. Further, if the state program providing rehabilitation services determines a need for reasonable accommodations to meet the hours and activities requirement, the state will allow the applicant or beneficiary to enroll in, or continue participating in the demonstration with modified requirements. Examples of possible reasonable accommodations could include: reduced monthly qualifying hours, alternative reporting requirement, and numerous other types of reasonable accommodations as determined by the state.

Further, if while enrolled in the demonstration, a beneficiary experiences a circumstance that gives rise to good cause for being non-compliant with the qualifying hours and activities requirement for a specific month, the state will still consider the beneficiary compliant. For example, if a beneficiary experiences a hospitalization or a serious illness during a specific month and notifies the state, the state will consider the beneficiary still in compliance. Additionally, the qualifying hours and activities requirement in this demonstration is designed to make it more likely that individuals will be able to obtain and retain private or employer-sponsored coverage as they gain additional work experience and their income rises, therefore providing the ability to obtain such commercial coverage.

While the state and CMS believe that these varied activities to meet the requirement, along with the guardrails and protections specified above, allow the majority of individuals eligible for this demonstration to have an equal opportunity to successfully comply and gain Medicaid coverage where they previously had none, CMS acknowledges that some vulnerable individuals may still not meet the requirements to opt into coverage. However, CMS believes that on the whole, this demonstration provides a significant expansion of Medicaid coverage for individuals who otherwise would not have access to coverage. CMS therefore believes that this novel approach to testing incentives for providing health coverage to individuals that otherwise would not have access to coverage supports the objectives of Medicaid and is worth testing.

Opposing commenters also asserted that Georgia's qualifying hours and activities requirement is complex and would place a reporting burden on beneficiaries. Many commenters indicated that beneficiaries would be unable to meet the qualifying hours and activities requirement, even if they would like to do so, because burdensome reporting requirements may make compliance too difficult. To address these concerns, Georgia will provide beneficiaries with multiple avenues to report their qualifying hours and activities, including an online portal, mail in or in-person. The state will also be required to accommodate beneficiaries who may have trouble reporting their hours due to a disability. Reporting will include self-attestation of activity hours. To further

minimize reporting requirements, beneficiaries are only required to provide documentation of their qualifying hours and activities once a month for the first six consecutive months of enrollment. After six consecutive months of reporting, beneficiaries will be exempt from the monthly reporting requirement for the remainder of the benefit year. Once exempt, the state will perform periodic and random audits to verify beneficiary documentation and compliance with the qualifying hours and activities. If a beneficiary has a disability affecting their ability to report their required hours, the state is required to provide the beneficiary reasonable accommodations.

Some commenters also cited that the Georgia Division of Family and Children Services (DFCS) lacks the capacity to timely process monthly reporting from beneficiaries completing the monthly hours and activities requirement. However, as noted above, beneficiaries who report their qualifying hours and activities for six consecutive months will no longer be required to report, easing the burden for both beneficiaries and for state resources. And, as with other parts of the qualifying hours and activities requirement, CMS will monitor monthly reporting processing times with the state and should that monitoring data identify a major issue, CMS reserves the right to require the state to submit a corrective action plan, or to suspend implementation of the demonstration if corrective actions do not effectively resolve any concerns.

Comments on the Demonstration's Financial and Administrative Burden on the State of Georgia, the Federal Government, and Healthcare Providers

Many commenters expressed concerns that the demonstration would be expensive for the state and/or federal government to implement and administer, and some commenters also expressed that a full expansion under the ACA to adults was more efficient. CMS expects, from a financial perspective, this demonstration will not be overly burdensome on the state or federal government. Like the majority of section 1115 demonstrations, Georgia's demonstration must be budget neutral. The state notes that it expects that its General Fund contributions to the state's Medicaid budget will remain below the national average while operating a cost-effective program rather than an entitlement program.

Furthermore, Georgia is making significant efforts to reduce the administrative burden associated with this demonstration by mirroring several qualifying hours and activities requirements to that of the state's current TANF activity requirements. The state of Georgia currently operates the TANF program through the Department of Family and Children Services and requires hours and activities reporting for that program. Mirroring these requirements will reduce the state's administrative burden because the technology and infrastructure to report these activities already exists and will be leveraged for this demonstration. To reduce administrative burden for providers, Georgia designed the benefits included in this demonstration to be the same as those provided through the existing Medicaid state plan, except for the limit on NEMT to only those beneficiaries who are 19 and 20 year olds and who would receive EPSDT services. This will save time and money by allowing providers to maintain their current Medicaid benefits infrastructure. Beneficiaries enrolled in an ESI plan will receive the benefits covered by the plan and will not receive additional Medicaid benefits.

Comments on the Premium and Cost Sharing Requirements

Many commenters expressed concerns regarding premium payments as a condition of eligibility for this demonstration. Commenters who were opposed to this proposed policy argued that many Medicaid beneficiaries live in extreme poverty and even small premiums and copayments could be financially infeasible for beneficiaries. CMS is acutely aware of the numerous financial difficulties faced by beneficiaries. A segment of the population eligible for this demonstration will be required to make sliding scale monthly premium payments based on family income. The premium payment rates are calculated to not exceed two percent of household income across each income bracket. Beneficiaries with incomes at or below 50 percent of FPL are exempt from paying any monthly premiums; beneficiaries with incomes from 50 to 84 percent of FPL will be required to pay \$7.00 a month; and beneficiaries with incomes from 85 to 95 percent FPL (effectively 100 percent with the 5 percent income disregard) will be required to pay \$11.00 a month.

Other commenters expressed similar concerns with the cost sharing aspects of this demonstration. To that end, the state will ensure that beneficiaries do not incur copayments and premiums that, when combined, exceed 5 percent of their aggregate household income. In accordance with 42 CFR 447.56(f), once a household reaches the cap, no further copayments can be charged to beneficiaries, and the premium amount will be reduced for the remainder of the quarter.

Furthermore, the inclusion of premiums and copayments in this demonstration will provide Georgians with an experience similar to commercial health insurance. This is expected to help beneficiaries build personal responsibility through financial contributions to their health and prepare them for an eventual transition into commercial insurance. Building personal responsibility will empower beneficiaries to more actively engage in their own health and develop important skills needed for a smooth transition into commercial insurance. These transitions are especially critical to maintain health outcomes that beneficiaries may achieve through this demonstration and to avoid potential disruptions in insurance status as the individual transitions out of Medicaid.

Comments Addressing Coverage Losses

Some commenters cited loss of Medicaid coverage as a rationale for not supporting this demonstration. Specifically, some commenters asserted that the qualifying hours and activities requirement would lead to loss of coverage among current Medicaid beneficiaries who are unable to comply. As noted above, this demonstration is an expansion of the state's Medicaid coverage and does not apply to beneficiaries currently enrolled in Medicaid outside of this demonstration. Therefore, this demonstration only offers coverage opportunities to individuals not currently eligible for Medicaid.

The state completed an initial analysis of the potential coverage impact of this demonstration and estimates that approximately 31,093 individuals will receive Medicaid coverage during the first year of the demonstration. The state further estimates that over the five-year demonstration period, approximately 64,336 Georgians will enroll in Medicaid or Medicaid-sponsored ESI

through this demonstration opportunity. Georgia estimates that there will be lower than average participation among the eligible population in the first demonstration year as the program is established. The state further estimates there will be a low enrollment attrition rate among the newly covered demonstration population during the first year of the demonstration. For demonstration years two through five, the state estimates that the attrition rate will be consistent with the existing Low-Income Medicaid (LIM) population (the LIM population is the Georgia Medicaid population comparable to the demonstration enrollees, as it follows similar TANF requirements and income limits).

The state has identified several circumstances in which a participating beneficiary could lose eligibility once enrolled. For example, a beneficiary could lose eligibility if their income exceeds 100 percent of the FPL; they become eligible for another eligibility category of assistance due to a change in circumstance; they choose to no longer make their premium payments; or they choose to no longer complete the required hours and qualifying activities. The state expects minimal disenrollments from this demonstration due to a failure to comply with the qualifying hours and activities requirement because of the reasonable accommodations and good cause hours the state has put in place to make the qualifying hours and activities requirement attainable. As mentioned previously, individuals or beneficiaries can report a disability either at the time of application, or after enrollment in the demonstration, and may request a reasonable accommodation to assist in meeting the qualifying hours and activities requirement. Further, Georgia is also providing beneficiaries with alternate opportunities through good cause conditions, including the ability to reduce the number of hours required for participation in qualifying hours and activities. Similarly, the state expects minimal disenrollments from this demonstration due to a failure to comply with the premium and other cost-sharing requirements because Georgia has taken steps to include protections to ensure that individuals can meet the requirements to stay enrolled in the demonstration.

This demonstration is likely to promote the objectives of Medicaid by testing whether non-Medicaid eligible individuals who are given an opportunity to “opt-in” to Medicaid if they comply with qualifying hours and activities requirement experience better health and financial independence, and if the state's provision of services to this population improves the fiscal sustainability of its Medicaid program. One of the purposes of the demonstration is to test whether the qualifying hours and activities requirement, as a condition of eligibility for Medicaid coverage, improves health and financial outcomes for beneficiaries. Those who comply with the qualifying hours and activities requirement will be able to obtain health coverage that would have been otherwise unavailable without this demonstration, and we expect that those who comply will experience the improved outcomes that are correlated with being employed or otherwise more engaged in their communities. Individuals who choose not to comply with the qualifying hours and activities requirement will be no worse off than they are without this demonstration. CMS recognizes that an individual's health and well-being are important and that there is a broad array of factors that impact one's health such as social, economic, and behavioral factors.

While CMS and the state acknowledge that some beneficiaries who gain coverage as a result of this expansion may choose not to continue to opt into the Medicaid program, the state is required to implement a number of strategies and supports for those who wish to “opt-in” to the Medicaid

program and comply with the qualifying hours and activities requirement. For example, the state will conduct active outreach and education, beyond standard noticing, to help ensure that applicants and beneficiaries understand the requirements and how to comply with them. Georgia will maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted at beneficiaries. As required in the STCs, the state must submit its Implementation Plan no later than 90 days after the approval of this demonstration, but before implementation of the demonstration. The Implementation Plan must include operational processes to address the following: application assistance, reporting and processing, disseminating notices, coordinated agency responsibilities, coordination with other insurance affordability programs, coordination with other state agencies, applicant and beneficiary protections, appeals, renewals processes, and outreach. The STCs also require the state to provide outreach and education to stakeholders regarding the qualifying hours and activities requirement and to provide related information on the state's website. While some individuals may respond to the new qualifying hours and activities requirement by choosing not to take advantage of the opportunity to “opt-in” to Medicaid, the goal is for everyone potentially eligible for this new coverage to be able to obtain it.

Commenters opposed to approval of this Georgia demonstration also cited a study assessing the impact of the Arkansas Works section 1115 demonstration. That study reported coverage losses for low-income adults enrolled in the demonstration and no significant changes in employment. CMS reviewed and considered this study, but disagrees with commenters on its relevance to approval of the Georgia demonstration, which will test a completely different model and which will have its own robust monitoring and evaluation design. Unlike the Arkansas Works demonstration, Georgia offers a new pathway to coverage for individuals who otherwise would not have Medicaid or other health coverage, and therefore is, by design, a significant coverage expansion. CMS believes it is worthwhile to test of the impact of incentives on the adoption of healthy behaviors and improved health outcomes in Georgia.

Comments on Other Demonstration Features

Some commenters expressed concern with not providing retroactive eligibility and hospital presumptive eligibility to beneficiaries. Many of the commenters were concerned that this will create economic hardships and gaps in health care coverage for vulnerable beneficiaries. However, not providing retroactive eligibility and hospital presumptive eligibility is likely to help promote Medicaid's objectives in at least two ways: (1) it may improve uptake of preventive services and thus improve beneficiary health by encouraging individuals to seek timely access to health coverage; and (2) it improves the fiscal sustainability of the Medicaid program, which helps Georgia to continue to provide Medicaid coverage to this non-mandatory demonstration population.

Other commenters opposed not providing NEMT benefits to this population. Commenters noted that not providing NEMT could make it harder for beneficiaries in rural areas who are disabled or lack transportation to obtain medical care. However, CMS believes this approach helps achieve one of the state's goals of recreating the experience of the commercial insurance market, which does not offer the NEMT benefit. Additionally, not offering NEMT is expected to improve the fiscal sustainability of the state's safety net and contribute to the provision of

additional services offered through this demonstration. Finally, beneficiaries ages 19-20 who are eligible for EPSDT services will maintain the NEMT benefit. Therefore, CMS believes that the risk associated with not offering NEMT to the demonstration population is outweighed by the value of this opt-in coverage that Georgia is providing.

Other commenters raised concerns generally about how this demonstration would impact access to care in rural parts of the state, particularly affecting rural safety net providers. Commenters indicated that a number of rural hospitals have closed recently in Georgia and this demonstration would be unlikely to help reduce future closings. However, CMS believes that by expanding Medicaid coverage to individuals who today lack any health insurance will indeed help support existing rural safety net providers by reducing uncompensated care and strengthening access to care in rural communities.

Finally, several commenters expressed concern that Medicaid wraparound services are not being provided for beneficiaries required to enroll in ESI. As stated above, one of the state's goals is to encourage beneficiaries to experience commercial insurance coverage, and as such, those who have access to cost effective ESI will be required to enroll and will be provided the benefits that are covered under the specific ESI plan, with premium assistance provided by the state. This also serves to improve the sustainability of the safety net by allowing the state to continue to provide this opt-in coverage for this optional demonstration population by covering cost-effective ESI for beneficiaries who qualify.

Supportive Comments Regarding Other Elements of the Demonstration

Lastly, some commenters expressed support for the qualifying hours and activities requirement provision of the demonstration, as well as support for the proposed demonstration in general. Among the comments, most indicated that the proposed demonstration would result in improved health outcomes and would likely promote independence and accountability for demonstration participants.

Other Information

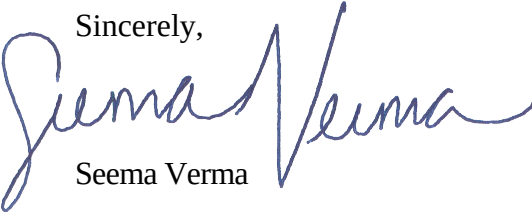
CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of expenditure authorities and STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receipt of your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Dina Payne. She is available to answer any questions concerning your section 1115 demonstration. Ms. Payne's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Dina.Payne1@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

A handwritten signature in blue ink, appearing to read "Seema Verma", with a stylized flourish at the end.

Seema Verma

Enclosures

cc: Etta Hawkins, State Monitoring Lead, Medicaid and CHIP Operations Group

Exhibit 3

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



January 4, 2021

Lynnette Rhodes
Medicaid Director & Executive Director of Medical Assistance Plans Division
Georgia Department of Community Health
2 Peachtree Street, NW, Suite 36450
Atlanta, GA 30303

Dear Ms. Rhodes:

Your state currently operates at least one Medicaid section 1115 demonstration. These demonstrations have proven to be a cornerstone of state innovation from which new best practices can emerge and next generation program design be fostered. They represent one of the most critical elements of our commitment to state flexibility and building a state and federal partnership centered on accountability and results.

By their nature, section 1115 demonstrations represent a contract between the state and federal government, governed by established terms and conditions and only approved after a determination by the Secretary of the Department of Health and Human Services (HHS) that such a demonstration would advance the objectives of the Medicaid program. In the rare event that CMS makes a determination that it must terminate, amend, or withdraw waiver authority, the standard terms and conditions in each demonstration generally provide for a process in which CMS will notify the state in writing and afford the state an opportunity to request a hearing prior to effective date.

Your terms and conditions describe this process at only a high level, without describing the advance notice or the specific timeline in which such an opportunity to be heard would occur. While a decision to terminate or withdraw waiver authority would likely only be made as a last measure, states have the right to due process over that decision as well as adequate notice to prepare to transition their programs to a new state of authority. That is why I am sending to you today a letter of agreement outlining additional details of the process, which CMS commits to applying prior to the effective date of any amendment or withdrawal of a demonstration.

By signing the letter of agreement, you are agreeing to abide by this process should CMS in the future take any such relevant action against an existing 1115 demonstration operating in your state. If you would like to commit to adhering to this process, I ask that you return this agreement, signed by the state Medicaid director or appropriate authority, as soon as possible. Please send to me directly or email the signed agreement to 1115demorequests@cms.hhs.gov.

Sincerely,

A handwritten signature in blue ink, reading "Seema Verma", is positioned below the word "Sincerely,". The signature is fluid and cursive, with the first and last names being clearly legible.

Seema Verma

Enclosure

CENTERS FOR MEDICARE & MEDICAID SERVICES

PROCEDURES FOR WITHDRAWING OR MODIFYING A SECTION 1115 DEMONSTRATION

CMS regulations state that each Section 1115 demonstration's Terms and Conditions "will detail any notice and appeal rights for the State for a termination, suspension or withdrawal of waivers or expenditure authorities." 42 CFR § 431.420(d) (3). While the precise language in each demonstration's Terms and Conditions varies slightly, these documents set forth only a general outline of the procedure to apply, for example: "CMS will promptly notify the State in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date." This letter agreement sets forth the procedures that CMS commits to applying prior to the effective date of any amendment or withdrawal of a demonstration.

If CMS determines that it will either (1) suspend or terminate a demonstration in whole or in part because the State has materially failed to comply with the terms of the demonstration project, or (2) withdraw waivers or expenditure authorities based on a finding that the demonstration project is not likely to achieve the statutory purposes, see 42 CFR § 431.420(d)(1)–(2), CMS will promptly notify the affected State in writing of its determination and the reasons for the suspension, termination, amendment, or withdrawal. CMS will also provide an effective date for its determination and a schedule for a hearing to challenge CMS' determination.

In order to ensure that affected states have adequate notice and opportunity to be heard, CMS shall make the effective date for its determination no sooner than 9 months after the date on which CMS transmits its determination to the affected State. The hearing and associated briefing shall adhere to the following schedule:

- Within 15 days of the date of CMS' determination, the affected State shall provide notice in writing to CMS that it disagrees with CMS' determination and plans to invoke its right to a hearing as part of a preliminary appeal.
- Within 90 days of the date of CMS' determination, the affected State shall submit a written brief to CMS outlining the bases for its disagreement.
- Within 90 days of the date the State submits its written brief, CMS shall send a written response to the affected State responding to the major arguments raised by the State.
- Within 60 days of the date that CMS sends its written response, the State shall submit a written rebuttal responding to the major arguments raised by CMS.
- Within 45 days of the date that the State sends its written rebuttal, CMS shall hold a hearing and provide the State with an opportunity to be heard regarding its disagreement with CMS' determination.
- Following the hearing, CMS shall issue a written decision either modifying or finalizing its initial determination.

The decision resulting from this preliminary appeals process shall be appealable to the Departmental Appeals Board using the procedures at 45 CFR Part 16. See Appendix A to 45 CFR Part 16, C. (b). Monetary damages cannot remedy a breach of this preliminary appeals process. Any breach constitutes irreparable harm and final agency action.

The preliminary appeals process set forth above applies to the following demonstrations:

**Georgia Planning for Healthy Babies
Pathways to Coverage**

Lynnette R. Rhodes

Lynnette Rhodes
Medicaid Director & Executive Director of Medical Assistance Plans Division
Georgia Department of Community Health
State of Georgia

Date: 1/5/2021

Seema Verma

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services

Date: January 4, 2021

Exhibit 4

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



February 12, 2021

Frank W. Berry
Commissioner
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, Georgia 30303-3159

Dear Mr. Berry:

On October 15, 2020, the Centers for Medicare & Medicaid Services (CMS) approved Georgia's request for a new section 1115 demonstration project, entitled "Georgia Pathways to Coverage" (Project Number 11-W-00342/4) in accordance with section 1115(a) of the Social Security Act (the Act). Among other things, the demonstration authorizes the state to require all Georgia Pathways to Coverage individuals who would become eligible under this demonstration, ages 19 through 64, to participate in and timely document and report 80 hours per month of community engagement activities, such as employment, education, job skills training, or community service, as a condition of initial and continued Medicaid eligibility. By its terms, the demonstration will expire on September 30, 2025.

Under section 1115 and 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, and CMS may withdraw waivers or expenditure authorities if it "find[s] that [a] demonstration project is not likely to achieve the statutory purposes." 42 C.F.R. 431.420(d); see 42 U.S.C. 1315(d)(2)(D).

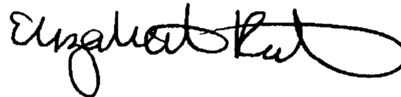
The Georgia Pathways to Coverage community engagement requirement is not in effect. Although the demonstration was approved in October 2020, the state has not implemented the demonstration to date. The COVID-19 pandemic has made community engagement infeasible. CMS has serious concerns about testing policies that condition health care coverage on meeting work or other community engagement requirements. The COVID-19 pandemic has had a significant impact on the health of Medicaid beneficiaries. Uncertainty regarding the current crisis and the pandemic's aftermath, and the potential impact on economic opportunities (including job skills training and other activities used to satisfy community engagement requirements, i.e., work and other similar activities), access to transportation and to affordable child care have greatly increased the risk that it would be unreasonably difficult or impossible for many individuals to meet the community engagement requirement approved in this demonstration, which would significantly compromise the demonstration's effectiveness in promoting coverage for its intended beneficiaries. In addition, the uncertainty regarding the lingering health consequences of COVID-19 infections further exacerbates the harm of lack of access to benefits for individuals who would be unable to access coverage under the demonstration because of their inability to meet the community engagement requirement.

Taking into account the totality of circumstances, CMS has preliminarily determined that allowing work and other community engagement requirements to take effect in Georgia would not promote the objectives of the Medicaid program. Therefore, CMS is providing the state notice that CMS is commencing a process of determining whether to withdraw the authorities approved in the Pathways to Coverage demonstration that permit the state to require work and other community engagement activities as a condition of Medicaid eligibility while leaving in place the demonstration's other provisions, including the extension of Medicaid eligibility to certain otherwise-ineligible individuals. See Special Terms & Conditions ¶ 10. If the state wishes 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. If CMS ultimately determines to withdraw those authorities, it "will promptly notify the State in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date." *Id.*

The Georgia Pathways to Coverage demonstration project also includes other authorities that CMS approved in the demonstration. CMS will also review those other authorities and will follow up with the state when that review is complete.

If you have any questions, please contact Judith Cash, Acting Deputy Director, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

A handwritten signature in black ink, appearing to read "Elizabeth Richter", with a stylized flourish at the end.

Elizabeth Richter
Acting Administrator

cc: Etta Hawkins, State Monitoring Lead, Medicaid and CHIP Operations Group

Exhibit 5

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



February 12, 2021

Lynnette Rhodes
Medicaid Director & Executive Director of Medical Assistance Plans Division
Georgia Department of Community Health
2 Peachtree Street, NW, Suite 36450
Atlanta, GA 30303

Dear Ms. Rhodes:

On January 4, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a letter to individual State Medicaid Directors that concerned procedural issues for states that operate a section 1115 demonstration. Specifically, an attachment to the January 4, 2021 letter proposed to delineate certain additional procedures for a preliminary hearing process, yet to be developed by CMS, that would be implemented in the event that CMS determines that it will either suspend or terminate a demonstration, in whole or in part, for material non-compliance with the terms of the demonstration project or based on a finding that the demonstration project is not likely to achieve the statutory purposes (see 42 C.F.R. § 431.420(d)(1)–(2)).

Consistent with federal regulations, the approved special terms and conditions (STCs) governing each demonstration project under section 1115 of the Social Security Act (Act) already generally specify procedures that CMS would use, in the event it suspends or terminates a demonstration project, in whole or in part, for material non-compliance or based on a finding that the demonstration project is not likely to achieve statutory purposes. As the attachment to the January 4, 2021 letter noted, the terms and conditions of the demonstrations at issue typically provide that “CMS will promptly notify the State in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS’ determination prior to the effective date.” See 42 C.F.R. § 431.420(d)(3) (providing that “[t]he terms and conditions for [a] demonstration will detail any notice and appeal rights for the State for a termination, suspension, or withdrawal of waivers or expenditure authorities”).

By proposing to delineate additional procedures for the withdrawal or suspension of a demonstration approval—particularly by purporting to require that the effective date of such a withdrawal or suspension be at least nine months after CMS transmits its withdrawal determination to a State—the January 4, 2021 letter did not address CMS’s need for flexibility to make and effectuate determinations under 42 C.F.R. 431.420(d)(1)–(2). The current COVID-19 pandemic and economic environment, along with an ongoing need for general CMS oversight of section 1115 demonstrations, necessitate that CMS maintain the regulatory flexibility to respond appropriately to current or changed circumstances by adjusting, suspending, or terminating an existing demonstration and associated authorities in whole or in part.

CMS needs to remain able to exercise its authority under the Act and implementing regulations to maintain continued oversight of demonstrations in order to ensure that they remain likely to achieve the statutory purposes. (see 42 U.S.C. 1315(d)(2)(E); 42 C.F.R. 431.420(d)(2)) Therefore, CMS is rescinding the January 4, 2021 letters, along with the specific provisions in the attachments to those letters, including those signed by states, and will not accept signed attachments from states based on those letters. Instead, CMS will adhere to the regulations and STCs, which generally provide that States will receive notice and an opportunity to request a hearing before a determination to suspend, modify, or withdraw a demonstration project becomes effective.

CMS remains committed to the state and federal partnership centered on meeting the diverse healthcare needs of the millions of beneficiaries served by Medicaid. States should continue to look to the approved STCs that govern their section 1115 demonstrations and reach out to their section 1115 demonstration project officer with any questions.

Sincerely,

A solid black rectangular box used to redact the signature of Elizabeth Richter.

Elizabeth Richter
Acting Administrator

Exhibit 6



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

March 12, 2021

Ms. Elizabeth Richter, Acting Administrator
Centers for Medicare & Medicaid Services

Ms. Judith Cash, Acting Deputy Director
Center for Medicaid & CHIP Services

Dear Acting Administrator Richter and Acting Deputy Director Cash,

The State of Georgia is responding to letters sent by the Centers for Medicare & Medicaid Services (CMS) on February 12, 2021 regarding the approved 1115 demonstration waiver, Georgia Pathways to Coverage (Georgia Pathways). In its letter CMS stated it is “commencing a process of determining whether to withdraw the authorities approved in the Pathways to Coverage demonstration that permit the state to require work and other community engagement activities as a condition of Medicaid eligibility,” and that CMS has “preliminarily determined” that those provisions of Georgia Pathways would not advance the objectives of the Medicaid program.

The State respectfully disagrees with that preliminary determination. CMS is improperly equating Georgia’s waiver with Medicaid community engagement waivers that CMS has approved in other states as Georgia’s waiver takes a fundamentally different approach. Georgia Pathways advances the statutory purposes of the Medicaid program by 1) promoting increased coverage for Georgians who are currently ineligible for Medicaid and 2) providing “rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” The qualifying hours and activities do not apply to individuals who are otherwise eligible for Medicaid. Rather the qualifying hours and activities are merely a pathway to Medicaid coverage for those who are otherwise ineligible for Medicaid.

Contrary to CMS’s suggestion, the COVID-19 pandemic provides no basis to excise the qualifying hours and activities from the Georgia Pathways program. Georgia Pathways provides a wide range of qualifying activities in which individuals can engage. Moreover, there is also a temporary “good cause” exception if, after enrolling in Medicaid through Georgia Pathways, an individual or immediate family member experiences a hospitalization or serious illness or needs to quarantine due to COVID exposure. If anything, the COVID-19 crisis makes the qualifying hours and activities — which include work, job training, education, or volunteering—more important, not less. CMS must allow this program to begin as planned and authorized.



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

A. The Georgia Pathways program voluntarily grants Medicaid eligibility to individuals who would not otherwise be covered.

Georgia has not fully expanded its Medicaid program and is statutorily barred from doing so under current state law. *See* O.C.G.A. § 49-4-142.1 et seq. In 2012, the U.S. Supreme Court ruled that states had the option of fully expanding Medicaid, but could not be mandated to do so under the Patient Protection and Affordable Care Act (PPACA). The PPACA’s Medicaid expansion was an attempt to “enlist[] States in a new health care program.” *NFIB v. Sebelius*, 567 U.S. 519, 584 (2012) (Roberts, C.J., joined by Breyer & Kagan, JJ.). While “[t]he original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children,” the PPACA “transformed” Medicaid “into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level.” *Id.* at 583. As a result, the expansion meant Medicaid “is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.” *Id.*

As a result of the Supreme Court’s ruling, “States may now choose to reject the expansion.” *Id.* at 587. States may do so for any reason, including “because they are unsure they will be able to afford their share of the new funding obligations, or because they are unwilling to commit the administrative resources necessary to support the expansion.” *Id.*; *see also* CMS, HHS, Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid 11 (Dec. 10, 2012) (explaining that “states have the flexibility to start or stop the expansion.”), <https://go.usa.gov/xmN4j>.

Georgia is one of twelve states that has chosen not to fully expand Medicaid under the ACA. In 2019, however, Georgia decided to pursue a Section 1115 waiver. Georgia began the process by researching other states’ experiences with expansion, conducting environmental scans of Georgia’s population, and analyzing potential options. Georgia officials held meetings with CMS officials in late 2019 to work collaboratively develop the waiver and incorporate a qualifying hours and activities requirement for newly eligible recipients.

Those meetings continued regularly—and often weekly—well into 2020, and CMS made several recommendations to improve Georgia’s plan. For example, CMS asked Georgia to modify its proposal to ensure that there would be coverage for new recipients affected by COVID-19. Georgia responded by agreeing to special terms and conditions (STCs) that excused compliance with the qualifying hours and community activities requirement through a “good cause exception” when a “beneficiary is quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, or exposure to COVID-19, or because of a closure of the place(s) where the beneficiary was meeting the hours requirement related to COVID-19 and as a result, is unable to fulfill the hours and activities requirement.” STC ¶36(h). Georgia and CMS also agreed that the State would provide “reasonable accommodations to individuals with disabilities protected by the ADA,” which may include an accommodation for disabilities caused by COVID-19 after a beneficiary enrolled. *See* STC ¶37(d).



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

These negotiations resulted in a comprehensive plan that benefitted all stakeholders. CMS advanced its goal of increasing Medicaid coverage; Georgia advanced its goal of promoting activities to help individuals attain independence and self-reliance; and Georgians with income up to 100% of the federal poverty level became eligible for Medicaid benefits for the first time. In short, even though Georgia had no obligation to expand eligibility, the State worked with CMS in good faith to adopt an innovative program to deliver coverage to a new category of individuals while helping them build important skills and become more independent and self-reliant.

B. Revoking the qualifying hours and activities of Georgia’s Section 1115 waiver would be arbitrary and unlawful.

CMS’ February 12, 2021 letter suggests that the agency intends to seek major changes to the carefully negotiated Georgia Pathways waiver. The letter states that “[t]he COVID-19 pandemic has made community engagement infeasible” and Georgia Pathways thus “would not promote the objectives of the Medicaid program.” However, the agency still wants to “leav[e] in place ... the extension of Medicaid eligibility to certain otherwise-ineligible individuals.” Any attempt to change the terms of the waiver at this late stage would be arbitrary and unlawful, and CMS must allow the Georgia Pathways program to proceed as initially designed.

First, any attempt to excise the qualifying hours and activities undermines the waiver’s intent and constitutes an arbitrary and unlawful bait-and-switch. Under *NFIB*, Georgia had *no obligation* to expand Medicaid to individuals with incomes below 133% of the poverty line. Nonetheless, Georgia worked closely with CMS and relevant stakeholders to develop an innovative program to voluntarily expand coverage to tens of thousands of otherwise-ineligible, low-income Georgians while ensuring that those individuals were taking steps to build skills, find work, complete additional education, or volunteer in their communities. Any attempt to excise the qualifying hours would arbitrarily upend the policy choices at the heart of this program. As the Supreme Court explained in *NFIB*, the “legitimacy” of any expansion of the Medicaid program requires that the State “voluntarily and knowingly accepts the terms of the contract.” 567 U.S. at 77 (Roberts, C.J., joined by Breyer & Kagan, JJ.). And “[r]especting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system.” *Id.*; see also *id.* at 675-79 (Scalia, Kennedy, Thomas, & Alito, JJ., dissenting) (same). Here, Georgia unequivocally did not “voluntarily and knowingly” agree to expand coverage absent the qualifying hours and activities.

Second, any attempt to excise the qualifying hours and activities would make it impossible to effectuate the expansion as is the qualifying hours and activities are core to the waiver. Implementing Pathways absent qualifying hours and activities would eliminate the mechanism for enrolling individuals in Medicaid and, ultimately, defeats the purpose of the demonstration waiver. Simply put, without the qualifying hours and activities, no one currently ineligible for Medicaid would be able to enroll in Medicaid under current Georgia law.



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OF COMMUNITY HEALTH**

Third, in a letter dated January 4, 2021, CMS reaffirmed its commitment to Georgia Pathways. That letter noted that programs like Georgia Pathways “have proven to be a cornerstone of state innovation from which new best practices can emerge and next generation program design be fostered.” CMS Ltr. 1 (Jan. 4, 2021). And the letter further affirmed that, “[b]y their nature, section 1115 demonstrations represent a contract between state and federal government.” *Id.* For that reason, the letter outlined the terms and conditions through which CMS could withdraw approval of the Georgia Pathways waiver. Among other provisions, those terms outlined that “CMS shall make the effective date for its determination no sooner than 9 months after the date on which CMS transmits its determination.” *Id.* at 2. Georgia agreed to CMS’ terms shortly thereafter.

CMS has now indicated that it wishes to rescind that agreement. CMS’ proffered reason for that attempt is no different than its proffered reason for eliminating the qualifying hours and activities: “The current COVID-19 pandemic and economic environment ... necessitate that CMS maintain the regulatory flexibility to respond appropriately to the current or changed circumstances” Yet, CMS did not identify any “changed circumstances” in the thirty-two days between January 4 to February 12, nor could it. As noted below, the pandemic’s conditions have only *improved* over that time period.

Fourth, CMS’ references to the COVID-19 pandemic provide no basis to excise the qualifying hours and activities. Unlike programs in some other states, Georgia’s waiver is unique and the first of its kind, as it does not impose any requirements on existing Medicaid recipients. Rather, Georgia provides a pathway for individuals to newly obtain Medicaid coverage through participation in a wide range of possible activities. Thus, as CMS previously recognized, “expanding Medicaid coverage to individuals not previously eligible will have a significant positive impact on access to health care during and after a public health emergency.” CMS Approval Ltr. 14 (Oct. 15, 2020). CMS makes no attempt to explain in its latest letter how *expanding* coverage in a pandemic would fail to “promote the objectives of the Medicaid program.” Moreover, the COVID-19 pandemic was ongoing when CMS approved Georgia Pathways in October. CMS raised specific concerns about the pandemic’s impact on potential beneficiaries throughout the waiver negotiations, and Georgia specifically addressed those concerns to CMS’ satisfaction in the STCs. CMS fails to explain why it has suddenly changed its position about the adequacy of these measures.

Fifth, if anything, the COVID-19 pandemic makes the qualifying hours and activities more important, not less. In approving the Georgia Pathways program, CMS highlighted that “recent research during the COVID-19 pandemic indicates that factors such as a lack of economic participation, social isolation, and other economic stressors have negative impacts on mental and physical health” CMS Approval Ltr. 1 n.1 (Oct. 15, 2020). Therefore, “incentives and requirements that increase such participation may have a positive effect on beneficiary health and economic mobility.” *Id.*

Even for individuals facing economic disruption or job losses, the qualifying hours and activities contains significant flexibility for beneficiaries to choose activities that will help them learn



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new skills and move toward independence and self-sufficiency. See STC ¶33 (documenting seven different categories of qualifying activities). Of course, new participants can qualify through public or private employment, including self-employment and employment as an independent contractor. They can also qualify for Medicaid coverage with a variety of other pursuits. On-the-job training counts. So does participation in job readiness activities related to the *preparation* for employment, including GED programs, rehabilitation activities, or vocational educational training. Enrollment in an institution of higher education qualifies as well. Beneficiaries can also volunteer with “public or non-profit organizations participating in projects that serve the community.” Additionally, a participant does not even need to do any of these activities full time. Georgia Pathways requires only eighty hours per month. See STC ¶32.

The program also contains a “good cause” exception for individuals already enrolled in Georgia Pathways who subsequently become unable to meet their qualifying hours due to injury or illness, including illness of a family member; the birth or adoption of a child; a family emergency, such as domestic violence; the loss of housing; and several other reasons. See STC ¶36. Moreover, the “good cause” exception expressly covers Georgia Pathways participants who are quarantining due to COVID-19 exposure or unable to meet the qualifying hours and activities due to a public health emergency. See STC ¶36(h). This robust “good cause” exception directly refutes the suggestion in CMS’ February 12, 2021 letter that COVID-19 has made it “infeasible” to implement the qualifying hours and activities. The program’s current terms—adopted in close coordination with CMS officials—contain more than ample flexibility for individuals affected by the pandemic.

Finally, any attempt to rescind the qualifying hours and activities would be especially arbitrary given that COVID cases, hospitalizations, and deaths are plummeting, both in Georgia and nationwide. President Biden recently announced that every adult in the country will have access to a vaccine by the end of May 2021. See William Wan et al., *Biden promises enough coronavirus vaccine for ‘every adult in America’ by the end of May*, Washington Post (March 2, 2021), <https://wapo.st/3uReWnP>. Georgia’s high schools, technical colleges, and university systems are open for both in-person and virtual settings. Moreover, as evidenced by Georgia’s relatively low unemployment rate of 5.3% in March 2021, employers are accelerating hiring as the pandemic wanes and the economy recovers. In short, there is no reason to believe that COVID-19 will make it infeasible for individuals go engage in the qualifying hours and activities beginning as planned on July 1, 2021.

For all of these reasons, revoking the qualifying hours and activities of the Georgia Pathways waiver would be arbitrary, unreasonable, and unlawful. We firmly believe that the Georgia Pathways waiver promotes the purposes of the Medicaid program by expanding coverage to currently uninsured individuals, is essential to helping beneficiaries build new skills and move toward independence, and contains sufficient flexibility to accommodate individuals impacted by COVID-19 or other injuries or illnesses. The State welcomes the opportunity to discuss this matter with CMS further given the importance of providing this new coverage option for Georgians. However, should CMS revoke approval of the waiver, Georgia will challenge the decision.



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

Sincerely,

A handwritten signature in blue ink, appearing to read "Frank W. Berry".

Frank W. Berry
Commissioner

cc: The Honorable Brian P. Kemp, Governor of Georgia
Ms. Etta Hawkins, State Monitoring Lead, Medicaid and CHIP Operations Group

Exhibit 7



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

Via email only: judith.cash@cms.hhs.gov

June 24, 2021

Judith A. Cash
Acting Deputy Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services

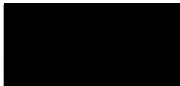
Dear Judith:

The Georgia Department of Community Health (DCH) appreciates the historical partnership between our agencies in moving Georgians toward increased opportunities for access to health care coverage, particularly through our section 1115 demonstration Pathways to Coverage ("Pathways").

Pursuant to the CMS letter issued February 12, 2021, we understand that CMS is continuing its examination of the status of the authorities approved for the Pathways demonstration by the prior administration and appreciate the continued discussions. Accordingly, as we rapidly approach the previously approved implementation date of July 1, 2021 to make Pathways available to Georgia's citizens, we are proposing to delay the go-live date until at least August 1, 2021.

We expect this proposal is amenable to you, and if you have questions or concerns, please contact me.

Respectfully,



Frank W. Berry

Exhibit 8



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

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).¹ 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.

¹ 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.² 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.”³

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)⁴ 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

² 42 U.S.C. § 1315.

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

⁴ 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,⁵ 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.⁶ 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 2020.⁷ Furthermore, the impacts of the pandemic and the economic fallout continue to remain particularly prevalent among Black and Latino⁸ populations, and other people of color, as well as in households with children.⁹

⁵ 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/>.

⁶ 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. 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>.

⁷ 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.

⁸ 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.

⁹ 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->

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.¹⁰ 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

¹⁰ 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](#); Tipirneni 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,¹¹ 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,¹² while the vaccination rates in the state remain lower in comparison to the national rates.¹³ We also remain concerned that the lingering effects of COVID-19 for some patients, including chronic fatigue, confusion, memory loss, and joint pain,¹³ (hereafter referred to as

¹¹ 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>.

¹² 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>.

¹³ 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.¹⁴ 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.¹⁵ 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.¹⁶ The Georgia Pathways to Coverage demonstration involves a

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

¹⁴ 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/>.

¹⁵ 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/>.

¹⁶ 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

National Estimates of Potential Coverage Losses. Kaiser Family Foundation. Retrieved from <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/>.

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.¹⁷ The reduction in probability of enrollment varied by estimated monthly payment amount; the estimated effects in the study suggest that, for example, for an

¹⁷ 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.¹⁸

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.¹⁹ 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.²⁰ 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,²¹ 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.²² 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

¹⁸ 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>.

¹⁹ 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>.

²⁰ 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.

²¹ 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>.

²² 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.²³ 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,²⁴ and individuals with lower incomes compared to those with higher incomes.²⁵ In Georgia, Black, Hispanic,²⁶ 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.²⁷ 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.²⁸ Further, premiums

²³ 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).

²⁴ 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.

²⁵ 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>.

²⁶ 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.

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

²⁸ 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; 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.²⁹ 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.³⁰ 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.³¹ Between 2017 and 2019, an average of 28 percent of non-elderly adults in Georgia below 100 percent of the FPL were uninsured.³² Additionally, 60 percent of the entire uninsured population over the age of 16 was already working at least part-time.³³ The rate of employment among this group was similar to that of Georgia’s Medicaid beneficiary population. For example, research

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).

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

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

³¹ 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/>.

³² 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>.

³³ 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.³⁴ 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.³⁵

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.³⁶ 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.³⁷

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).³⁸ 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.

³⁴ 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/>.

³⁵ Garfield et al. (2021). Work Among Medicaid Adults.

³⁶ Garfield et al. (2021). Work Among Medicaid Adults.

³⁷ 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>.

³⁸ 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.³⁹ 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."⁴⁰ 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.⁴¹ 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.⁴² 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

³⁹ 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>.

⁴⁰ 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>.

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

⁴² 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.⁴³ 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.⁴⁴

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.⁴⁵ 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).⁴⁶ 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.

⁴³ 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>.

⁴⁴ Wagner & Schubel (2020).

⁴⁵ Solomon, J. (2019).

⁴⁶ 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.⁴⁷ 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.⁴⁸ 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.⁴⁹ 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.⁵⁰ 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.⁵¹ 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

⁴⁷ 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>.

⁴⁸ 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; 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>.

⁴⁹ Wagner, J. & Schubel, J. (2020).

⁵⁰ Hill, I., Burroughs, E. & Adams, G. (2020).

⁵¹ Ku, L. & Ross, D.C. (2002).

their coverage resumed.⁵² 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.⁵³ 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.⁵⁴ 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,⁵⁵ 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 2019.⁵⁶

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.⁵⁷ 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.⁵⁸ 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

⁵² University of Wisconsin-Madison Institute for Research on Poverty. (2019).

⁵³ Sommers et al. (2020).

⁵⁴ Sommers et al. (2020).

⁵⁵ 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>.

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

⁵⁷ 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; 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>.

⁵⁸ 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.⁵⁹

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.⁶⁰ 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.⁶¹ 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

⁵⁹ 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).

⁶⁰ 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>.

⁶¹ 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,⁶² while also experiencing overall higher rates of COVID cases and deaths.⁶³ If employment opportunities are limited,

⁶² 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/>.

⁶³ 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.⁶⁴

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,⁶⁵ and as many as 30 percent still experienced symptoms at least six months after their infections.⁶⁶ 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.⁶⁷ 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.⁶⁸ 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.⁶⁹ 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.⁷⁰ 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),⁷¹ 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

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

⁶⁵ 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>.

⁶⁶ 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>.

⁶⁷ 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>.

⁶⁸ Ziauddeen et al. (2021).

⁶⁹ 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/>.

⁷⁰ 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/>.

⁷¹ 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.⁷²

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.⁷³ 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.⁷⁴

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.⁷⁵ 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).⁷⁶

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.⁷⁷ Working mothers were more likely to reduce work hours to aid in

⁷² 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>.

⁷³ 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).

⁷⁴ 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/>.

⁷⁵ 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>.

⁷⁶ 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/>.

⁷⁷ Ranji et al. (2021).

caregiving activities compared to working fathers during the pandemic.⁷⁸ Additionally, while women have been responsible for the majority of childcare obligations during the pandemic, they are also more likely to experience long COVID.⁷⁹ 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.⁸⁰

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).⁸¹ 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.⁸² As of November 2021, many public transportation systems continue to operate at limited capacity, on modified schedules, and/or with higher fare rates.⁸³

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).⁸⁴ 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.⁸⁵ 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.⁸⁶ 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.⁸⁷

⁷⁸ 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>.

⁷⁹ Logue et al. (2021).

⁸⁰ Sykes et al. (2021).

⁸¹ 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>.

⁸² Georgia Department of Transportation. (2020). Georgia Statewide Transition Plan. Retrieved from http://www.dot.ga.gov/InvestSmart/Transit/StatewideTransitPlan/PublicMeeting/2020/GeorgiaStatewideTransitPlan_DRAFT.pdf.

⁸³ 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).

⁸⁴ Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment.

⁸⁵ 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/>.

⁸⁶ 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/>

⁸⁷ 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.⁸⁸ Between July and September of 2021, Black workers were approximately 1.4 times more likely to be unemployed compared to White workers in Georgia.⁸⁹ 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.⁹⁰

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.⁹¹ 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.⁹² Moreover, in a survey of adults living in renter households, approximately 30 percent of respondents reported difficulty covering usual expenses in October 2021.⁹³ 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.⁹⁴

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.⁹⁵ 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 2019.⁹⁶ In Georgia, 286,000 individuals did not have access to an internet provider as of

⁸⁸ 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/>.

⁸⁹ Moore, K. (2021).

⁹⁰ Butler, T.S. (2021).

⁹¹ 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>.

⁹² 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.

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

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

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

⁹⁶ 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 2021.⁹⁷ 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.⁹⁸ 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.⁹⁹ 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.¹⁰⁰

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;¹⁰¹ 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.¹⁰² Further, the risk of experiencing long COVID is greater for those who live in poverty and for non-White populations, including Black, Latinx,¹⁰³ American Indian/Alaska Native, Asian, and Native Hawaiian and Pacific islander populations.¹⁰⁴ Individuals in these groups are

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

⁹⁸ 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.

⁹⁹ 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.

¹⁰⁰ 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).

¹⁰¹ 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>.

¹⁰² 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.

¹⁰³ 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.

¹⁰⁴ 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.¹⁰⁵

Furthermore, Black and Hispanic adults have been more likely than White adults to report symptoms of anxiety and/or depressive disorder during the pandemic.¹⁰⁶ 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.¹⁰⁷ 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.¹⁰⁸

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

¹⁰⁵ 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).

¹⁰⁶ 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/>.

¹⁰⁷ 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>.

¹⁰⁸ 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 2021.¹⁰⁹ Compared to pre-pandemic conditions, these data suggest that the labor force is still down in November 2021 by approximately 2.5 million individuals.¹¹⁰

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.¹¹¹

Layoffs can also impact an individual's mortality and morbidity risks.¹¹² 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.¹¹³ 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.¹¹⁴ For Georgians living with long COVID symptoms who also experienced layoffs, health care access could be especially important in the aftermath of the pandemic.

¹⁰⁹ 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>.

¹¹⁰ 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.

¹¹¹ 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.

¹¹² 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>.

¹¹³ 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_gje.pdf.

¹¹⁴ 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.¹¹⁵ 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.

¹¹⁵ 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 population¹¹⁶ while COVID-19 vaccination rates in Georgia are currently below the national average. As of

¹¹⁶ 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.¹¹⁷ Evidence suggests that low-wage work is associated with the spread of COVID-19 due to unsafe work conditions.¹¹⁸ 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.¹¹⁹ 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-19.¹²⁰

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,¹²¹ but would lose coverage because of the inherently complex reporting requirements.¹²² 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.¹²³ 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

¹¹⁷ The Mayo Clinic. (2021). U.S. COVID-19 vaccine tracker.

¹¹⁸ 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; see also Wolfe, Harknett, and Schneider (2021).

¹¹⁹ Wolfe, Harknett, and Schneider (2021).

¹²⁰ 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).

¹²¹ 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.

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

¹²³ 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.¹²⁴ 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.¹²⁵

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.¹²⁶ This would be more challenging for individuals who are self-employed and therefore may not have such documentation readily available.¹²⁷ 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.¹²⁸

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.¹²⁹ In addition, the nuances of

¹²⁴ Solomon, J. (2019).

¹²⁵ 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.

¹²⁶ 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; see also Katch, H., Wagner, J. & Aron-Dine, A. (2018).

¹²⁷ Katch, H., Wagner, J. & Aron-Dine, A. (2018).

¹²⁸ Katch, H., Wagner, J. & Aron-Dine, A. (2018).

¹²⁹ 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.¹³⁰ 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.¹³¹ Moreover, the mental stress and negative health implications of administratively burdensome programs may be more pronounced among populations of racial minorities.¹³²

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.”¹³³ While unemployment and job losses have been shown to adversely affect health,¹³⁴ 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.¹³⁵ 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

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>.

¹³⁰ 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/>.

¹³¹ Herd & Moynihan (2020).

¹³² 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>.

¹³³ 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).

¹³⁴ 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; 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).

¹³⁵ 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.¹³⁶ Pandemic-related complications, such as limited access to transportation and accessible and affordable child care,¹³⁷ 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.¹³⁸ Moreover, about half of Georgian children under 13 in a working family are from a low-income working family.¹³⁹ Additionally, nine percent of licensed child care programs in the state closed permanently since the beginning of the pandemic.¹⁴⁰ 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.¹⁴¹ 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,¹⁴² and lack of child care was one of the most frequently cited reasons for not working at the end of 2020.¹⁴³ 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-19.¹⁴⁴ Because Georgia Pathways to Coverage would not provide child care exemptions, good cause exceptions, or credit toward qualifying

¹³⁶ 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/>.

¹³⁷ 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.

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

¹³⁹ 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>.

¹⁴⁰ 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>.

¹⁴¹ 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>.

¹⁴² Tagami, T. (2021).

¹⁴³ McGrath, J. (2021).

¹⁴⁴ 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,¹⁴⁵ 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.¹⁴⁶ 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.¹⁴⁷ 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.¹⁴⁸ 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.¹⁴⁹ 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.¹⁵⁰ 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.¹⁵¹ 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

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

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

¹⁴⁷ Tagami, T. (2021).

¹⁴⁸ 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.

¹⁴⁹ Ho and Boak (2021).

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

¹⁵¹ Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from 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.¹⁵² 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

¹⁵² 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 handwritten signature in blue ink that reads "Chiquita Brooks-LaSure". The signature is written in a cursive, flowing style.

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 \$1.00 for rentals and supplies
Pharmacy – Copayment varies based on the cost to the state.	\$10.00 or less: \$0.50 \$10.01 to \$25.00: \$1.00 \$25.01 to \$50.00: \$2.00 \$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.

- a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- b. 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.
- c. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be

identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the 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 OR 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.¹

¹ 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

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 or Agg*	WOW Only, WW Only, or Both	BASE YEAR [define]	TREND	DY 1	DY 2	DY 3	DY 4	DY 5
Low Income 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.

Table 9: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
	Cumulative Target Definition	Percentage
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

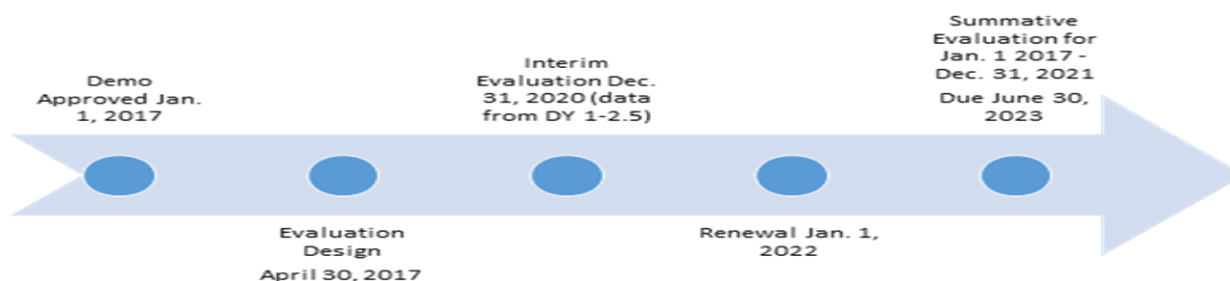
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, 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
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

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

- 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.

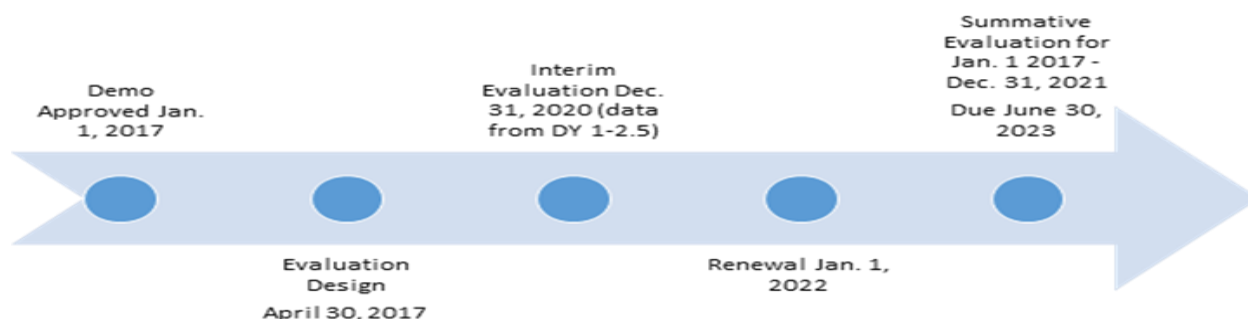
The format for the Interim and Summative Evaluation reports is as follows:

- 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)**

Exhibit 9

STATE OF GEORGIA

DEPARTMENT OF COMMUNITY HEALTH



Patients First Act Implementation Project

**IMPLEMENTATION ADVANCE PLANNING DOCUMENT
FFY 2021 - 2022**

SUBMITTED AUGUST 25, 2021



Patients First Act Implementation Project
Implementation Advance Planning Document

DOCUMENT HISTORY

DATE	AUTHOR	VERSION	CHANGE REFERENCE
September 18, 2020	DCH	1.00	Implementation APD submitted to CMS for review and approval
October 29, 2020	DCH	1.01	Updates made to version 1.00 and re-submitted to CMS with changes made between version 1.00 and 1.01 highlighted; "DXC Technologies" updated to "Gainwell" to reflect vendor's name change.
November 14, 2020	DCH	1.02	Updates made to version 1.01 and resubmitted to CMS with changes made between version 1.01 and 1.02 highlighted; changes primarily include the 1332 waiver cost allocation as well as additional detail describing the IES functionality benefitting both the 1332 waiver and the Medicaid Program
August 25, 2021	DCH	2.00	Annual Implementation APD update FFY 2021; formal submission to CMS for review and approval

CMS APPROVAL HISTORY

APPROVAL DATE	APPROVAL LETTER ID
November 17, 2021	GA-2020-09-18-EE-IAPD-GA Patients First Act-FFY2021

STATE AGENCY CONTACT INFORMATION

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SECTION 1 EXECUTIVE SUMMARY – UPDATED JULY 2021

The Patients First Act (PFA) Implementation Project is a joint effort between Georgia Department of Community Health (DCH, Department) and the Georgia Department of Human Services (DHS). The purpose of the project is to design, develop, and implement modifications and enhancements to the State's existing Eligibility and Enrollment (E&E) system / Integrated Eligibility System (IES), Medicaid Management Information System (MMIS) and Fiscal Agent (FA) Services, and Third Party Liability (TPL) Services to enable the implementation of the Georgia Pathways Program (1115 waiver) and the Georgia Access Program (1332 waiver).

This Implementation Advance Planning Document (APD) provides an annual update on the project's status to the Centers for Medicare & Medicaid Services (CMS). On November 17, 2021, CMS approved federal funding for the project for the period of Federal Fiscal Year (FFY) 2020 through FFY 2022 effective September 28, 2020 (GA-2020-09-18-EE-IAPD-GA Patients First Act-FFY2021), including:

- \$812,978 in MMIS funding (\$474,236 for TPL Services and \$338,742 for MMIS and FA Services)
- \$65,337,761 in E&E / IES funding

This Implementation APD Update requests:

- \$1,177,478 in MMIS funding (includes MMIS and TPL) for the period of FFY 2021 through FFY 2022, which is an increase of \$364,500 in requested funding
- \$75,178,997 in E&E funding for the period of FFY 2021 through FFY 2022, which is an increase of \$9,841,236 in requested funding

The increases are due to licensing and contracted services costs that are estimated to be higher than originally forecast.

This APD also reflects a transition to an outcome-based certification process. Exhibit 1: Pathways Program Outcomes and Metrics presents the outcomes and metrics for the 1115 waiver.

OUTCOMES	METRICS
Georgia Pathway policies will increase access to primary care.	The percentage of members 20 years and older who had an ambulatory or preventive care visit
Georgia Pathway policies will reduce the number of uninsured in Georgia.	Number of adults ages 19-64 in Georgia without healthcare coverage
Georgia Pathway policies will increase the number of Georgia Pathways participants who transition to commercial health insurance, including employer sponsored insurance and marketplace plans, after separating from Medicaid.	Number of members with reported enrollment in commercial coverage, including ESI and Marketplace plans, within 1 year of disenrollment from Medicaid



Patients First Act Implementation Project
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OUTCOMES	METRICS
Georgia Pathway policies will encourage members to use Member Rewards Account for services outside of copays.	The percentage of members who use their Member Rewards Account for added services
Georgia Pathway policies will increase the number of Georgia residents below and up to 100 percent of the FPL enrolled in employer sponsored insurance.	Number of enrolled members with employer sponsored insurance
Georgia Pathways policies will increase the number of adults below and up to 100 percent of the FPL who are engaged in at least 80 hours a month of employment or employment-related activities.	Percentage of adults engaged in at least 80 hours per month of work or other employment-related activities
Georgia Pathways policies will increase wage growth for those made eligible for Medicaid through the Demonstration.	Incomes of those enrolled in Pathways or who transition off of Pathways to commercial coverage
The General Fund contribution will remain below the national average as measured by the National Association of State Budget Officers (NASBO).	The State share of Medicaid as a percentage of the State budget

Exhibit 1: Pathways Program Outcomes and Metrics

The outcome and corresponding metric for the 1332 waiver are shown in Exhibit 2: Georgia Access Program Outcomes and Metrics.

OUTCOMES	METRICS
The Georgia Access Model will attract uninsured individuals into the market resulting in increased growth in enrollment.	Number of consumers selecting plans and effectuating coverage in the individual market during waiver years, starting in Plan Year 2023 compared to without the waiver

Exhibit 2: Georgia Access Program Outcomes and Metrics

In addition to the revised MMIS federal funding request and the adoption of the outcomes-based certification process described above, other significant updates include:

- The Department received federal approval for the Georgia Access Program (1332 waiver) on November 1, 2020. Work is underway to design, develop, and implement necessary enhancements and modifications to state Medicaid IT systems to enable the Georgia Access Program, which will be implemented by November 2022 Open Enrollment for effectuated enrollment on January 1, 2023.
- The Department received federal approval for the Georgia Pathways to Coverage Program (1115 waiver) on October 15, 2020. Work to design, develop, and implement the necessary enhancements and modifications to state Medicaid IT systems for Release 1 of the Georgia Pathways Program (1115 waiver) has been completed. Activities to design, develop, and implement the functionality required for Release 2 are underway.
- On February 12, 2021, CMS notified DCH that it would be reviewing the waiver authorities approved for the Pathways to Coverage Program. On July 27, 2021, DCH



notified CMS that it would further delay the planned July 1, 2021 effective date of the Pathways Program to support continued discussions regarding the status of approved waiver authorities and Georgia's goals and objectives for the program.

The Implementation APD has been updated to provide the most current project timeline, budgets, cost allocation, and activity and deliverable status. Although the Pathways Program implementation has been delayed as noted above, project activities to design, develop, test, and prepare for implementation continue as planned. Those activities impacted by the decision to delay the implementation are identified as "Pending".

1.1 Business Need – Updated July 2021

During Georgia's 2019-2020 Regular Session, the General Assembly passed Senate Bill 106, the Patients First Act (the Act), which Governor Brian Kemp signed into law on March 27, 2019. The Act authorized DCH to submit a Section 1115 Medicaid demonstration waiver which could include an increase in the income threshold up to 100 percent of the federal poverty level (FPL) and also authorized the Governor to submit a Section 1332 waiver to identify innovative health insurance coverage solutions for the commercial health insurance marketplace. The Act grants the authority to implement the waivers upon federal approval. The Department received federal approval for the 1115 waiver and 1332 waiver on October 15, 2020 and November 1, 2020, respectively.

Together the 1115 and 1332 waivers represent Georgia's initiative to empower its citizens to increase their access to affordable healthcare coverage and improve their health and well-being.

Georgia Pathways 1115 Demonstration Waiver – Updated July 2021

The Georgia Pathways 1115 demonstration waiver provides for adults, aged 19 to 64, with incomes up to 100 percent of the FPL who are not otherwise eligible for Medicaid, to gain access to affordable, quality healthcare. To further support individuals on their journey to self-sufficiency and the destination of commercial health insurance coverage, Georgia Pathways embraces private market policies and principles, such as premiums, copayments, member rewards accounts, and prospective Medicaid eligibility for a segment of the program's population. The Department received federal approval for the Pathways Program on October 15, 2021, and DCH and DHS began design, development, and implementation activities to support a planned effective date of July 1, 2021 for this new category of assistance.

1332 State Relief and Empowerment Waiver – Updated July 2021

Georgia has received approval of a 1332 State Relief and Empowerment Waiver to improve the access and affordability of healthcare coverage within the individual market and improve the eligibility determination and referral process for individuals transitioning to and from Medicaid and the individual market. The impacted population will be individuals with incomes over 100 percent of the FPL who are currently purchasing coverage through healthcare.gov.

The 1332 waiver implements two new programs in the State, including the implementation of a Reinsurance Program and the Georgia Access Program. The Reinsurance Program will stabilize the individual market, reducing premiums and incentivizing carriers to offer plans in



more regions across the State by reimbursing health insurers a portion of high cost claims. With approval of the 1332 waiver, the Reinsurance Program will be effective in January 2022. This program does not impact the Medicaid population or the IES; therefore, any expenditures associated with the Reinsurance Program are excluded from this APD.

The second program in the 1332 waiver is the establishment of the Georgia Access Program in which the State will transition its individual market from the Federally Facilitated Exchange (FFE) to a competitive private insurance marketplace that provides Georgia's residents with better access, improved customer service, and expanded choice of affordable coverage options. In the Georgia Access Program, residents will use private vendors (web-brokers and carriers) to shop for and select commercial insurance, including Qualified Health Plans (QHPs). These private vendors will be certified by the State to participate in the Georgia Access Program and interface with the IES which will determine consumer eligibility for Medicaid, QHPs, and Advanced Premium Tax Credits (APTCs). The Georgia Access Program will be implemented by November 2022 Open Enrollment for effectuated enrollment on January 1, 2023.

The budget costs reflected in this APD for the 1332 waiver include only implementation costs associated with the IES system development needed to enable the Georgia Access Program. The budget does not include the non-technology programmatic aspects associated with the transition of Georgia's individual market from Healthcare.gov to the State which encompasses a multitude of regulatory and other non-technical implementation activities spanning a number of agencies, including the Georgia Office of Insurance and Safety Fire Commissioner (OCI) and Office of Health Strategy and Coordination (OHSC) within the Governor's Office. Approximately 76 percent of the IES system development required to enable the Georgia Access Program are extensions of existing functionality that further streamline and support efficiency in Medicaid. Because the functionality benefits both the Georgia Access Program and the Medicaid Program, the State is requesting Medicaid Federal Financing Participation (FFP) on the share of the 1332 waiver system implementation costs that benefit the Medicaid Program.

1.2 Patients First Act Implementation Project Overview – Updated July 2021

The Patients First Act is one of Governor Kemp's stated healthcare priorities seeking to further the State's vision of creating a "A Healthy Georgia" by providing Georgians with access to affordable, quality healthcare. Without the required system functionality to support program business processes, implementation of the new waiver programs is not possible.

To address the need for the system functionality necessary to enable the waiver programs and to meet the State's implementation deadlines, DCH and DHS chartered the Patients First Act Implementation Project. Based on an analysis of waiver policy and system requirements, the agencies have determined that the State should leverage existing IT assets to support the Georgia Pathways Program and Georgia Access Program, including the following:

- Eligibility & Enrollment / Integrated Eligibility System (operated by Deloitte Consulting)
- MMIS and Fiscal Agent Services (operated by Gainwell Technologies)
- Third Party Liability Services (operated by HMS)



The implementation of the Georgia Pathways Program (1115 waiver) impacts all three Medicaid IT systems, while the implementation of the Georgia Access Program (1332 waiver) impacts only the E&E / IES.

Multiple workstreams have been engaged to successfully accomplish the scope of work. Three workstreams are focused on the necessary modifications and enhancements to the E&E / IES, MMIS, and TPL systems and related services. In addition, there are five support services workstreams to help ensure project success, including waiver advisory, monitoring and reporting services, project management office (PMO) services, organizational change management (OCM) services, and independent verification and validation (IV&V) services.

The State developed a multi-phase approach to the Patients First Act Implementation Project with priority given to implementation of the core Pathways functionality. The project's release strategy is summarized as follows:

- Georgia Pathways Release 1: Core Functionality (Oct 2020 – Jul 2021(Pending))
- Georgia Pathways Release 2: Renewals and Health Insurance Premium Payment (HIPP) Integration (Jan 2021 – Jan 2022)
- Georgia Pathways Release 3: Member Rewards Account (MRA) Integration (Aug 2021 – Jul 2022)
- Georgia Access Program: All Access Program Functionality (Apr 2021 – Nov 2022)

A high-level timeline for the project is shown in Exhibit 3: Project Timeline. The project began in Q1 FFY 2021 and is planned to end in Q1 FFY 2023.

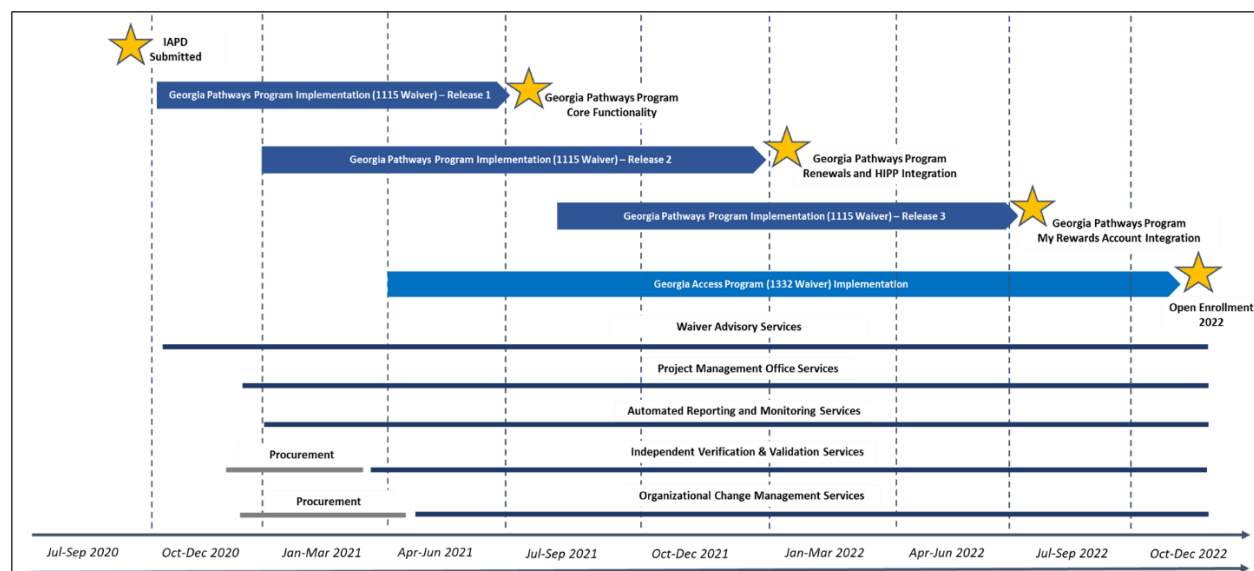


Exhibit 3: Project Timeline

In this Implementation APD, the State describes the project organization, personnel, roles and responsibilities, acquisitions, activities, and deliverables for the Patients First Act Implementation effort.



1.3 Project Budget and Funding Request – Updated July 2021

The State estimates the Georgia Pathways Program (1115 waiver) will cost approximately \$1.8 billion over the next five years to implement and operate. The budgets and cost allocation included in this APD to modify the State's existing Medicaid IT systems to support the Georgia Pathways Program represent approximately 4 percent and 3.4 percent of the overall program cost, respectively.

The State estimates the Georgia Access Program (1332 waiver) will cost approximately \$2.5 billion over the next five years to implement and operate. The budgets and cost allocation included in this APD to modify the State's existing IES / E&E to support the Georgia Access Program represent approximately 0.68 percent and 0.38 percent of the overall program cost, respectively.

Because the project involves the E&E / IES system, MMIS and FA Services, and TPL Services, the State has created three separate funding requests as shown below.

Exhibit 4: MMIS and FA Services Budget and Funding provides a summary of the MMIS and FA Services expenditures and funding for FFY 2021 and FFY 2022. These expenditures support the design, development, and implementation of MMIS and FA Services functionality enabling the Georgia Pathways Program (1115 waiver).

FFY	EXPENDITURES	FEDERAL SHARE	STATE SHARE
2021	\$346,913	\$312,222	\$34,691
2022	\$179,467	\$161,520	\$17,947
TOTAL	\$526,380	\$473,742	\$52,638

Exhibit 4: MMIS and FA Services Budget and Funding

The estimated MMIS and FA Services expenditures for the period of FFY 2021 through FFY 2022 are \$526,380, with a federal share of \$473,742 and a state share of \$52,638. This is an increase of \$150,000 in the project budget and an increase of \$135,000 in funding for FFY 2021.

With this APD, DCH requests \$473,742 in funding for MMIS and FA Services, including \$312,222 for FFY 2021 and \$161,520 for FFY 2022.

Exhibit 5: TPL Services Budget and Funding provides a summary of the TPL Services expenditures and funding for FFY 2021 and FFY 2022. These expenditures support the design, development, and implementation of HIPP Program functionality enabling the Georgia Pathways Program (1115 waiver).

FFY	EXPENDITURES	FEDERAL SHARE	STATE SHARE
2021	\$149,276	\$134,348	\$14,928
2022	\$632,653	\$569,388	\$63,265
TOTAL	\$781,929	\$703,736	\$78,193

Exhibit 5: TPL Services Budget and Funding



The estimated TPL Services expenditures for the period of FFY 2021 through FFY 2022 are \$781,929, with a federal share of \$703,736 and a state share of \$78,193. This is an increase of \$255,000 in the project budget and an increase of \$229,500 in federal funds for FFY 2022.

With this APD, DCH requests \$703,736 in funding for TPL Services, including \$134,348 for FFY 2021 and \$569,388 for FFY 2022.

Exhibit 6: E&E / IES Budget and Funding provides a summary of the E&E / IES expenditures and funding for FFY 2021 through Q1 FFY 2023. These expenditures support the design, development, implementation, and operation of E&E / IES functionality enabling the Georgia Pathways Program (1115 waiver) and Georgia Access Program (1332 waiver). The funding request for the Georgia Access Program (1332 waiver) includes only the share of costs benefitting the Medicaid Program.

FFY	EXPENDITURES	FEDERAL SHARE	STATE SHARE
2021	\$45,116,667	\$39,064,392	\$6,052,275
2022	\$48,785,090	\$36,114,605	\$12,670,485
2023	\$9,450,402	\$6,917,011	\$2,533,391
TOTAL	\$103,352,159	\$82,096,008	\$21,256,051

Exhibit 6: E&E / IES Budget and Funding

The estimated total E&E / IES expenditures benefitting the Medicaid Program for the period of FFY 2021 through FFY 2022 are \$93,901,757 with a federal share of \$75,178,997 including \$39,064,392 in FFY 2021 and \$36,114,605 in FFY 2022. This is an increase of \$275,600 and \$9,565,636 in federal funds for FFY 2021 and FFY 2022, respectively.

With this APD, DCH requests \$75,178,997 in E&E funding, including \$39,064,392 for FFY 2021 and \$36,114,605 for FFY 2022.

Note: The total E&E / IES budget of \$103,352,159 is \$8,356,774 greater than the total E&E budget included in the E&E Medicaid Detailed Budget Tables (MDBTs) because \$8,356,774 of costs benefit non-Medicaid programs and are excluded from the MDBTs.

The detailed project budgets and cost allocation are provided in Section 9 and Section 10 of this Implementation APD. Additionally, the following documents are attached in support of the Patients First Act Implementation Project Implementation APD Budget:

- MDBT_GA-MMIS-MDBT Project Summary 1115 Waiver
- MDBT_GA-E&E-MDBT Project Summary 1115-1332 Waiver

1.4 T-MSIS Reporting

The State will continue to transmit monthly T-MSIS files to CMS, providing the critical data and reporting used to assess the performance of Georgia's medical assistance plans. Timely, accurate, and complete beneficiary eligibility and enrollment data needed for T-MSIS will continue to be provided to CMS. The State will work closely with the E&E / IES, MMIS, and TPL contractors to identify any impacts to T-MSIS and plan for and execute a smooth transition,



including comprehensive and rigorous testing and data validation, in order to prevent any lapse in Georgia's T-MSIS reporting or impact to T-MSIS data quality and completeness.



SECTION 2 RESULTS OF ACTIVITIES INCLUDED IN PLANNING APD

The State does not have a separate Planning APD for the Patients First Act Implementation Project. Planning Phase activities for the project are included in this Implementation APD.



SECTION 3 STATEMENT OF NEEDS AND OBJECTIVES

DCH is the lead agency for health care planning, purchasing, and oversight in Georgia. With a mission to provide Georgians with access to affordable, high quality healthcare, the Department is dedicated to creating a "Healthy Georgia". The Department currently enrolls over 1.4 million individuals through its Medicaid managed care program which includes non-disabled adults up to approximately 35 percent of the FPL and children living in households with incomes up to 138 percent of the FPL. Additionally, over 532 thousand aged, blind, and disabled (ABD) low income individuals are enrolled in Medicaid through the State's fee-for service program.

3.1 Patients First Act – Updated July 2021

During the 2019-2020 Regular Session, the Georgia General Assembly passed Senate Bill 106, the Patients First Act (the Act). Georgia Governor Brian Kemp signed The Patients First Act into law on March 27, 2019. The Act authorized DCH to submit a Section 1115 Medicaid demonstration waiver which could include an increase in the income threshold up to 100 percent of the FPL and also authorized the Governor to submit a Section 1332 waiver to identify innovative health insurance coverage solutions for the commercial health insurance marketplace. The Act grants the authority to implement the waivers upon federal approval. The Department received federal approval for the 1115 waiver and 1332 waiver on October 15, 2020 and November 1, 2020, respectively.

Together the 1115 and 1332 waivers represent Georgia's initiative to empower its citizens to increase their access to affordable healthcare coverage and improve their health and well-being. The two waivers compliment each other. The 1115 waiver creates a new category of Medicaid assistance for individuals up to 100 percent of the FPL who lack access to affordable healthcare coverage options today. The Georgia Pathways Program includes elements of consumerism such as premiums, copays, and a member rewards account to help prepare Medicaid members for the eventual transition to commercial coverage once their income exceeds 100 percent of the FPL.

Georgia's 1332 waiver helps to make individual market healthcare coverage more affordable for individuals at and above 100 percent of the FPL with the establishment of the Reinsurance Program. Transitioning Georgia's individual market from HealthCare.gov to the Georgia Access Program under the 1332 waiver in which the E&E / IES determines the eligibility for both Medicaid and individual market subsidies further streamlines the transition and referral process of Medicaid members into/out of the individual market.

Below, overviews of the State's new 1115 and 1332 waiver programs are presented in further detail.

3.1.1 Georgia Pathways 1115 Demonstration Waiver – Updated July 2021

The Georgia Pathways 1115 demonstration waiver provides for adults, aged 19 to 64, with incomes up to 100 percent of the FPL who are not otherwise eligible for Medicaid, to gain access to affordable, quality healthcare. The State will use its existing managed care delivery system to provide services to this population.



To further support individuals on their journey to self-sufficiency and the destination of commercial health insurance coverage, Georgia Pathways embraces private market policies and principles, such as premiums, copayments, member rewards accounts, and prospective Medicaid eligibility for a segment of the Georgia Pathways population.

Key aspects of the program include:

- **Qualifying Activities:** Individuals must report 80 hours of work-related qualifying activities to satisfy both initial and ongoing eligibility criteria.
- **Pathways HIPP Program:** The State will build upon its existing voluntary HIPP program by paying Employer Sponsored Insurance (ESI) premiums and cost-sharing for members with access to health insurance if it is cost-effective for the State rather than moving them to a Medicaid managed care plan.
- **Premium Payments:** Individuals eligible for Georgia Pathways with incomes between 50 percent and up to 100 percent of the FPL will be required to make flat rate monthly premium payments as a condition of eligibility.
- **Copayments:** Individuals enrolled in Georgia Pathways will be subject to copayments assessed retrospectively for services already received.
- **Member Rewards Account:** All individuals enrolled in Georgia Pathways, except those in the Pathways HIPP program, will have access to a MRA where premium payments are deposited along with additional dollars earned for engaging in healthy behaviors. Funds in the MRA can be used for copayments and to pay for additional services not covered by Medicaid, such as dental services.

The Department received federal approval for the Pathways Program on October 15, 2021, and DCH and DHS began design, development, and implementation activities to support a planned effective date of July 1, 2021 for this new category of assistance.

Georgia Pathways Program Goals

The State's goals for the Georgia Pathways Program (1115 Waiver) are to improve access, affordability, and quality of healthcare through strategies that:

- Improve the health of low-income Georgians by increasing their access to affordable healthcare coverage by encouraging work and other employment-related activities.
- Reduce the number of uninsured Georgians.
- Promote member transition to commercial health insurance.
- Empower Georgia Pathways participants to become active participants and consumers of their healthcare.
- Support member enrollment in employer-sponsored insurance by providing premium assistance for qualifying employer-sponsored health plans, if doing so is cost-effective for the State.
- Increase the number of persons who become employed or engaged in employment-related activities.



- Increase wage growth for those who are employed.
- Support the long-term, fiscal sustainability of the Medicaid program.

The outcomes and corresponding metrics for the Georgia Pathways Program are shown in Exhibit 1: Pathways Program Outcomes and Metrics.

3.1.2 1332 State Relief and Empowerment Waiver – Updated July 2021

Georgia has received approval of a 1332 State Relief and Empowerment Waiver to improve the access and affordability of healthcare coverage within the individual market and improve the eligibility determination and referral process for individuals transitioning to and from Medicaid and the individual market. The impacted population will be individuals with incomes over 100 percent of the FPL who are currently purchasing coverage through healthcare.gov. The 1332 waiver implements two new programs:

Part 1 – Reinsurance Program: Georgia will implement a Reinsurance Program in Plan Year 2022 to stabilize the individual market, reducing premiums and incentivizing carriers to offer plans in more regions across the State by reimbursing health insurers a portion of high cost claims. The reinsurance program will be implemented by the OHSC, working in coordination with the Georgia DOI. The State will establish the Reinsurance Program for effectuated enrollment on January 1, 2022.

Note: The Reinsurance Program will be implemented through a separate effort and is excluded from the scope and budget of this APD.

Part 2 – Georgia Access Program: Georgia will transition its individual market from the FFE to the new Georgia Access Program. The program will create a competitive private insurance marketplace that provides Georgia's residents with better access, improved customer service, and expanded choice of affordable coverage options. In the Georgia Access Program, residents will use private vendors (web-brokers and carriers) to shop for and select commercial insurance, including Qualified Health Plans. These private vendors will be certified by the State to participate within the Georgia Access Program and interface with the IES which will determine consumer eligibility for Medicaid, QHPs, and Advanced Premium Tax Credits. The State will establish the Georgia Access Program, which will be implemented by November 2022 Open Enrollment for effectuated enrollment on January 1, 2023. Transitioning Georgia's individual market from HealthCare.gov to the Georgia Access Program in which the IES determines the eligibility for both Medicaid and individual market subsidies further streamlines the transition and referral process of Medicaid members into/out of the individual market.

Authority for the implementation and ongoing oversight of the Georgia Access Program will be implemented by the OHSC, under the Office of the Governor, working in coordination across state agencies including OCI, DHS, and DCH.

1332 Waiver Goals – Updated July 2021

The State's goals for the Georgia Access Program (1332 Waiver) are to improve the access and affordability of individual healthcare coverage in Georgia, including:

- Streamlining referrals and transitions to/from Medicaid and the individual market



- Fostering innovation to provide better access to healthcare coverage
- Expanding choice and affordability of options for consumers
- Attracting uninsured individuals into the market
- Maintaining access to metal level Qualified Health Plans and catastrophic plans
- Maintaining protections for individuals with pre-existing conditions

The outcome and corresponding metric for the Georgia Access Program are shown in Exhibit 2: Georgia Access Program Outcomes and Metrics.

How 1332 Waiver Georgia Access Program Improves Efficiency in Medicaid

There are four primary ways that Georgia's 1332 waiver, the Georgia Access Program, improves efficiency in Medicaid:

1. Improves efficiency in the referral process when someone applies for individual market coverage, reducing account transfer "bounce backs" that happen today with the Federally Facilitated Marketplace (FFM).
2. Improves the transition for individuals currently in the individual market into Medicaid when someone falls below 100 percent of the FPL and is no longer eligible for APTCs.
3. Improves the transition when a member is no longer eligible for Medicaid into the individual market, reducing the likelihood of the individual going uninsured.
4. Improves the customer experience for individuals enrolled in Medicaid and the individual market for portions of the year. Today, these individuals receive 1095 A and 1095 B forms from multiple systems, resulting in a burdensome process to reconcile any discrepancies. With the Georgia Access Program, the customer experience is streamlined as one system will issue their 1095 forms.

Georgia Access Program Design – Enhancing Medicaid Referrals

The Georgia Access Program enhances and streamlines the Medicaid referral and eligibility determination process for individuals who are applying through the individual market. Every consumer who applies for coverage through the Georgia Access Program will first be file-cleared through the Enterprise Master Person Index (EMPI) and assessed for Medicaid eligibility. This process will be enabled by the enrollment platforms being connected through real-time services to Georgia's Medicaid eligibility system making it easier to accurately and quickly determine if a consumer is eligible for individual market subsidies or for Medicaid.

Today, Healthcare.gov does not have the authority to make Medicaid eligibility determinations for most states, including Georgia. Additionally, while Healthcare.gov performs a Minimum Essential Coverage (MEC) check to avoid overlapping enrollments, it does not interface with the State's EMPI to retrieve known information about the applicant(s) to accelerate the application process or support verifications. Instead, Healthcare.gov makes an initial assessment and then passes the application to the State's Medicaid eligibility determination system through an "account transfer function" relying on the State's system to decide eligibility for the consumer.

There are a few key challenges with the current model:



- Healthcare.gov only assesses for Modified Adjusted Gross Income (MAGI) Medicaid and is unable to make assessments for non-MAGI Medicaid categories, such as Aged, Blind, or Disabled Medicaid. This means that consumers who apply through the FFE may actually be eligible for other categories of Medicaid assistance according to the State's rules but remain unaware of those opportunities only knowing they have been referred to the State for further application processing.
- Healthcare.gov uses a consumer's prior year tax return to calculate MAGI Medicaid eligibility, whereas states use more current sources of income for Medicaid eligibility determinations, such as current year pay stubs, Department of Labor reporting, or external data sources like The Work Number provided by Equifax. This causes the FFE to be less accurate when estimating a consumer's current income, which is the basis for determining Medicaid eligibility.
- Medicaid referrals from Healthcare.gov to the states are frequently determined ineligible for Medicaid. In Georgia for 2019, a total of 119,973 referrals were made throughout the year from the FFE to the State for Medicaid assessment, with 63 percent of the volume received during Open Enrollment. Only 12 percent of the referrals from the FFE were determined eligible and approved for Medicaid. Consumers who are denied for Medicaid are sent back as account transfers to Healthcare.gov, often referred to as "bounce backs." One of the most common reasons for "bounce back" is that the FFE and states use different sources to estimate a consumer's income. When the FFE uses the prior year's tax return, and states use more recent data sources, consumers can get caught in a loop of referrals back and forth. This is particularly problematic when the consumer's prior year tax return shows they are under 100 percent of the FPL, but current income sources put them over 100 percent of the FPL.

Under the Georgia Access Program, the State will use a single system to perform eligibility determinations for the individual market and for Medicaid. By having the enrollment platforms for the individual market connected directly to Georgia's Medicaid eligibility system, the Georgia Access Program eliminates the FFE "middleman" making the process more efficient and accurate.

When an individual applies through an enrollment platform in the Georgia Access Program, the E&E / IES always first performs a check for the consumer's Medicaid eligibility, including while the person is being assisted by agents and brokers. If the consumer is Medicaid eligible, the E&E / IES will take the information provided in the single streamlined application through the enrollment platform and auto-create and process a Medicaid application for the individual.

Rationale for Medicaid 90/10 Funding for the E&E / IES Technology Implementation for the Georgia Access Program

Approximately 76 percent of the E&E / IES system development required to enable Georgia Access are extensions of existing E&E / IES functionality that further streamline and support efficiency in Medicaid. Because the functionality benefits both the Georgia Access Program and the Medicaid Program, the State is requesting Medicaid FFP on the share of the 1332 waiver system implementation costs that benefit the Medicaid Program.

The extension of the E&E / IES through new and modified functionality will help to facilitate handoffs between multiple programs and systems and allow DCH, DHS, and their contractors to



coordinate behind the scenes to provide Georgia's citizens with a more seamless experience, both at the point of initial eligibility determination as well as during change reporting and renewal. Utilizing the case structure the E&E / IES employs to group individuals into households, enrollments will be coordinated for families whereby some household members may be Medicaid eligible while others pursue coverage via the individual market. As such, the State requests enhanced Medicaid IT funding to support the design, development, enhancement, and implementation of the functionality.

Extension of E&E / IES Functionality

Exhibit 7: Extension of E&E / IES Functionality Benefitting Medicaid and Non-Medicaid Programs describes direct extensions and reuse of E&E / IES architecture and frameworks benefitting both the Georgia Access Program (1332 waiver) and Medicaid Program, allowing for:

- Efficiencies for Application Processing, Eligibility Determination, and Task Routing
- Efficiencies for Customer Communication and Outreach
- Efficiencies for Caseload Management and Customer Service

EXTENSION OF E&E / IES FUNCTIONALITY BENEFITTING BOTH THE GEORGIA ACCESS PROGRAM AND MEDICAID PROGRAM

EFFICIENCIES FOR APPLICATION PROCESSING, ELIGIBILITY DETERMINATION, AND TASK ROUTING

Item One: Extending existing verification interfaces with the Federal Data Services Hub to be incorporated into the eligibility determination processes with enrollment platforms

How It Supports Medicaid: Allows for efficiencies for Application Processing, Eligibility Determination, and Task Routing

Functional Explanation: Extending existing verification interfaces with the FDSH to be incorporated into the eligibility determination processes with enrollment platforms for the Georgia Access Program

FDSH and other data exchanges will be made available to web-brokers to support eligibility determination for QHP and APTC calculation, as well as to identify applicants who may potentially be eligible for Medicaid or CHIP and referred to the state for application processing (see Item Three for the referral process).

Item Two: Extending existing auto-renewal processes to check for continued eligibility for QHP, APTC, and CSR at annual open enrollment

How It Supports Medicaid: Allows for efficiencies for Application Processing, Eligibility Determination, and Task Routing

Functional Explanation: Extending existing auto-renewal processes to check for continued eligibility for QHP, APTC, and CSR at annual open enrollment

Re-assessment of ongoing eligibility and automated transition between QHP and Medicaid/CHIP

Item Three: Transition current FFE Account Transfer interface to support referral and assessment of potential Medicaid eligibility for individuals shopping via web brokers/carriers or determined potentially eligible for Medicaid at auto-renewal based on update household circumstances

How It Supports Medicaid: Allows for efficiencies for caseload management and customer services

Functional Explanation: Transition current FFE Account Transfer interface to support referral and assessment of potential Medicaid eligibility for individuals shopping via web brokers/carriers or determined potentially eligible for Medicaid at auto-renewal based on update household circumstances

See Item One, this is the interface that will support transferring household/application information between EDEs and the IES (bi-directional) at applications or renewal when an applicant/recipient is determined to



EXTENSION OF E&E / IES FUNCTIONALITY BENEFITTING BOTH THE GEORGIA ACCESS PROGRAM AND MEDICAID PROGRAM

need to be handed off for processing and enrollment (e.g., an applicant pursues QHP enrollment via a broker but is determined to be potentially eligible for Medicaid or CHIP).

EFFICIENCIES FOR CUSTOMER COMMUNICATION AND OUTREACH

Item Four: Packaging of coverage notices generated by the IES (e.g., benefit determination notices, enrollment effectuation notices, 1095-A and 1095-B forms, etc.) in same mailing

How It Supports Medicaid: Allows for efficiencies in customer communication and outreach

Functional Explanation: Packaging of coverage notices generated by the IES (e.g., benefit determination notices, enrollment effectuation notices, 1095-A and 1095-B forms, etc.) in same mailing

Allows for reduced mailing costs and aggregation of forms and notices generated along similar timeframes (e.g., the same day) into a single envelope to a household, regardless of whether the generation is from periodic processes or eligibility/enrollment changes resulting from Medicaid, CHIP, or QHP/APTC enrollment

EFFICIENCIES FOR CASELOAD MANAGEMENT AND CUSTOMER SERVICE

Item Five: Monitoring of caseload, both Medicaid and individual market enrollees, for changes routed to the IES from external data sources and impacting eligibility

How It Supports Medicaid: Allows for efficiencies for caseload management and customer service

Functional Explanation: Monitoring of caseload, both Medicaid and individual market enrollees, for changes routed to the IES from external data sources and impacting eligibility

Processing of information received to determine impact and take automated action on both QHP enrollments as well as Medicaid/CHIP enrollments. For example, individuals enrolled in QHP and turning age 65 who are now entitled to enroll in Medicare.

Item Six: Incorporate QHP, APTC, and Cost Sharing Reduction (CSR) eligibility and enrollment details into existing household summary views for customer service and case management

How It Supports Medicaid: Allows for efficiencies for caseload management and customer service

Functional Explanation: Incorporate QHP, APTC, and CSR eligibility and enrollment details into existing household summary views for customer service and case management

One-stop views for state eligibility and program staff to review household information, eligibility determination, and household member enrollments in either QHP or Medicaid/CHIP coverage

Item Seven: Extending existing integrated reporting framework for program participation metrics

How It Supports Medicaid: Allows for efficiencies for caseload management and customer service

Functional Explanation: Extending integrated reporting framework for program participation metrics

One-stop views for state eligibility and program staff to view summary information regarding enrollments in QHP, Medicaid, or CHIP and aggregated eligibility information for analytics, quality control, and reporting on waiver demonstration criteria

Item Eight: Reuse of existing role-based security framework to provide authorized users access to enrollment details for appeals review or customer service inquiries

How It Supports Medicaid: Allows for efficiencies for caseload management and customer services

Functional Explanation: Reuse of existing role-based security framework to provide authorized users access to enrollment details for appeals review or customer service inquiries

Dynamic display of household information on one-stop views based on role permissions assigned to each customer service unit (e.g., a unit supporting inquiries on APTC calculations will have different security permissions versus a DHS Division of Family and Children Services (DFCS) unit of eligibility staff)

Exhibit 7: Extension of E&E / IES Functionality Benefitting Medicaid and Non-Medicaid Programs



3.2 Patients First Act Implementation Project

To address the need for the system functionality necessary to enable waiver program business processes and to meet the State's implementation deadlines, DCH and DHS chartered the Patients First Act Implementation Project. Based on an analysis of waiver policy and system requirements, the agencies have determined that the State should leverage existing IT assets to support the new programs, including:

- Eligibility & Enrollment / Integrated Eligibility System (operated by Deloitte Consulting)
- MMIS and Fiscal Agent Services (operated by Gainwell)
- Third Party Liability Services (operated by HMS)

The implementation of the Georgia Pathways Program (1115 waiver) impacts all three systems, and the implementation of the Georgia Access Program (1332 waiver) impacts only the E&E / IES.

3.2.1 Project Scope – Updated July 2021

The scope of the Patients First Act Implementation Project is to perform the design, development, and implementation of new and modified system functionality to enable the Georgia Pathways Program and Georgia Access Program.

The budgeted costs described in this APD for the 1332 waiver include only implementation costs associated with E&E / IES system development needed to enable the Georgia Access Program. The budget does not include the non-technology programmatic aspects associated with the transition of Georgia's individual market from Healthcare.gov to the State which encompasses a multitude of regulatory and other non-technical implementation activities spanning a number of agencies, including the DOI and OHSC within the Governor's Office.

Multiple workstreams are engaged to successfully accomplish the scope of work, including three design, development, and implementation workstreams and four support services workstreams. These workstreams are described below in Exhibit 8: Project Workstreams.

WORKSTREAM	PURPOSE	PLANNED/ACTUAL START	PLANNED/ACTUAL END
Eligibility & Enrollment / Integrated Eligibility System Workstream	This workstream encompasses planning, design, development, and implementation activities required to modify and extend Georgia's E&E / IES functionality to support Georgia Pathways Program and Georgia Access Program business processes.	October 2020	November 2022



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WORKSTREAM	PURPOSE	PLANNED/ACTUAL START	PLANNED/ACTUAL END
Medicaid Management Information System Workstream	This workstream encompasses planning, design, development, and implementation activities required to modify and extend Georgia's MMIS and Fiscal Agent services to support Georgia Pathways Program business processes.	October 2020	July 2022
Third Party Liability Services Workstream	This workstream encompasses planning, design, development, and implementation activities required to modify and extend Georgia's TPL systems and services to support Georgia Pathways Program business processes.	January 2021	January 2022
Member Rewards Account Workstream	This workstream encompasses planning, design, development, and implementation activities required to enable MRA functionality in support of Georgia Pathways Program business processes.	October 2021	July 2022
Waiver Advisory Services	This workstream provides 1115 and 1332 waiver policy subject matter expertise and business input to support the effort of the IES, TPL, and MMIS workstreams.	October 2020	November 2022
Project Management Office Services	This workstream provides project management services for the project, including integration management, schedule management, risk management, issue management, and status reporting.	December 2020	November 2022
Automated Reporting and Monitoring Services	This workstream designs and implements the reporting necessary for the periodic monitoring of the 1115 waiver demonstration.	January 2021	November 2022
Independent Verification & Validation Services	This workstream encompasses the procurement and execution of IV&V services for the project. These services provide independent third party oversight and assessment of project processes and artifacts and monitors project activities against plans.	March 2021	November 2022



WORKSTREAM	PURPOSE	PLANNED/ACTUAL START	PLANNED/ACTUAL END
Organizational Change Management Services	This workstream encompasses the procurement and execution of OCM services for the Patients First Act Implementation Project. These services focus on the people side of change, preparing internal and external stakeholders for change to help ensure a successful implementation.	April 2021	November 2022

Exhibit 8: Project Workstreams

3.2.2 Project Approach and Timeline – Updated July 2021

The State designed a multi-phase approach to the Patients First Act Implementation Project as described in Exhibit 9: Release Plan. Priority has been given to implementation of the core Pathways functionality.

PHASE	PLANNED DATES	DESCRIPTION
Georgia Pathways Program – Release 1	Oct 2020 – Jul 2021 (Pending)	Core Functionality: self-service capabilities; worker processing; qualifying activities; eligibility; mobile; correspondence and notices; reports
Georgia Pathways Program – Release 2	Jan 2021 – Jan 2022	Renewals and HIPP Integration: renewals; qualifying activity audit; ESI cost effectiveness determination; Pathways HIPP program
Georgia Pathways Program – Release 3	Aug 2021 - Jul 2022	My Rewards Account Integration: premium calculation and collection; review premium information (mobile); premium payment reports and correspondence
Georgia Access Program	Apr 2021 – Nov 2022	Program Functionality: web broker and private entity integration; eligibility determination; 1095-A forms; self-service to support 'no wrong door'; processing to store basic healthcare application and MPI file clearance; correspondence; reports

Exhibit 9: Release Plan

A high-level timeline for the project is shown in Exhibit 10: Project Timeline. The project began in Q1 FFY 2021, with the initiation of the E&E / IES and MMIS workstreams, and is planned to end in Q1 FFY 2023, with the deployment of the Georgia Access Program to support November 2022 Open Enrollment.



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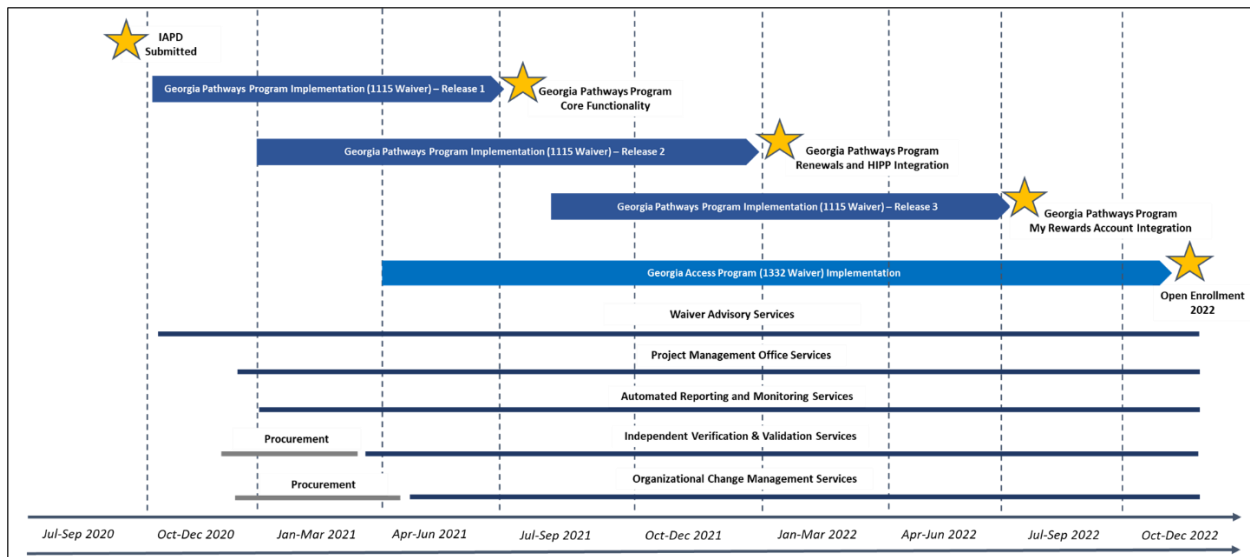


Exhibit 10: Project Timeline

The Patients First Act Implementation Project is compliant with federal regulations and guidelines issued by CMS, including the standards and conditions for Medicaid information technology (IT), as outlined in 42 CFR 433.112.



SECTION 4 REQUIREMENTS ANALYSIS, FEASIBILITY STUDY AND ALTERNATIVE CONSIDERATIONS

In this section, summary results of the State's Requirements Analysis, Feasibility Study, and Alternatives Analysis are provided.

4.1 Requirements Analysis – Updated July 2021

To complete the Requirements Analysis, the State developed a set of preliminary high-level business requirements for system enhancements and modifications necessary to support the implementation and operation of the Georgia Pathways Program and Georgia Access Program. Upon the initiation of the project, these preliminary requirements were further refined and elaborated in joint application requirements (JAR) and joint application design (JAD) sessions facilitated by the MMIS and FA Services, IES, and TPL Services contractors. The resulting detailed requirements are being used / were used for solution design and development activities.

An overview of the State's requirements analysis approach is provided below.

4.1.1 Requirements Analysis Approach – Updated July 2021

The Requirements Analysis process followed by the State included:

- Participation in Waiver Technical Design Sessions
- Review of Waiver Programs
- Georgia Pathways Requirements Definition Sessions
- Requirements Validation
- JAR / JAD Sessions

Each of these steps is described in more detail in the sections below.

Participation in Waiver Technical Design Sessions

DCH and DHS business and IT subject matter experts (SMEs) were actively involved in the development of the Georgia Pathways and Georgia Access Programs, participating in 25 technical design sessions in 2020. Exhibit 33: Waiver Technical Design Sessions in Appendix D lists the session dates and participants. This involvement allowed the SMEs to make policy recommendations to better align waiver program design with existing business and system processes. Additionally, these sessions established the knowledge and understanding of the waiver programs required to identify the necessary system modifications and enhancements.

Review of Waiver Programs

In preparation for requirements definition sessions, the State's Executive Sponsor and Project Director presented overviews of the Georgia Pathways Program and Georgia Access Program to DCH and DHS business and IT SMEs. These sessions included a review of:



- Waiver program objectives
- Waiver program scope
- Waiver program policy

The interactive sessions provided business and IT SMEs the opportunity to seek clarification on waiver policy and processes prior to the requirements definition sessions. Exhibit 34: Waiver Review Sessions in Appendix D lists the session dates and state participants.

Georgia Pathways Requirements Definition Sessions

Requirements definition sessions were scheduled with DCH and DHS business and IT SMEs to elicit the requirements for new and modified functionality to enable Georgia Pathways Program implementation, including:

- MMIS and FA Services
- TPL Services
- E&E / IES

DCH and DHS business and IT SMEs were identified to participate in the requirements definition sessions. Altogether, four sessions were held. Exhibit 35: Requirements Definition Sessions in Appendix D provides the dates and state participants of the requirements definition sessions.

Requirements Validation

The output of the requirements definition sessions was captured and consolidated. The consolidated requirements were distributed to the DCH and DHS business and IT SMEs to review and validate. Additional input and feedback received by the SMEs was incorporated into the preliminary requirements documentation.

JAR / JAD Sessions – Updated July 2021

Upon project initiation, the E&E / IES, MMIS and FA Services, and TPL Services contractors conducted a series of JAR / JAD sessions with DCH and DHS business and IT SMEs. Exhibit 36: JAR / JAD Sessions in Appendix D provides the dates and topics of the JAR and JAD sessions that have been held / are planned.

4.1.2 Solution Requirements – Updated July 2021

Exhibit 11: Georgia Pathways Program Solution Requirements presents a high-level summary of the new or updated functionality required for the implementation of the Georgia Pathways Program by functional area and system.

AREA	SYSTEM	FUNCTIONAL AND NON-FUNCTIONAL REQUIREMENTS
Application, Eligibility and Renewals	IES	Customer Portal Updates
	IES	Telephonic Application Updates
	IES	Paper Application Updates



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AREA	SYSTEM	FUNCTIONAL AND NON-FUNCTIONAL REQUIREMENTS
	IES	Qualifying Hours and Activities Reporting (Customer Portal)
	IES	Qualifying Hours and Activities Reporting (Telephonic)
	IES	Qualifying Hours and Activities Verification
	IES	Interface with Work Number
	IES	Eligibility Determination
	IES/MMIS	Interface between IES and MMIS
	IES/GVRA	Interface between IES and GVRA
	IES/TCSG	Interface between IES and TCSG
	IES/BOR	Interface between IES and Board of Regents
	IES	Eligibility Notices
	MMIS	CMO Enrollment
	IES	Qualifying Hours and Activities Counter
	IES	Qualifying Hours and Activities Reporting Waiver
	IES	Qualifying Hours and Activities Notices
	IES	Change Reporting
	IES	Renewals
	IES	Auto-Renewals
	IES	Renewal Notices
Premiums, Copayments and My Rewards Account	IES	Premium Calculation
	IES	Tobacco Surcharge Application
	IES	Premium Collection
	IES	Premium Tracking/Counter
	IES	Application of Premium Waivers
	IES	Premium Notices
	MMIS	Copayment Logic Modifications for Non Emergent Use of ED
	IES	Premium Credit in MRA Account
	MRA	Copayment Debit from MRA Account
	MRA	Healthy Behavior Credit to MRA Account
	MRA	Approved Expense Debit from MRA Account
	IES	Interface between IES and MRA Vendor
	MRA	Copayment Notice
	MRA	MRA Account Notices
Mandatory HIPP	IES/TPL	Interface between IES and TPL Vendor
	TPL	Initial Cost Effectiveness Determination
	TPL	Outreach to Employer/Employee for ESI Information
	TPL	Ongoing Cost Effectiveness Determinations
	TPL	Periodic Reviews for ESI Access
	TPL	Verification of Monthly Premium Deduction from Paystub
	MMIS/TPL	Advanced Premium Payment



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AREA	SYSTEM	FUNCTIONAL AND NON-FUNCTIONAL REQUIREMENTS
	TPL	Verification of Advanced Cost Share Payment Request
	MMIS/TPL	Advanced Cost Share Payment
	MMIS/TPL	Reimbursement for Cost Share
	TPL	Verification of Cost Share Reimbursement Request
	IES/TPL	HIPP Notices
	IES	New Status for Applicants Pending ESI
	MMIS/TPL	Temporary FFS Enrollment
	MMIS	FFS Enrollment Notice
	MMIS	Mandatory HIPP Status
	MMIS	Mandatory HIPP-FFS Status
	PBM	New Pharmacy Benefit Plan
	PBM	Financial Files and Reports
	PBM	FFS Pharmacy non-OPR Editing Process
	PBM	Pharmacy system configuration changes
	PBM/MMIS	Eligibility interface changes
Good Cause Exceptions, Reasonable Accommodations, and Program Audits	IES	Submission of Good Cause Exception Request (Customer Portal)
	IES	Submission of Good Cause Exception Request (Telephonic)
	IES	Review and Verification of Good Cause "Other" Requests
	IES	Good Cause Outcome Notice
	IES	Good Cause Hours Counter
	IES	Submission of Reasonable Accommodation Request (Customer Portal)
	IES	Submission of Reasonable Accommodation Request (Telephonic)
	IES	Routing from ABD Eligibility Specialist to Specialized Unit
	IES	Scheduling of Interview for Reasonable Accommodations Request
	IES	Verification of Disability Documentation for Referral Request
	IES	Indicator of Referral to Other Agency
	IES	Indicator of Extended Time to Engage in a Qualifying Activity
	IES	Transfer Referral and Data to GVRA
	IES	Transfer GVRA Eligibility Status
	IES	Authorization of Pathways Eligibility based on GVRA Engagement
	IES	Verification of Documentation from Employer for Hours Reduction
	IES	Reduction of Qualifying Hours and Activities Threshold
	IES	Reasonable Accommodations Notices
	IES	Random Sampling Audit Logic
	IES	Flagging Logic for High-Risk Cases
	IES	Auditing Notices
Reporting	IES	Application and Eligibility Reports
	IES	Enrollment and Compliance Reports



AREA	SYSTEM	FUNCTIONAL AND NON-FUNCTIONAL REQUIREMENTS
	IES	Qualifying Activities Reports
	TPL	Mandatory HIPP Reports
	MRA	MRA Reports
	IES	Reasonable Accommodations Reports

Exhibit 11: Georgia Pathways Program Solution Requirements

The detailed requirements documentation for the Georgia Pathways Program is available upon CMS request.

Additionally, the State has identified functionality within the E&E / IES that is necessary to implement the Georgia Access Program, but will also enable a more streamlined eligibility and enrollment process as individuals transition to and from the individual market and Medicaid. Examples include, but are not limited to:

- Extending existing verification interfaces with the federal data services hub (FDSH)
- Packaging of 1095-A and 1095-B forms in same mailing
- Monitoring of caseload for changes impacting eligibility
- Incorporating qualified health plan (QHP), advance premium tax credit (APTC), and cost sharing reduction (CSR) eligibility and enrollment details into existing household summary views for customer service and case management
- Extending existing auto-renewal processes to check for continued eligibility for QHP, APTC, and CSR at annual open enrollment
- Extending existing integrated reporting framework for program participation metrics
- Reusing the existing role-based security framework to provide authorized users access to enrollment details for appeals review or customer service inquiries
- Transitioning the current FFE Account Transfer interface to support referral and assessment of potential Medicaid eligibility for individuals shopping via web brokers/carriers or determined potentially eligible for Medicaid at auto-renewal based on update household circumstances

This extension of the state's E&E / IES will help to facilitate handoffs between multiple programs and systems and allow DCH, DHS, and their contractors to coordinate behind the scenes to provide Georgia's citizens with a more seamless experience, both at the point of initial eligibility determination as well as during redetermination. As such, the State requests enhanced Medicaid IT funding to support the design, development, and implementation of the functionality required for the Georgia Access Program that also benefits the Medicaid Program, which is summarized in Exhibit 12: Georgia Access Program Functionality.

AREA	SYSTEM	FUNCTIONAL AND NONFUNCTIONAL REQUIREMENTS
Georgia Access Functionality	IES	QHP, APTC, and CSR Eligibility and Calculation
	IES	Enrollment Aggregation and APTC Reporting
	IES	Eligibility Appeals Process



AREA	SYSTEM	FUNCTIONAL AND NONFUNCTIONAL REQUIREMENTS
	IES	1095-A Annual Reporting
	IES	Enrollment and 834 Processing
	IES	Verification Interfaces with FDSH and State Data Sources
	IES	New API Connections and Testing
	IES	Post-Enrollment Caseload Monitoring and Change Identification
	IES	One-Time Transition from FFE to Georgia Access
	IES	Auto Renewal Processing

Exhibit 12: Georgia Access Program Functionality

The detailed requirements documentation for the Georgia Access Program is available upon CMS request.

4.2 Feasibility Study and Alternatives Analysis

In 2020, the State conducted a Feasibility Study and Alternatives Analysis. To conduct the Alternatives Analysis the State performed the following steps:

- Identified the alternatives based on an analysis and understanding of the business needs and requirements
- Established a set of evaluation criteria and weightings that reflect the State's priorities for the project against which each alternative was measured
- Evaluated each of the alternatives through the application of the evaluation criteria
- Determined the best alternative for the State

The results of the Alternative Analysis are summarized in the following sections.

4.2.1 Alternatives

Based on the requirements analysis, DCH and DHS determined that the State should leverage existing Medicaid IT assets to support the implementation of the waiver programs. The majority of waiver program requirements will be addressed through modifications and enhancements to Georgia's E&E / IES, building on state and federal investment in the system to date and enabling significant reuse of functionality and code. The remaining requirements will be met through changes to the current MMIS and FA Services and TPL Services.

With the upfront decision made to use existing assets, the State identified four solution alternatives for consideration. Exhibit 13: Alternatives provides a brief description of the alternatives. The alternatives include a go / no go alternative (Status Quo) as well as multiple labor alternatives available to the State for developing the new and modified IES functionality.

ALTERNATIVE	DESCRIPTION
A - Status Quo	With this alternative, there would be no changes made to the IES to enable the implementation of Georgia's waiver programs. Without the supporting functionality, the waiver programs could not be implemented.



ALTERNATIVE	DESCRIPTION
B - Contract through Competitive Procurement	With this alternative, the State would conduct a competitive procurement for the design, development, and implementation of the IES modifications and enhancements required to support the implementation of Georgia's waiver programs.
C - Contract with Incumbent Vendors	With this alternative, the State would contract with the incumbent contractor for the design, development, and implementation of the IES modifications and enhancements required to support the implementation of Georgia's waiver programs.
D – In-House Development	With this alternative, the State would perform the design, development, and implementation of the IES modifications and enhancements required to support the implementation of Georgia's waiver programs via an in-house development effort.

Exhibit 13: Alternatives

4.2.2 Evaluation Criteria and Scoring

Four evaluation criteria and twelve evaluation factors were used to evaluate the alternatives. The evaluation criteria reflect areas of strategic importance to the State in its alternative recommendation. Through a consistent application of the evaluation factors, DCH and DHS were able to assess the strengths and weaknesses of the alternatives and arrive at the option that represents the greatest value. Each evaluation criterion was weighted to define its importance to the State relative to the other criteria. Exhibit 14: Evaluation Criteria and Weighting outlines the evaluation criteria, evaluation factors, and weighting used to perform the alternatives.

CRITERIA	WEIGHTING	EVALUATION FACTOR(S)
Statutory Fulfillment	35	- The alternative directly or indirectly satisfies a state or federal mandate or regulation. - The alternative improves the time required to respond to a state or federal mandate or regulation. - The alternative achieves or supports the objectives or anticipated outcomes of a state or federal mandate or regulation.
Strategic Alignment	15	- The alternative is aligned with the mission and strategic priorities of the State. - The alternative results in the ability of DCH and DHS to anticipate and respond to new business needs or demands.
Cost	15	- The alternative has procurement costs that are lower than the other alternatives. - The alternative has implementation costs that are lower than the other alternatives. - The alternative has operations and maintenance costs that are lower than the other alternatives.



CRITERIA	WEIGHTING	EVALUATION FACTOR(S)
Risk	35	- Cost - There is probability that the budget will be exceeded. - Schedule - There is probability that the schedule will be exceeded. - Resources - There is probability that the necessary resources (required number, skills, experience) to perform the work will not be available. - Performance - There is probability that the services or deliverables will not meet the State's requirements or expectations.

Exhibit 14: Evaluation Criteria and Weighting

4.2.3 Analysis Results

As shown in Exhibit 15: Scoring Scale, a four-point scale was used to score each of the alternatives, with the assigned score indicating the degree to which the alternative achieves the evaluation criteria and factors.

SCORE	DEFINITION
0	The alternative does not address the factor or provides no value.
1	The alternative somewhat addresses the factor or provides minimal value.
2	The alternative addresses the factor and provides moderate value.
3	The alternative addresses the factor and provides significant value.

Exhibit 15: Scoring Scale

Criterion scores for each alternative were derived by adding the score for each evaluation factor and multiplying the total by the criterion weighting. The overall score for each alternative was then calculated by summing the four criterion scores. The results are shown in Exhibit 16: Scoring of Alternatives.



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FACTOR(S)	RATING ALT A	RATING ALT B	RATING ALT C	RATING ALT D
STATUTORY FULFILLMENT				
The alternative directly or indirectly satisfies a state or federal mandate or regulation.	0	3	3	3
The alternative improves the time required to respond to a state or federal mandate or regulation.	0	0	3	0
The alternative achieves or supports the objectives or anticipated outcomes of a state or federal mandate or regulation.	0	3	3	3
Sub-Total	0	6	9	6
Weighted Sub-Total	0	2.1	3.2	2.1
STRATEGIC ALIGNMENT				
The alternative is aligned with the mission and strategic priorities of the State.	0	3	3	3
The alternative results in the ability of DCH and DHS to anticipate and respond to new business needs or demands.	0	3	3	3
Sub-Total	0	6	6	6
Weighted Sub-Total	0	0.9	0.9	0.9
COST				
The alternative has procurement costs that are lower than the other alternatives.	3	0	3	1
The alternative has implementation costs that are lower than the other alternatives.	3	1	1	2
The alternative has operations and maintenance costs that are lower than the other alternatives.	3	3	1	3
Sub-Total	9	4	5	6
Weighted Sub-Total	1.4	0.6	0.8	0.9
Risk				
Cost - There is probability that the budget will be exceeded.	3	2	3	1
Schedule - There is probability that the schedule will be exceeded.	3	1	3	1
Resources - There is probability that the necessary resources (required number, skills, experience) to perform the work will not be available.	3	3	3	1



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FACTOR(S)	RATING ALT A	RATING ALT B	RATING ALT C	RATING ALT D
Performance - There is probability that the services or deliverables will not meet the State's requirements or expectations.	3	2	3	1
Sub-Total	12	8	12	4
Weighted Sub-Total	4.2	2.8	4.2	1.4
Total Weighted Score	5.6	6.4	9.1	5.3

Exhibit 16: Scoring of Alternatives



Summary findings and considerations from the analysis of alternative approaches are presented below.

Alternative A: Status Quo (Not Recommended)

With this alternative, there would be no changes made to the E&E / IES to enable the implementation of Georgia's waiver programs. Without the supporting functionality, the waiver programs could not be implemented.

Key Findings and Considerations

While Alternative A would be the least costly and a low risk alternative, DCH and DHS do not have the option to maintain the "status quo". The proposed system modifications and enhancements are in response to provisions in *The Patients First Act* (O.C.G.A. 49-4-142.3) to implement the Georgia Pathways 1115 Demonstration Waiver and Georgia Access 1332 State Relief and Empowerment Waiver upon receiving federal approval.

The Patients First Act is one of Governor Kemp's stated healthcare priorities seeking to further the State's vision of creating a "A Healthy Georgia" by providing Georgians with access to affordable, quality healthcare. Without the supporting system functionality to automate and enable program business processes, implementation is not possible. Because Alternative A does not address the needs and priorities of the State, it is not an acceptable or viable alternative.

Alternative B: Contract through Competitive Procurement (Not Recommended)

With this alternative, the State would conduct a competitive procurement for the design, development, and implementation of the E&E / IES modifications and enhancements required to support Georgia's waiver programs.

Key Findings and Considerations

The objective of Alternative B is the opportunity to achieve more favorable pricing from other vendors to perform the scope of work through a competitive procurement. While a competitive procurement could result in lower costs, the risk to the project associated with bringing in a new vendor to modify and enhance the E&E / IES is significant.

Vendors could easily underestimate the learning curve of taking over the E&E / IES and the required level of effort to complete the project, resulting in the potential for lengthy schedule delays, performance issues, and budget overruns. Because the project is a priority of the State, the State's risk tolerance is low. Additionally, large state IT procurements are costly and commonly take months to complete. For example, the last E&E / IES procurement took over seven months to complete, not including the time to prepare the solicitation documents for release.

Overall, the schedule, cost, and performance risk, as well as the time and cost of a competitive procurement, resulted in the State's rejection of Alternative B as a feasible or acceptable option.



Alternative C: Contract with Incumbent Vendors (Recommended)

With this alternative, the State would contract with the incumbent vendor for the design, development, and implementation of the E&E / IES modifications and enhancements required to support Georgia's waiver programs.

Key Findings and Considerations

Alternative C provides the least risky alternative and also offers speed to implementation of the required functionality. The incumbent contractor is the vendor that originally developed the E&E / IES and continues to operate and maintain it. As a result, the vendor has a strong understanding of the State's business processes and operations and existing day-to-day working relationships with DHS and DCH project personnel and contractors. This knowledge and experience significantly lowers the schedule and performance risk associated with this alternative. Given the importance of this project to the State, the ability to manage implementation risk is a critical decision factor. Additionally, this alternative allows the State to avoid the time and cost required to conduct a competitive procurement and quickly initiate design, development, and implementation activities in order to meet the State's eight month timeline for implementation of the Georgia Pathways Program.

In summary, Alternative C provides the option to quickly respond to the state mandate, while significantly mitigating schedule and performance risk; therefore, the State has identified this option as the best value.

Alternative D: In-House Development (Not Recommended)

With this alternative, the State would perform the design, development, and implementation of the IES modifications and enhancements required to support Georgia's waiver programs via an in-house development effort.

Key Findings

The objective of Alternative D is to lower implementation and operational costs by performing the scope of work with in-house resources. The potential savings associated with this option are attractive, however, the implementation risks are very high.

At this time, the State does not have sufficient state or contract personnel to undertake a project of this size and complexity. The time required to locate, hire, and orient the number of project personnel with the requisite skills and experience would likely delay the project schedule. Similar to Alternative B, the State could easily underestimate the required learning curve and level of effort, greatly increasing project schedule and performance risk. However, unlike Alternative B, with in-house development there would be no enforceable service level agreements (SLAs) or performance guarantees to help mitigate the risk. An additional consideration is the potential impact in-house development would have on the incumbent vendor's SLAs and performance guarantees, perhaps rendering them unenforceable as well.

The overall risk to the State of taking on such a large, complex project under an aggressive eight month implementation deadline as an in-house development effort with no contractual mechanisms to mitigate the risk makes Alternative D an unacceptable option.



4.2.4 Recommended Alternative

The alternatives analysis process has concluded that it is in the best interest of the State to proceed with the using the incumbent vendor to make the necessary E&E / IES modifications and enhancements.

Advantages of the recommended approach include:

- Enables DCH and DHS to respond to the state mandate to implement core functionality for the Georgia Pathways Program by July 1, 2021, with subsequent releases finalized on July 1, 2022, and the Georgia Access Program implemented by November 2022
- Supports the State's priority of enabling innovative healthcare coverage solutions to expand access to affordable, quality healthcare
- Provides the ability to quickly initiate design, development, and implementation activities, enabling a shorter implementation timeframe than the other alternatives
- Avoids the cost and time associated with conducting a competitive procurement
- Limits the risks associated with an in-house development effort
- Offers significant risk mitigation, helping to offset higher implementation costs
- Minimizes resource risk, providing skilled resources, many of whom have several years of development experience with Georgia's E&E / IES and established relationships with DCH and DHS project personnel and other state Medicaid IT contractors
- Minimizes performance, cost, and schedule risk by using the contractor who originally developed and currently operates and maintains the E&E / IES
- Enables the use of contractual payment terms, service level agreements, and performance guarantees to help mitigate performance, schedule, and cost risk



SECTION 5 COST BENEFIT ANALYSIS

On September 9, 2020, the State received a waiver from CMS on the Cost Benefit Analysis for the Patients First Act Implementation Project. The implementation of the modifications and enhancements to the State's MMIS, E&E / IES, and TPL systems and services is in response to provisions in the *The Patients First Act* (O.C.G.A. 49-4-142.3) to implement the Georgia Pathways 1115 Demonstration Waiver and Georgia Access 1332 State Relief and Empowerment Waiver upon receiving federal approval.

As such, the direct benefits to the State from this project are associated with the successful on time, on budget delivery of new and modified functionality to support the implementation of these waivers. The innovative approach of these two waivers seeks to further the State's vision of creating "A Healthy Georgia" by providing Georgians with access to affordable, quality healthcare. These and other goals and outcomes are described further in Section 1 and Section 3 of this APD.



SECTION 6 NATURE AND SCOPE OF ACTIVITIES

The scope of the Patients First Act Implementation Project includes multiple workstreams to plan, design, develop, and implement necessary enhancements and modifications to state Medicaid IT systems to enable Georgia's waiver programs. Additional project support workstreams include waiver advisory, reporting and monitoring, project management, OCM, and IV&V services. The scope of the work is being performed by a mix of state and contractor resources and is summarized below by workstream.

MMIS and Fiscal Agent Services Enhancements and Modifications

- Conduct project planning for MMIS and Fiscal Agent enhancements and modifications
- Define, elaborate, and validate solution requirements
- Design and develop system and service enhancements and modifications
- Perform testing of new and modified functionality including system, interface, integration, regression, performance, and user acceptance testing
- Implement new and modified functionality and services, including training end users and updating user manuals and system documentation

E&E / IES Enhancements and Modifications

- Perform project planning
- Define, elaborate, and validate solution requirements
- Conduct JAR analysis and management
- Design and develop system enhancements and modifications
- Perform testing of new and modified functionality, including system, interface, integration, regression, performance, and user acceptance testing
- Implement new and modified functionality, including training end users and updating user manuals and system documentation

TPL Services Enhancements and Modifications – Updated July 2021

- Conduct project planning for HIPPP program enhancements and modifications
- Define and validate solution requirements
- Design and develop system enhancements and modifications
- Perform testing of new and modified functionality, including system, interface, integration, regression, stress, performance, and user acceptance testing
- Implement new and modified functionality and services, including training end users and updating user manuals and system documentation
- Implement Pharmacy Benefit Manager (PBM) modifications, including eligibility interface changes, a pharmacy financial file, and a financial report to support the 1115 waiver HIPPP program

Waiver Advisory Services

- Support the development and validation of solution requirements and ensure alignment with the approved waiver design and policy



- Provide planning and advisory support to programmatic and enterprise SMEs across the Implementation Phase activities

Automated Reporting and Monitoring Services – Updated July 2021

- Design and implement automated reporting to support waiver demonstration monitoring protocol
- Develop program dashboards for tracking key program metrics

Project Management Office Services

- Develop and implement project management standards, tools, and processes for the Patients First Act Implementation Project
- Provide project management support for the project, overseeing multiple project workstreams
- Prepare project reporting, including status reports, integrated master schedule, budget reports, and key risks, issues, action items, and decisions
- Coordinate and facilitate project status meetings
- Implement and support the Patients First Act Implementation Project governance structure
- Establish and maintain the project risk, issue, action item, and decision logs and the project document repository
- Conduct business process analysis and planning activities

IV&V Services

- Prepare a Statement of Need for IV&V Services
- Conduct a competitive procurement for IV&V Services
- Perform IV&V Services for the Patients First Act Implementation Project
- Conduct IV&V assessments, develop findings and recommendations, and prepare the required state IV&V reports

OCM Services

- Prepare a Statement of Need for OCM Services
- Conduct a competitive procurement for OCM Services
- Perform OCM Services for the Pathways Program implementation Project
- Conduct stakeholder assessments
- Develop and execute change management and communications strategies and plans
- Support the State's change management sponsors and change agents

The Patients First Act Implementation Project workstreams follow PMBOK® project management methodology to adhere to project management best practices and track progress against goals.



SECTION 7 PROJECT MANAGEMENT PLAN

To complete the Patients First Act Implementation Project, the State is using a mix of state personnel and contractor resources as described in the sections that follow.

7.1 Waiver Implementation Project Organization – Updated July 2021

The Patients First Act Implementation Project organization is a multi-agency effort led by the Office of the Governor. Exhibit 17: Patients First Act Implementation Project Organization depicts the project organization structure and identifies state employee and contractor resources.



Patients First Act Implementation Project Implementation Advance Planning Document

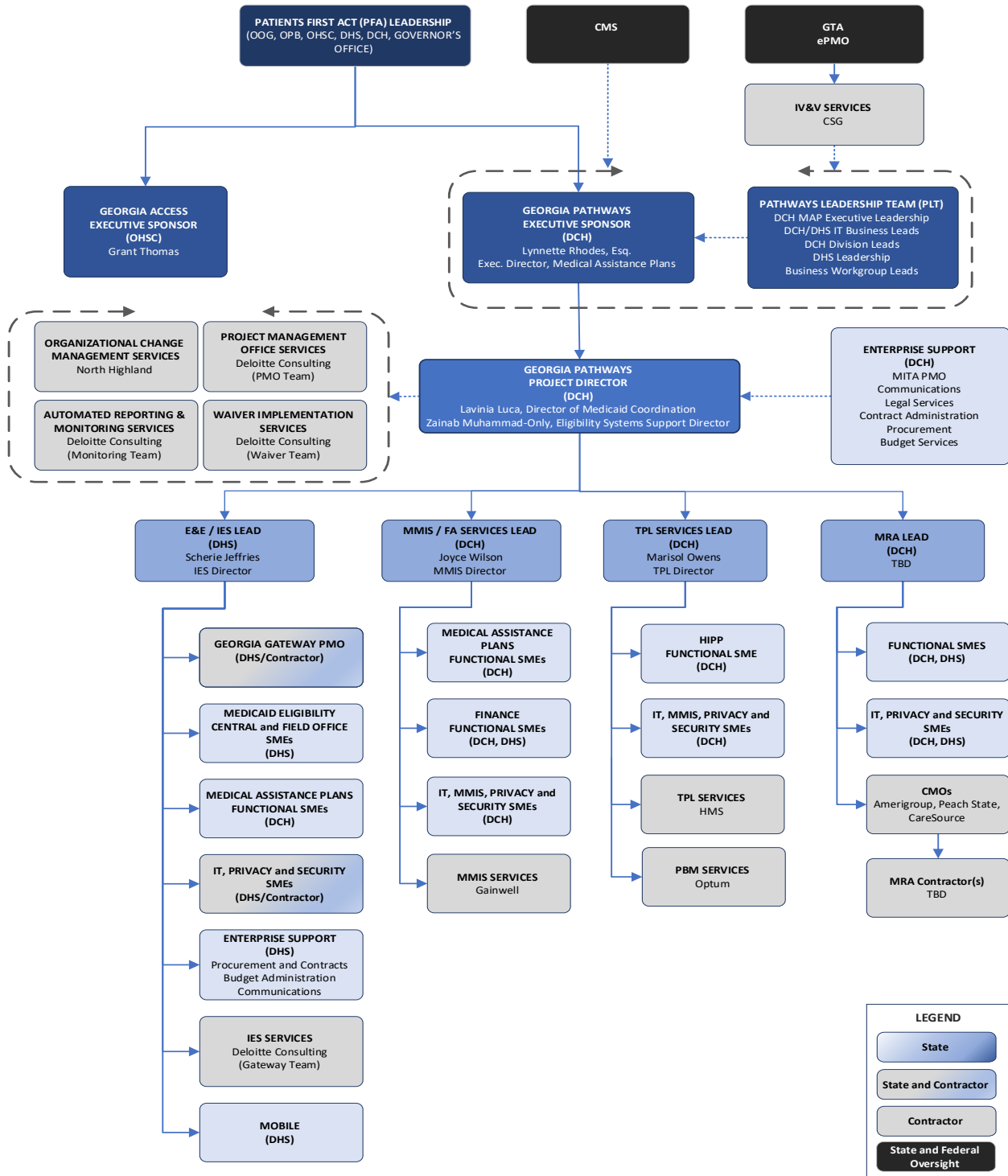


Exhibit 17: Patients First Act Implementation Project Organization

An overview of Patients First Act Implementation Project roles and responsibilities is provided in Section 7.2 below.



7.2 Roles and Responsibilities – Updated July 2021

Exhibit 18: Project Roles and Responsibilities identifies key state employee and contractor personnel. There are approximately 31 state employee personnel full time equivalents (FTEs) assigned to support Patients First Act Implementation Project activities.

Note: An asterisk (*) indicates a resource who is not included in the project budget and cost allocation. These resources are either external to DCH and DHS or are already claimed through the DCH MITA PMO APD or agency indirect cost rate.

ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
Patients First Act Leadership	- Provides guidance on the project's overall strategic direction - Approves and influences project initiatives - Advises Executive Sponsors - Provides authority for use of state resources to implement defined strategies - Resolves decisions, risks, and issues escalated from the Executive Sponsors - Monitors project budget and high impact risks and issues	Caylee Noggle, Commissioner*	DCH	Employee	0.025
		Ryan Loke, Deputy Commissioner and Chief Health Policy Officer*	DCH	Employee	0.025
		Lynnette Rhodes, Exec. Director, Medical Assistance Plans	DCH	Employee	0.025
		Scherie Jeffries, Deputy Commissioner and Director Office of Georgia Gateway	DHS	Employee	0.025
		Jon Anderson, Chief Deputy Division Director, OFI	DHS	Employee	0.025
		Grant Thomas, Director*	OHSC	Employee	0.025
		TBD	OOG	Employee	0.025
		Kelly Farr, Director*	OPB	Employee	0.025
		Anand Balasubramanian, Technology Advisor*	OPB	Contractor	0.025



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
Waiver Executive Sponsors	- Responsible for project success and delivering anticipated project outcomes - Obtains state and federal approval and funding for the project - Acts as project champion to both internal and external stakeholders - Provides authority for the use of state resources to implement defined strategies - Provides guidance on overall strategic direction - Resolves decisions, risks, and issues escalated from the Project Directors and Waiver Implementation Advisory Group - Escalates project risks, issues, and decisions to the Patients First Act Leadership Team - Provides DCH final approval of contractor deliverables and authorizes invoicing - Interfaces with state and federal oversight agencies	Lynnette Rhodes, Esq., Executive Director, Medical Assistance Plans	DCH	Employee	0.175
		Grant Thomas, Director	OSHC	Employee	0.12
Pathways Leadership Team	- Acts as project champion and change leader to internal stakeholders - Responsible for project success - Provides programmatic and IT leadership to the project - Reviews and provides opinion and advice in relation to plans, activities, risks, issues, and	Ryan Loke, Deputy Commissioner and Chief Health Policy Officer*	DCH	Employee	0.10
		Lynnette Rhodes, Executive Director, Medical Assistance Plans	DCH	Employee	0.10
		Brian Dowd, Deputy Exec. Director, Policy, Compliance and Operations Office	DCH	Employee	0.10



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
	decisions arising from the project work streams	Catherine Ivy, Deputy Exc. Director Service Administration and Delivery	DCH	Employee	0.10
	▪ Ensures alignment of waiver implementation with overall DCH / DHS program and IT strategic objectives, policies, and practices	Kelvin Holloway, Deputy Exc. Director Performance and Care Management	DCH	Employee	0.10
	▪ Acts as a sounding board to the Executive Sponsors and Project Managers to discuss, advance, and provide perspectives on the more complex elements of the project, that are relevant to their area(s) of expertise or experience	Zainab Muhammad-Only, Eligibility Systems Support Director	DCH	Employee	0.10
		Lavinia Luca, Director of Medicaid Coordination	DCH	Employee	0.10
		Lisa Walker, CFO*	DCH	Employee	0.10
		Venu Gurram, CIO	DCH	Employee	0.10
	▪ Provides advice and recommendations in relation to the implementation approach and methodology	Matt Jarrard, Deputy CIO / MES Chief	DCH	Employee	0.05
		Joyce Wilson, MMIS Lead	DCH	Employee	0.10
	▪ Provides comment on drafts of key project deliverables as requested	Matthew Krull, Legal Services	DCH	Employee	0.10
		Carla Willis, Director Performance, Quality and Outcomes	DCH	Employee	0.10
		Marisol Owens, TPL Director	DCH	Employee	0.10
		Anika Washington, Eligibility Policy Manager	DCH	Employee	0.10
		Charles Strong, Communications Director	DCH	Employee	0.10
		Tara Dickerson, Deputy General Counsel	DCH	Employee	0.10
		Stephanie Ashlaw, PCK Director	DCH	Employee	0.10
		Scherie Jeffries, Deputy Commissioner	DHS	Employee	0.10
		Venkat Krishnan, CIO	DHS	Employee	0.10



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
		Jon Anderson, Chief Deputy Division Director, OFI	DHS	Employee	0.10
		Paul Rayapudi, Project Manager	DHS	Contractor	0.10
Georgia Pathways (1115 Waiver) Implementation Project Director	- Leads the project, with a focus on 1115 waiver implementation activities - Oversees the Project Management Services, OCM Services, Business Workgroups, and contractors - Liaises with the Pathways Leadership Team and Executive Sponsor - Resolves 1115 waiver risks, issues, and decisions escalated from the workstream leads - Reports 1115 waiver implementation status and escalates risks, issues, and decisions to the Pathways Leadership Team and Executive Sponsor - Responsible for 1115 waiver implementation success	Lavinia Luca, Director of Medicaid Coordination	DCH	Employee	0.90
		Zainab Muhammad-Only, Eligibility Systems Support Director	DCH	Employee	0.25
Georgia Access (1332 Waiver) Implementation Project Director	- Leads the project team, with a focus on 1332 waiver activities - Liaises with the 1332 Waiver Executive Sponsor - Resolves 1332 waiver implementation risks, issues, and decisions escalated from the project work streams - Reports 1332 waiver implementation status and	Grant Thomas, Director	OHSC	Employee	0.85



ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
	escalates risks, issues, and decisions to the 1332 Waiver Implementation Executive Sponsor Responsible for 1332 Waiver Implementation success				
Enterprise Support - DCH	- Advises on federal funding requirements and MITA priorities - Liaises with CMS to obtain federal approval and funding for the project	Marty Hicks, Director, MITA PMO*	DCH	Employee	0.10
	Advises the project team on DCH legal matters	Matthew Krull, Legal Services	DCH	Employee	0.75
	- Advises the project team on contractual matters - Prepares and negotiates DCH contract amendments	Lindsey Breedlove, Director, Contracts Administration	DCH	Employee	0.10
		Jorge Correa, Deputy Director, Contracts Administration	DCH	Employee	0.10
		David Grossman, Attorney, Contracts Administration	DCH	Employee	0.10
	- Supports project procurements, including contract amendments, to ensure compliance with state procurement law - Coordinates any required state contract approvals	Czarina Woods, Director, Office of Procurement Services	DCH	Employee	0.10
	Provides DCH budgeting and financial reporting support to the project team	Ilona Share, Finance Manager II, MMIS/Federal Reporting*	DCH	Employee	0.05
		Ametria Baker, Budget Manager, Financial Management*	DCH	Employee	0.05
	Oversees communications to external stakeholders, including providers, partner agencies, and members	Charles Strong, Communications Director	DCH	Employee	0.15



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
E&E / IES Lead	- Oversees the enhancements to the State's IES - Responsible for IES Enhancements workstream success - Leads the IES Enhancements team, including state and contractor personnel - Provides guidance and direction to workstream team members - Liaises with the Project Directors and PMO - Reports project status and escalates risks, issues, and decisions as needed - Provides final approval of the IES Contractor deliverables and authorizes invoicing	Scherie Jeffries, Deputy Commissioner	DHS	Employee	0.50
MMIS Lead	- Oversees the enhancements to the MMIS - Responsible for MMIS Enhancements workstream success - Leads the MMIS Enhancements team, including state and contractor personnel - Provides guidance and direction to workstream team members - Liaises with the Project Directors and PMO - Reports project status and escalates risks, issues, and decisions as needed	Joyce Wilson, MMIS Director	DCH	Employee	0.25



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
	Provides final approval of MMIS Contractor deliverables and authorizes invoicing				
TPL Lead	- Oversees the enhancements to the TPL solution - Responsible for TPL Enhancements workstream success - Leads the TPL Enhancements team, including state and contractor personnel - Provides guidance and direction to workstream team members - Liaises with the Project Directors and PMO - Reports project status and escalates risks, issues, and decisions as needed - Provides final approval of TPL Services Contractor deliverables and authorizes invoicing	Marisol Owens, TPL Director	DCH	Employee	0.20
MRA Lead	- Oversees the implementation of MRA functionality - Responsible for MRA workstream success - Leads the MRA implementation team, including state and contractor personnel - Provides guidance and direction to workstream members - Liaises with the Project Directors and PMO	TBD	DCH	Employee	0.25



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
	Reports project status and escalates risks, issues, and decisions as needed				
Medical Assistance Plans Functional SMEs	- Provides expertise on Medicaid program policies, operations, and reporting - Serves a key role in project activities, including requirements definition and validation, testing, training, and change management - Reviews project deliverables and provides feedback - Supports the workstream lead in resolving or escalating issues and risks	Catherine Ivy, Deputy Executive Director Service Administration and Delivery	DCH	Employee	0.05
		Randall Solomon, Director, Managed Care	DCH	Employee	0.05
		Zainab Muhammad-Only, IES Project Manager	DCH	Employee	0.25
		Maya Carter, Director of Operations System Support	DCH	Employee	0.05
		Anika Washington, Eligibility Policy Manager, Policy Unit	DCH	Employee	0.25
		Teresa Fair, Eligibility Policy SME	DCH	Employee	0.50
		Brian Dowd, Deputy Exec. Director, Policy, Compliance and Operations Office	DCH	Employee	0.25
		Woody Dahmer, Managed Care Services and Compliance Director	DCH	Employee	0.05
		Kunita Snead, Healthcare Program Consultant 3	DCH	Employee	0.50
		Donna Johnson, Healthcare Program Consultant 3	DCH	Employee	0.50
		Stephanie Ashlaw, PCK Director	DCH	Employee	0.25
		Dophamia Dean, Healthcare Program Consultant III	DCH	Employee	0.25
		Sandra Middlebrooks, Senior Contract Compliance Manager	DCH	Employee	0.05
		Carla Willis, Performance Quality and Outcomes Director	DCH	Employee	0.25
		Mary Pierce, IES UAT Tester	DCH	Employee	0.25
		Brian Roth, Eligibility Systems Support Manager	DCH	Employee	0.25



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		Mollie Elder, IES UAT Tester	DCH	Employee	0.25
		Judith Adan, IES UAT Tester	DCH	Employee	0.25
		Mashonda Fortune, Enrollment Systems Support Manager	DCH	Employee	0.25
		Richard Kim, Senior Manager Financial Analytics and Statistics*	DCH	Employee	0.05
Finance Functional SMEs	- Provides expertise on departmental, state, and federal financial policies, operations, and reporting - Serves a key role in project activities, including requirements definition and validation, testing, training, and change management - Reviews project deliverables and provides feedback - Supports the workstream lead in resolving or escalating issues and risks	Ilona Share, Finance Manager, MMIS/Federal Reporting*	DCH	Employee	0.10
		Kim Morris, Director of Reimbursement Services*	DCH	Employee	0.05
		Shawna Johnston, Financial Services*	DCH	Employee	0.05
		Kathy Weiss, Deputy CIO	DHS	Employee	0.10
		Kimberly Slaughter, Administrative Officer	DHS	Employee	0.10
		Sherman Harris, Director, Information Security	DCH	Employee	0.25
IT, MMIS, and Security SMEs (MMIS, IES, and TPL Work Streams)	- Provides expertise on departmental, state, and federal IT, privacy, and security policies and industry best practices - Provides MMIS and IES expertise - Serves a key role in project activities, including requirements definition and validation, testing, training, and change management - Reviews project deliverables and provides feedback - Supports the workstream lead in resolving or escalating issues and risks	Suzannah Lipscomb, HIPAA Privacy and Security	DCH	Employee	0.05
		Waverly Wesson, MMIS Manager	DCH	Employee	0.25
		Tina Hawkins, MMIS Manager	DCH	Employee	0.25
		Daphanie Calliste, MMIS Manager	DCH	Employee	0.25
		Marquis Lovett, Business Analyst	DCH	Employee	1.00
		Tiffany Griffin, Business Analyst II	DCH	Employee	0.25
		Debbie Jackson, Business Analyst II	DCH	Employee	0.25
		Mohandas Sundareswaran, Chief Enterprise Architect	DHS	Employee	0.20
		Sushil Jain, OIT Architect	DHS	Contractor	0.30



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
		Rajasekher Satyaneni, Director	DHS	Employee	0.20
		Sreeji Vijayan, Director	DHS	Employee	0.30
		Scherie Jeffries, Assistant Deputy Commissioner	DHS	Employee	0.20
		TBD, Lead Developer / DBA	DHS	Contractor	0.20
		Mona Jackson	DHS	Employee	0.20
		TBD, Technical Resource 1	DHS	Contractor	0.20
		TBD, Technical Resource 2	DHS	Contractor	0.20
		Aditya Vasireddy, Interface Lead	DHS	Contractor	0.20
		Randy Coleburn, CISO	DHS	Employee	0.20
		Shirlan Johnson, Sr. Information Assurance and Compliance Officer	DHS	Employee	0.20
		William Dickerson, Information Security Analyst	DHS	Employee	0.30
		Andrea Walker, Information Security Analyst	DHS	Employee	0.30
		TBD, DBA	DHS	Employee	1.00
		TBD, Cloud Administrator 1	DHS	Employee	1.00
		TBD, Cloud Administrator 2	DHS	Contractor	1.00
		TBD, Java Technical Resource 1	DHS	Contractor	1.00
		TBD, Java Technical Resource 2	DHS	Contractor	1.00
		TBD, Analytics Developer 1	DHS	Contractor	1.00
		TBD, Analytics Developer 2	DHS	Contractor	1.00
MMIS and FA Services	Performs requirements definition, validation, and elaboration	Gainwell Technologies	n/a	Contractor	TBD



ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
	- Plans, designs, develops/configures, and implements MMIS enhancements - Supports UAT and defect resolution - Conducts end user training - Reports status of project activities and escalates risks, issues, and decisions to the MMIS Lead				
Georgia Gateway PMO	- Provides expertise on IES business rules, workflows, and reporting - Serves a key role in project activities, including requirements definition, validation, and elaboration, testing, and training - Reviews project deliverables and provides feedback - Supports the workstream lead in resolving or escalating issues and risks - Assists IES Lead in overseeing contractors	Scherie Jeffries, Assistant Deputy Commissioner	DHS	Employee	0.50
		Mohandas Sundareswaran, Chief Enterprise Architect	DHS	Employee	0.20
		Sushil Jain, Architect	DHS	Contractor	0.40
		Rajasekher Satyaneni, Director	DHS	Employee	0.50
		Sreeji Vijayan, Director	DHS	Employee	0.70
		TBD, Lead Developer / DBA	DHS	Contractor	0.50
		TBD, Technical Resource 1	DHS	Contractor	0.80
		TBD, Technical Resource 2	DHS	Contractor	0.80
		Aditya Vasireddy, Interface lead	DHS	Contractor	0.80
		Jayshree Sawant, Business Analyst	DHS	Employee	1.00
		Brandon Phifer, Business Analyst	DHS	Employee	1.00
		TBD, Business Analyst 2	DHS	Contractor	1.00
		Mona Jackson, UAT Support	DHS	Employee	0.80
		Jean Cheese, Training Lead	DHS	Contractor	1.00
		Denise Denny, Pre-UAT Testing	DHS	Employee	1.00



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
		Mildred Da Costa, Pre-UAT Testing	DHS	Contractor	1.00
		Cassius Franswah, Pre-UAT Testing	DHS	Contractor	1.00
		Abdul Ibrahim, ADA Tester	DHS	Contractor	1.00
		Jon Anderson, Chief Deputy Division Director, OFI	DHS	Employee	0.20
Medicaid Eligibility Central and Field Office SMEs	- Provides expertise on Medicaid eligibility policies, processes, operations, and reporting - Serves a key role in project activities, including requirements definition, validation, and elaboration, testing, and training - Reviews project deliverables and provides feedback - Acts as field office change agents - Supports the workstream lead in resolving or escalating issues and risks	Wesley Merritt, OFI Quality Operations Director	DHS	Employee	0.50
		Kristen Hernandez, Business Support Analyst	DHS	Employee	0.50
		Bradley Green, Medicaid Unit Manager	DHS	Employee	0.50
		Tracey White, ABD Medicaid Policy Specialist	DHS	Employee	0.50
		Mandy Corlee, Manager	DHS	Employee	0.50
		Zainab Muhammad-Only, Eligibility System Support, Director	DHS	Employee	0.50
		Christian Scarcella, Business Support Analyst	DHS	Employee	0.50
		Jeffery Brunner, Business Analyst	DHS	Employee	0.50
HIPP Functional SME	- Provides expertise on HIPP policies, operations, and reporting - Serves a key role in project activities, including requirements definition, validation and elaboration, testing, training, and change management - Reviews project deliverables and provides feedback	Dennis James, Program Specialist	DCH	Employee	0.30
		TBD	DCH	Employee	0.50



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
	Supports the workstream lead in resolving or escalating issues and risks				
Mobile - DHS	- Performs requirements validation and elaboration - Plans, designs, develops/configures, and implements new mobile functionality - Supports UAT and defect resolution	Mohandas Sundareswaran, Chief Enterprise Architect	DHS	Employee	0.20
Enterprise Support - DHS	- Supports project procurements, including contract amendments, to ensure compliance with state procurement law - Coordinates any required state contract approvals - Prepares and negotiates DHS contracts and contract amendments	Procurement and Contracts	DHS	Employee	0.30
	Provides DHS budgeting and financial reporting support to the project	Budget Administration	DHS	Employee	0.50
		Kathy Weiss, Deputy CIO	DHS	Employee	0.50
	Oversees communications to external stakeholders, including providers, partner agencies, and members	Communications	DHS	Employee	0.20
Care Management Organizations (CMOs)	- Oversees implementation of MRA functionality - Contracts with MRA vendor(s)	CareSource Peach State Health Plan Amerigroup	n/a	Contractor	TBD
MRA Services	Implements MRA functionality	TBD	n/a	Sub-contractor	TBD



ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
E&E / IES Services	- Performs requirements validation and elaboration - Plans, designs, develops/configures, and implements IES modifications and enhancements - Supports UAT and defect resolution - Conducts end user training - Reports status of project activities and escalates risks, issues, and decisions to the IES Lead - Maintains day-to-day operations of the IES and all of its components including portals, interfaces, batches, data, applications, reports, correspondence, etc. - Performs ongoing maintenance of the IES, including identifying system issues, working with DHS to prioritize issues, managing releases, and creating and maintaining appropriate documentation - Performs functional and technical enhancements to the system as authorized	Deloitte	n/a	Contractor	TBD
Waiver Advisory Services	- Provides waiver subject matter expertise and advisory support to the project team - Supports functional SMEs with waiver implementation activities - Provides planning and project management support to functional	Deloitte	n/a	Contractor	5.50



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
	SMEs across state agencies with the design and implementation of necessary changes to operating models, processes, and procedures				
Automated Monitoring and Reporting Services	- Develops monitoring protocol and identify required metrics - Developed automated reporting for required monitoring reports - Generates reports for required federal reporting (quarterly and annual) - Develops program dashboards for tracking key program metrics	Deloitte	n/a	Contractor	4
PMO Services	- Implements project management processes and tools - Assists the Project Directors with day-to-day project management activities and duties, including oversight, status reporting, and schedule, risk and issue management and reporting, etc. - Supports workstreams leads with day to day project management activities and duties - Supports workstream requirements definition activities - Provides strategic analysis services - Implements and supports governance processes - Reviews project deliverables and provides feedback	Deloitte	n/a	Contractor	4



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ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
PBM Services	- Performs requirements definition, validation, and elaboration - Plans, designs, develops/configures, and implements PBM enhancements for HIPP Program - Supports UAT and defect resolution - Conducts end user training - Reports status of project activities and escalates risks, issues, and decisions to the TPL Lead	Optum	n/a	Contractor	2.50
TPL Services	- Performs requirements definition, validation, and elaboration - Plans, designs, develops/configures, and implements TPL enhancements - Supports UAT and defect resolution - Conducts end user training - Reports status of project activities and escalates risks, issues, and decisions to the TPL Lead	Health Management Services (HMS)	n/a	Contractor	4.25
OCM Services	- Leads the change management effort for state employees (central and field), partner agencies, members, and providers - Develops OCM strategies and plans for the project - Develops and implements change management processes and tools	North Highland	n/a	Contractor	2.75



ORG ENTITY	RESPONSIBILITIES	RESOURCE	AGENCY	TYPE	FTE
	- Trains and supports DCH and DHS change sponsors and change agents - Develops and executes communications plan to address stakeholder issues and manage reactions to the project				
IV&V Services	- Provides oversight and independent verification and validation of project progress - Provides reporting on project status and health to state (GTA) oversight agency	CSG	n/a	Contractor	2.00

Exhibit 18: Project Roles and Responsibilities



7.3 Project Governance – Updated July 2021

The State employs a multi-layered approach to govern, manage, and monitor the Patients First Act Implementation Project and enable successful decision making, accountability, and escalations, which is critical for a project involving multiple agencies and contractors. The governance structure includes the use of a Patients First Act Leadership, Executive Sponsors, Project Director, and a PMO overseeing the work of the project team. Additionally, an IV&V Services contractor conducts project monitoring activities and reports directly to the state oversight agency, the Georgia Technology Authority.

The project's tiered governance structure is described in more detail below.

Patients First Act Leadership

The project is governed by the PFA Leadership composed of executives from the Office of the Governor (OOG), Office of Planning and Budget (OPB), DCH, DHS, and OHSC. The PFA Leadership:

- Provides management direction and support to the project, including resolving escalated risks and issues
- Reviews and approves any changes exceeding specified thresholds to the project's scope, schedule, and budget
- Provides guidance and advice on the strategic direction of the project

PFA Leadership holds regular meetings to review items escalated by the project and to monitor the status of project performance.

Executive Sponsors

The Executive Sponsors provide leadership and guidance on the strategic direction of the project and have overall responsibility for the success of the project. The Executive Sponsors are ultimately responsible for securing spending authority and resources for the project and escalating risks, issues, and decisions to PFA Leadership as necessary. The Georgia Pathways Executive Sponsor is supported by the Pathways Leadership Team (PLT) and Pathways Project Director to review project plans, activities, risks, issues, and decisions and provide opinions and recommendations.

Project Management Team

The Project Management Team consists of the Project Director and PMO Services contractor. The Project Management Team oversees the project's activities and processes. The Project Director is charged with keeping the project aligned with the identified goals and working with the PMO Services contractor to ensure a successful implementation. The PMO Services contractor oversees the day-to-day collaboration and efforts of both the state and contractor teams and tracks and monitors progress against the project plan. As needed, the Project Management Team escalates risks, issues, and decisions to the Executive Sponsors.



Project Team

The Project Team conducts daily project activities, working in conjunction with the Project Management Team. Four workstream leads oversee the enhancements and modifications to the TPL Services, MMIS and FA Services, E&E / IES, as well as the implementation of My Rewards Account functionality. Within these workstreams, the State's functional, technical, and operational SMEs provide expertise in their respective areas, including Medicaid eligibility, Medicaid policy, IT, MMIS, TPL, HIPPA, security and privacy, and finance. Enterprise support is provided by state personnel within legal services, procurement, contract administration, budget, project management, and communications.

The Project Team also includes contractor resources – a Waiver Advisory Services contractor, Automated Monitoring and Reporting contractor, OCM Services contractor, PBM Services contractor, TPL Services contractor, E&E / IES contractor, and MMIS and FA Services contractor. The Project Team supports the Project Management Team by reporting the status of project activities and communicating risks and issues. As necessary, the Project Team escalates risks, issues, and decisions to the Project Management Team.

Independent Verification and Validation

The IV&V Services contractor provides the requisite IV&V services throughout the life of the project in compliance with state requirements. The IV&V contractor provides unbiased reviews and assessments to help ensure the project is meeting its desired goals, adheres to state and federal regulations and guidance, complies with internally documented or recognized industry standards and processes, produces deliverables that meet requirements, and effectively engages stakeholders.

7.4 Acquisitions – Updated July 2021

Exhibit 19: Acquisitions describes procurements that have been completed or are planned for the Patients First Act Implementation effort.

The State will comply with all applicable state and federal requirements for the acquisitions identified in the exhibit below, including the submission of acquisition documents to CMS in accordance with 45 CFR 95.611 and the retention of software ownership rights specified in 45 CFR 95.617. Additionally, pursuant to Georgia's State Purchasing Act, the State Purchasing Division (SPD) of the Georgia Department of Administrative Services (DOAS) administers state procurement functions and policies and reviews state entity compliance with administrative rules. DCH will follow state procurement procedures to request and receive the prior approval required from SPD for contract amendments.

ACQUISITION	CONTRACT TYPE	PROCUREMENT STRATEGY	ESTIMATED COST	CONTRACT DURATION
Waiver Advisory Services Deloitte Consulting	Fixed Fee	Competitive Procurement	\$650,000	Oct 20 – Dec 20
Waiver Advisory Services Deloitte Consulting	Fixed Fee	Contract Amendment	\$8,100,000	Jan 21 – Nov 22



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ACQUISITION	CONTRACT TYPE	PROCUREMENT STRATEGY	ESTIMATED COST	CONTRACT DURATION
Automated Reporting and Monitoring Services – Georgia Pathways Program Deloitte Consulting	Fixed Fee	DOAS Statewide Contract	\$3,200,000	Jan 21 – Nov 25*
E&E / IES Services Deloitte Consulting (Contract # 2014035 Amendment 14)	Fixed Fee	Contract Amendment	\$33,404,340	Oct 20 – Jun 23
E&E / IES Services Deloitte Consulting	Fixed Fee	Contract Amendment	\$5,000,000	Oct 21 – Jul 22
TPL Services HMS	Fixed Fee	Contract Amendment	\$322,500	Jan 21 – Jun 22
PBM Services Optum	Fixed Fee	Change Request	\$225,000	Apr 21 – Jan 22
Project Management Office Services – Georgia Pathways Program Deloitte Consulting	Fixed Fee	DOAS Statewide Contract	\$2,340,000	Dec 20 – Jul 22
Organizational Change Management Services – Georgia Pathways Program North Highland	Fixed Fee	ITPAS Competitive Procurement	\$755,396	Apr 21 – Jul 22
Independent Verification & Validation Services – Georgia Pathways Program CSG	Fixed Fee	ITPAS Competitive Procurement	\$446,560	Mar 21 – Jul 22
Organizational Change Management Services – Georgia Access Program	Fixed Fee	TBD	\$3,000,000	Oct 21 – Nov 22
Project Management Office Services – Georgia Access Program	Fixed Fee	TBD	\$2,600,000	Oct 21- Nov 22
Independent Verification & Validation Services – Georgia Access Program	Fixed Fee	TBD	\$500,000	Oct 21 – Nov 22

Exhibit 19: Acquisitions



Note: The contract amount listed for Automated Reporting and Monitoring Services includes both implementation and operational fees. Only implementation fees are included in the APD budget.

Several of the procurements listed above will be accomplished through contract amendments with incumbent contractors. It should be noted that the original (base) contracts awarded to these vendors are the result of competitive procurements.

The E&E / IES and TPL Services contractors have existing contracts to provide operations and maintenance services. These contractors also implemented the E&E / IES and TPL solutions and, as such, are the best qualified and least risky alternative to the State to design and implement the necessary system enhancements and modifications. The Waiver Advisory Services contractor supported the design of the 1115 and 1332 waivers. The original contract was executed in June 2019. The contract has been amended to enable the contractor to continue to provide advisory support and reporting and monitoring services throughout the Implementation Phase.

The State engaged a Project Management Office Services contractor to support the Patients First Act Implementation Project. These services were acquired using a statewide convenience contract managed by DOAS.

OCM Services and IV&V Services for the project were procured competitively through the Georgia Technology Authority's Information Technology Project Assurance Services (ITPAS) procurement vehicle. Under ITPAS, state agencies are able to competitively procure IV&V, management, OCM, and quality assurance services. A statement of need (SON) is released to a set of pre-qualified vendors. Based on an evaluation of the responses received, the State selects the vendor offering the best value.

The project budget in Section 9 includes the actual and estimated costs of the acquired services, including any contract amendments. All vendor contracts are fixed fee contracts. Contractor deliverables are identified in Exhibit 21: Deliverable Schedule which can be found in Section 8. The State uses contractual terms and conditions, including payment terms, service level agreements, and performance guarantees, to help ensure quality and timely delivery of contractor services.



SECTION 8 PROPOSED ACTIVITY SCHEDULE

The Activity Schedule and Deliverable Schedule provided in the sections below will be updated and elaborated as the project planning progresses.

8.1 Activity Schedule – Updated July 2021

Exhibit 20: Activity Schedule presents Patients First Act Implementation Project activities and milestones by workstream, including:

- Eligibility & Enrollment / Integrated Eligibility System Workstream
- Medicaid Management Information System and Fiscal Agent Workstream
- Third Party Liability Services Workstream
- Waiver Advisory, Reporting and Monitoring Services Workstream
- Project Management Office Services Workstream
- Organizational Change Management Services Workstream
- Independent Verification & Validation Services Workstream

The information provided includes the entity with primary responsibility for the activity/milestone and planned or actual start and end dates.



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ACTIVITY/MILESTONE	RESPONSIBLE	PLANNED/ACTUAL START	PLANNED/ACTUAL COMPLETION
INTEGRATED ELIGIBILITY SYSTEM WORKSTREAM			
Initiate E&E / IES Workstream	DCH / DHS / Deloitte	~~September 2020~~ October 2020	~~September 2020~~ October 2020
GEORGIA PATHWAYS - PHASE 1			
Requirements	DCH / DHS / Deloitte	~~September 2020~~ October 2020	~~December 2020~~ March 2021
Design	DCH / DHS / Deloitte / Gainwell	~~September 2020~~ October 2020	~~December 2020~~ March 2021
Development	Deloitte	~~November 2020~~ October 2020	~~March 2021~~ April 2021
System / Trading Partner Integration Testing	Deloitte / Gainwell	~~January 2021~~ November 2020	~~March 2021~~ June 2021
User Acceptance Testing (UAT)	DCH / DHS / Deloitte	~~February 2021~~ November 2020	June 2021
Training / Readiness	DCH / DHS / Deloitte	~~June 2021~~ November 2020	~~June 2021~~ July 2021
Implementation	Deloitte	July 2021	July 2021 (Pending)
GEORGIA PATHWAYS - PHASE 2			
Requirements	DCH / DHS / Deloitte	January 2021	~~February 2021~~ June 2021
Design	DCH / DHS / Deloitte / HMS	~~February 2021~~ January 2021	~~April 2021~~ June 2021
Development	Deloitte	March 2021	~~July 2021~~ August 2021
System / Trading Partner Integration Testing	Deloitte / HMS	~~July 2021~~ June 2021	~~September 2021~~ November 2021
UAT	DCH / DHS / Deloitte	~~September 2021~~ July 2021	December 2021
Training / Readiness	DCH / DHS / Deloitte	~~December 2021~~ March 2021	~~December 2021~~ February 2022
Implementation	Deloitte	~~January 2022~~ January 2022	January 2022
GEORGIA PATHWAYS - PHASE 3			



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ACTIVITY/MILESTONE	RESPONSIBLE	PLANNED/ACTUAL START	PLANNED/ACTUAL COMPLETION
Requirements	DCH / DHS / Deloitte	~~July 2021~~ August 2021	~~August 2021~~ October 2021
Design	DCH / DHS / Deloitte	~~August 2021~~ September 2021	November 2021
Development	Deloitte	November 2021	~~January 2022~~ February 2022
System / Trading Partner Integration Testing	Deloitte / Premium Collection Vendor / MRA Vendor	January 2022	~~April 2022~~ May 2022
UAT	DCH / DHS / Deloitte	~~February 2022~~ April 2022	June 2022
Training / Readiness	DCH / DHS / Deloitte	June 2022	~~June 2022~~ July 2022
Implementation	Deloitte	July 2022	July 2022
GEORGIA ACCESS			
Requirements	DCH / DHS / OHSC / Deloitte	~~April 2021~~ May 2021	~~June 2021~~ August 2021
Design	DCH / DHS / OHSC / Deloitte / Brokers / Carriers	~~June 2021~~ July 2021	~~September 2021~~ October 2021
Development	Deloitte	~~September 2021~~ July 2021	~~January 2022~~ April 2022
System / Trading Partner Integration Testing	Deloitte / Brokers / Carriers / CMS / IRS	~~December 2021~~ October 2021	June 2022
UAT	DCH / DHS / OHSC / Deloitte	~~July 2022~~ June 2022	September 2022
Training / Readiness	DCH / DHS / OHSC / Deloitte	~~October 2022~~ June 2022	~~November 2022~~ September 2022
Implementation	Deloitte	~~November 2022~~ September 2022	November 2022
MEDICAID MANAGEMENT INFORMATION SYSTEM AND FISCAL AGENT WORKSTREAM			
Phase 1 - Initiate MMIS and FA Workstream	DCH / Gainwell	~~September 2020~~ October 2020	~~September 2020~~ November 2020
Phase 1 - Requirements	DCH / Gainwell	~~September 2020~~ October 2020	~~November 2020~~ December 2020



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ACTIVITY/MILESTONE	RESPONSIBLE	PLANNED/ACTUAL START	PLANNED/ACTUAL COMPLETION
Phase 1 - Design	Gainwell	December 2020	December 2020
Phase 1 - Development	Gainwell	~~December 2020~~ January 2021	~~January 2021~~ March 2021
Phase 1 - System / Trading Partner Integration Testing	Gainwell	~~January 2021~~ February 2021	~~March 2021~~ April 2021
Phase 1 - UAT	DCH	~~March 2021~~ April 2021	June 2021
Phase 1 - Implementation	Gainwell	~~June 2021~~ July 2021	July 2021 (Pending)
Phase 2 - Requirements	DCH / Gainwell	March 2021	June 2021
Phase 2 - Design	Gainwell	June 2021	June 2021
Phase 2 - Development	Gainwell	July 2021	September 2021
Phase 2 - System / Trading Partner Integration Testing	Gainwell	September 2021	November 2021
Phase 2 - UAT	DCH	November 2021	January 2022
Phase 2 - Implementation	DCH / Gainwell	January 2022	January 2022
THIRD PARTY ELIGIBILITY SERVICES WORKSTREAM			
PLANNING			
Create High-Level Project Plan with Key Dates	DCH/Deloitte/HMS	January 2021	~~January 2021~~ February 2021
Create Detailed Project Plan for DCH Deliverables	DCH	~~February 2021~~ January 2021	February 2021
Create Detailed Project Plan for IES Contractor Deliverables	Deloitte	~~February 2021~~ January 2021	February 2021
Create Detailed Project Plan for HMS Deliverables	HMS	~~February 2021~~ January 2021	February 2021
Merge and Reconcile Deliverable Timing	DCH/Deloitte/HMS	~~February 2021~~ January 2021	February 2021
STAFFING			



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ACTIVITY/MILESTONE	RESPONSIBLE	PLANNED/ACTUAL START	PLANNED/ACTUAL COMPLETION
Recruit for Pathways HIPP Staff	HMS	July 2021	~~August 2021~~ September 2021
Develop Staff Training Materials	HMS	~~July 2021~~ August 2021	September 2021
Hire Pathways HIPP Staff	HMS	~~September 2021~~ July 2021	~~October 2021~~ September 2021
Training for Pathways HIPP Staff	HMS	~~October 2021~~ September 2021	~~December 2021~~ January 2022
INFRASTRUCTURE AND DEVELOPMENT			
Staffing Infrastructure	HMS	July 2021	September 2021
Pathways Communication	HMS	February 2021	November 2021
Updating Notices and Member Materials	HMS	February 2021	August 2021
SYSTEM DEVELOPMENT			
Joint Requirements and Design	HMS	January 2021	August 2021
Development	HMS	May 2021	October 2021
Testing (QA and UAT)	HMS	June 2021	December 2021
Go-Live	HMS	January 2022	January 2022
REPORTS			
Joint Requirements and Design	HMS	January 2021	July 2021
Development	HMS	March 2021	October 2021
SIT	HMS	June 2021	October 2021
UAT	HMS	October 2021	November 2021
Finalize Business Operational Process for Reporting	HMS	August 2021	November 2021
Training	HMS	December 2021	January 2022



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ACTIVITY/MILESTONE	RESPONSIBLE	PLANNED/ACTUAL START	PLANNED/ACTUAL COMPLETION
Go-Live	HMS	January 2022	January 2022
PBM			
Phase 1 – Complete Requirements	Optum	April 2021	April 2021
Phase 1 – Testing for Eligibility Files	Optum	June 2021	June 2021
Phase 1 Effective Date	Optum	August 2021	August 2021
Phase 2 – Complete Requirements	Optum	November 2021	November 2021
Phase 2 – Testing for Eligibility Files	Optum	November 2021	December 2021
Phase 2 Effective Date	Optum	January 2022	January 2022
WAIVER ADVISORY SERVICES WORKSTREAM			
Initiate Waiver Advisory Services Workstream	DCH / DHS / Deloitte	October 2020	October 2020
Provide Workgroup Support / Inputs to Status Reports	Deloitte	October 2020	November 2022
Provide On-going Policy, Design, and CMS Support	Deloitte	October 2020	November 2022
Document GVRA Processes and Prepare Draft GVRA Deliverable	Deloitte / GVRA	February 2021	April 2021
Review and Finalize GVRA Deliverable	Deloitte / DCH / GVRA	April 2021	May 2021
Prepare Draft Implementation Plan 1	Deloitte	October 2021	January 2021
Review and Finalize Implementation Plan 1	Deloitte / DCH	January 2021	February 2021
Prepare Draft Implementation Plan 2	Deloitte	August 2021	December 2021
Review and Finalize Implementation Plan 2	Deloitte / DCH	December 2021	January 2022
AUTOMATED REPORTING AND MONITORING SERVICES WORKSTREAM			
Design and Implement Automated Reporting to Support 1115 Waiver Demonstration Monitoring Protocol	Deloitte	January 2021	June 2022
Complete Review of Monitoring Metrics	Deloitte	January 2021	April 2021



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ACTIVITY/MILESTONE	RESPONSIBLE	PLANNED/ACTUAL START	PLANNED/ACTUAL COMPLETION
Prepare Draft Protocol Workbook and Template	Deloitte	January 2021	April 2021
Review and Finalize Workbook and Template	Deloitte / DCH	April 2021	April 2021
Prepare Dashboard Requirements	Deloitte	April 2021	July 2021
Dashboard Design	Deloitte	May 2021	July 2021
Dashboard Development	Deloitte	July 2021	August 2021
Dashboard Test (SIT and UAT)	Deloitte	September 2021	October 2021
Dashboard Deployment	Deloitte	October 2021	October 2021
Develop Quarterly Monitoring Reports for CMS Submission	Deloitte / DCH	February 2021	November 2022
PROJECT MANAGEMENT OFFICE SERVICES WORKSTREAM			
Initiate Project Management Services Workstream	DCH / DHS / Deloitte	~~October 2020~~ December 2020	~~October 2020~~ December 2020
Design and Implement Project Management Standards, Processes, and Tools	Deloitte	~~October 2020~~ December 2020	~~November 2020~~ January 2021
Establish and Maintain Project Document Repository	Deloitte	~~October 2020~~ December 2020	~~October 2020~~ November 2022
Develop and Maintain Integrated Master Schedule	Deloitte	~~October 2020~~ December 2020	~~November 2020~~ November 2022
Perform Risk and Issue Management and Manage RAID Log	Deloitte	~~October 2020~~ December 2020	November 2022
Perform Integrated Project Status Reporting	Deloitte	~~October 2020~~ December 2020	November 2022
Implement and Execute Project Governance Committees, Processes, and Procedures	Deloitte	~~October 2020~~ December 2020	November 2022
Prepare for / Participate in Critical Panel Reviews and Other State and Federal Oversight Meetings	Deloitte	~~December 2020~~ February 2021	November 2022
ORGANIZATIONAL CHANGE MANAGEMENT SERVICES WORKSTREAM			
PROCUREMENT			
Develop OCM Services Procurement Document(s)	DCH / DHS	~~October 2020~~ December 2020	~~October 2020~~ February 2020



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ACTIVITY/MILESTONE	RESPONSIBLE	PLANNED/ACTUAL START	PLANNED/ACTUAL COMPLETION
Conduct OCM Services Procurement	DCH / DHS	~~November 2020~~ February 2021	~~December 2020~~ April 2021
Execute OCM Services Contract	DCH	~~January 2021~~ April 2021	~~January 2021~~ April 2021
OCM SERVICES			
Onboard OCM Services Contractor	DCH / DHS / North Highland	~~January 2021~~ April 2021	~~January 2021~~ April 2021
Perform OCM Services	North Highland	~~January 2021~~ April 2021	November 2022
INDEPENDENT VERIFICATION AND VALIDATION SERVICES WORKSTREAM			
PROCUREMENT			
Develop IV&V Services Procurement Document(s)	DCH / DHS	~~September 2020~~ October 2020	~~September 2020~~ October 2020
Conduct IV&V Services Procurement	DCH / DHS	~~November 2020~~ February 2021	~~November 2020~~ March 2021
Execute IV&V Services Contract	DCH	~~December 2020~~ March 2021	~~December 2020~~ March 2021
IV&V SERVICES			
Onboard IV&V Services Contractor	DCH / DHS / GTA / CSG	~~December 2020~~ March 2021	~~December 2020~~ March 2021
Perform IV&V Services	CSG	~~December 2020~~ March 2021	November 2022

Exhibit 20: Activity Schedule



8.2 Deliverable Schedule – Updated July 2021

Exhibit 21: Deliverable Schedule provides the major Patients First Act Implementation Project deliverables by workstream. The information provided includes the deliverable name, entity responsible for the deliverable, and planned and actual deliverable completion dates.

DELIVERABLE	RESPONSIBLE	PLANNED DELIVERY	ACTUAL DELIVERY
INTEGRATED ELIGIBILITY SYSTEM WORKSTREAM			
GEORGIA PATHWAYS – RELEASE 1			
Detailed Requirements Documentation	Deloitte	October 2020	January 2021
Detailed Requirements Traceability Matrix	Deloitte	January 2021	January 2021
Detailed System Design – Customer Portal	Deloitte	December 2020	January 2021
Detailed System Design – Mobile	Deloitte	December 2020	January 2021
Detailed System Design – Data Collection	Deloitte	December 2020	January 2021
Detailed System Design – Eligibility	Deloitte	December 2020	January 2021
Detailed System Design – Interfaces	Deloitte	December 2020	January 2021
Detailed System Design – Correspondence	Deloitte	December 2020	January 2021
Detailed System Design – Reports	Deloitte	December 2020	March 2021
Detailed System Design – Support Functions	Deloitte	December 2020	January 2021
Environment Build-Out (DEV, SIT, UAT)	Deloitte	March 2021	March 2021
February Coverage/Code Quality Report	Deloitte	March 2021	March 2021
March Code Coverage/Code Quality Review Report	Deloitte	April 2021	April 2021
April Code Coverage/Code Quality Review Report	Deloitte	April 2021	April 2021
May Code Quality Review Report	Deloitte	June 2021	June 2021
June Code Coverage/Code Quality Review Report	Deloitte	July 2021	July 2021
Updated Configuration Management Plan	Deloitte	April 2021	April 2021
System Integration Plan	Deloitte	April 2021	April 2021
Unit Test Checklists	Deloitte	March 2021	April 2021
SIT Test Results	Deloitte	April 2021	June 2021
UAT Test Results and Sign Off	Deloitte	May 2021	June 2021
CR and UAT Defect Documentation	Deloitte	June 2021 (Recurring)	June 2021 (Recurring)
Training Materials	Deloitte	May 2021	May 2021
Updated System Documentation (ongoing M&O contractual responsibility)	Deloitte	June 2021	



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DELIVERABLE	RESPONSIBLE	PLANNED DELIVERY	ACTUAL DELIVERY
Implementation/Acceptance – Go/No-Go Decision and Production Deployment	Deloitte	June 2021	June 2021 (Pending)
GEORGIA PATHWAYS – RELEASE 2			
Detailed Requirements Documentation	Deloitte	January 2021	June 2021
Detailed System Design – Eligibility	Deloitte	April 2021	June 2021
Detailed System Design – Interfaces	Deloitte	April 2021	June 2021
Detailed System Design – Correspondence	Deloitte	April 2021	June 2021
Detailed System Design – Reports	Deloitte	April 2021	June 2021
Environment Build Out (DEV, SIT, UAT)	Deloitte	August 2021	
August Code Coverage/Code Quality Review Report	Deloitte	September 2021	
September Code Coverage/Code Quality Review Report	Deloitte	October 2021	
October Code Coverage/Code Quality Review Report	Deloitte	November 2021	
November Code Coverage/Code Quality Review Report	Deloitte	December 2021	
December Code Coverage/Code Quality Review Report	Deloitte	January 2021	
January Code Coverage/Code Quality Review Report	Deloitte	January 2021	
Unit Test Checklists	Deloitte	~~July 2021~~ August 2021	
SIT Test Results	Deloitte	~~September 2021~~ November 2021	
UAT Test Results	Deloitte	December 2021	
Training Materials	Deloitte	~~December 2021~~ November 2021	
Updated System Documentation (ongoing M&O contractual responsibility)	Deloitte	June 2021	
Implementation/Acceptance – Go/No-Go Decision and Production Deployment	Deloitte	January 2022	
GEORGIA PATHWAYS – RELEASE 3			
Detailed Requirements Documentation	Deloitte	September 2021	
Detailed System Design – Customer Portal	Deloitte	October 2021	
Detailed System Design – Mobile	Deloitte	October 2021	
Detailed System Design – Eligibility	Deloitte	October 2021	
Detailed System Design – Interfaces	Deloitte	October 2021	
Detailed System Design – Correspondence	Deloitte	October 2021	
Detailed System Design – Reports	Deloitte	October 2021	



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DELIVERABLE	RESPONSIBLE	PLANNED DELIVERY	ACTUAL DELIVERY
Environment Build Out (DEV, SIT, UAT)	Deloitte	February 2022	
Unit Test Checklists	Deloitte	~~January 2022~~ March 2022	
Premium Collections and Management	Deloitte	~~April 2022~~ May 2022	
SIT Test Results	Deloitte	~~April 2022~~ May 2022	
UAT Test Results	Deloitte	June 2022	
Training Materials	Deloitte	June 2022	
Updated System Documentation (ongoing M&O contractual responsibility)	Deloitte	June 2021	
Implementation/Acceptance – Go/No-Go Decision and Production Deployment	Deloitte	June 2022	
GEORGIA ACCESS			
Detailed Requirements Documentation	Deloitte	June 2021	July 2021
Detailed System Design – Customer Portal	Deloitte	October 2021	
Detailed System Design – Eligibility	Deloitte	October 2021	
Detailed System Design – Interfaces	Deloitte	October 2021	
Detailed System Design – Correspondence	Deloitte	October 2021	
Detailed System Design – Reports	Deloitte	October 2021	
Detailed System Design – Support Functions	Deloitte	October 2021	
Unit Test Checklists	Deloitte	~~March 2022~~ April 2022	
SIT Test Results	Deloitte	June 2022	
Training Materials	Deloitte	~~September 2022~~ April 2022	
Updated System Documentation	Deloitte	October 2022	
Implementation/Acceptance – Go/No-Go Decision and Production Deployment	Deloitte	~~October 2022~~ September 2022	
MEDICAID MANAGEMENT INFORMATION SYSTEM AND FISCAL AGENT WORKSTREAM			
Release 1 - Requirements Documentation	Gainwell	November 2020	November 2020
Release 1 - Updated User and System Documentation	Gainwell	June 2021	July 2021
Release 2 - Requirements Documentation	Gainwell	June 2021	June 2021
Release 2 - Updated User and System Documentation	Gainwell	January 2022	January 2022
THIRD PARTY LIABILITY SERVICES WORKSTREAM			
Process and Procedures Documentation	HMS	April 2021	April 2021
Develop Design Document (BRD)	HMS	August 2021	



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DELIVERABLE	RESPONSIBLE	PLANNED DELIVERY	ACTUAL DELIVERY
Develop Notices / Handbook / Communications	HMS	August 2021	
Develop Testing Plan	HMS	December 2021	
Updated User and System Documentation	HMS	~~December 2021~~ January 2022	
Release 1 Pharmacy – Testing Results	Optum	June 2021	June 2021
Release 1 Pharmacy – Change Order	Optum	August 2021	
Release 2 Pharmacy – Testing Results	Optum	December 2021	
Release 2 Pharmacy – Change Order	Optum	January 2022	
AUTOMATED MONITORING AND REPORTING SERVICES			
1115 Demonstration Monitoring Reports – Release 1 – DY1Q1	Deloitte	July 2021	March 2021
1115 Demonstration Monitoring Reports – Release 1 – DY1Q2	Deloitte	May 2021	May 2021
1115 Demonstration Monitoring Reports – Release 1 – DY1Q3	Deloitte	September 2021	
1115 Demonstration Monitoring Reports – Release 1 – DY1Q4 (Annual)	Deloitte	January 2022	
Submission of CMS Monitoring Protocol	Deloitte	May 2021	May 2021
Monitoring Requirements Document	Deloitte	June 2021	June 2021
Monitoring Program Management Dashboard Requirements Deliverable	Deloitte	July 2021	July 2021
1115 Demonstration Monitoring Reports – Release 2	Deloitte	January 2022	
1115 Demonstration Monitoring Reports – Release 3	Deloitte	July 2022	
WAIVER ADVISORY SERVICES WORKSTREAM			
Phase 1 Project Governance Structure	Deloitte	February 2020	February 2020
Phase 1 CMS Prep Materials – Jan to March 2020	Deloitte	March 2020	March 2020
Phase 1 CMS Prep Materials – April to June 2020	Deloitte	July 2020	July 2020
Phase 1 Preliminary Detailed Program Design Document	Deloitte	July 2020	July 2020
Phase 1 Preliminary Budget Neutrality Model and Analysis Write-up Updates	Deloitte	July 2020	July 2020
Phase 1 Draft Future State Operating Model	Deloitte	September 2020	September 2020
Phase 1 CMS Prep Materials – July to Sept 2020	Deloitte	August 2020	August 2020
Phase 1 CMS Prep Materials – Oct to Dec 2020	Deloitte	December 2020	December 2020
Phase 1 Updated Pathways Detailed Program Design	Deloitte	January 2021	January 2021



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DELIVERABLE	RESPONSIBLE	PLANNED DELIVERY	ACTUAL DELIVERY
Phase 2 Updated Pathways Detailed Program Design	Deloitte	May 2021	May 2021
Phase 2 Workgroup Support / Inputs to Status Reports - Feb to Mar 2021	Deloitte	April 2021	April 2021
Phase 2 Workgroup Support / Inputs to Status Reports - April to June 2021	Deloitte	July 2021	July 2021
Phase 2 Workgroup Support / Inputs to Status Reports - July to Sept 2021	Deloitte	October 2021	
Phase 2 Workgroup Support / Inputs to Status Reports - Oct to Dec 2021	Deloitte	December 2021	
Submission of CMS Implementation Plan 1	Deloitte	February 2021	February 2021
Submission of CMS Implementation Plan 2	Deloitte	January 2022	
Phase 2 CMS Meeting Support – Feb to Mar 2021	Deloitte	April 2021	April 2021
Phase 2 CMS Meeting Support – April to June 2021	Deloitte	July 2021	July 2021
Phase 2 CMS Meeting Support – July to Sept 2021	Deloitte	October 2021	
Phase 2 CMS Meeting Support – Oct to Dec 2021	Deloitte	December 2021	
Documented GVRA Operational Processes for Pathways Referrals	Deloitte	March 2021	May 2021
PROJECT MANAGEMENT SERVICES WORKSTREAM			
Project Status Reports	Deloitte	October 2020 (Recurring)	January 2021 (Recurring)
Communications Plan	Deloitte	January 2021	January 2021
Project Management Plan	Deloitte	November 2020	February 2021
Integrated Master Schedule (Initial and Updates)	Deloitte	November 2020 (Recurring)	January 2021 (Recurring)
ORGANIZATIONAL CHANGE MANAGEMENT SERVICES WORKSTREAM			
Stakeholder Analysis	OCM Services Contractor	~~February 2021~~ October 2021	
Stakeholder Readiness	OCM Services Contractor	November 2021	
Stakeholder Gap Analysis	OCM Services Contractor	December 2021	
Change Management Plan	OCM Services Contractor	~~March 2021~~ February 2022	
Communication Strategy	OCM Services Contractor	~~March 2021~~ December 2021	
Status Reports	OCM Services Contractor	May 2021 (Recurring)	May 2021 (Recurring)
Project Plan / Schedule	OCM Services Contractor	June 2021	June 2021
INDEPENDENT VERIFICATION AND VALIDATION SERVICES WORKSTREAM			

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DELIVERABLE	RESPONSIBLE	PLANNED DELIVERY	ACTUAL DELIVERY
Monthly Project Dashboard Report	IV&V Services Contractor	May 2021 (Recurring)	May 2021 (Recurring)

Exhibit 21: Deliverable Schedule



SECTION 9 PROPOSED BUDGET

In the following section, the State presents the project budget by system (MMIS and FA Services, TPL Services, and E&E / IES) and waiver (1115 waiver and 1332 waiver).

The State estimates the Georgia Pathways Program (1115 waiver) will cost approximately \$1.8 billion over the next five years to implement and operate. The budgets included in this APD to modify the State's existing Medicaid IT systems to support the Georgia Pathways Program represent approximately 4 percent of the overall program cost.

The State estimates the Georgia Access Program (1332 waiver) will cost approximately \$2.5 billion over the next five years to implement and operate. The budgets included in this APD to modify the State's existing E&E / IES to support the Georgia Access Program represent approximately 0.68 percent of the overall program cost.

9.1 MMIS and FA Services Budget (1115 Waiver) – Updated July 2021

The estimated expenditures to design, develop, and implement the MMIS and FA Services functionality enabling the 1115 waiver include:

- **State Personnel:** Salaries and benefits for the estimated State FTEs required to support the design, development, and implementation of the MMIS and FA Services functionality enabling the 1115 waiver
- **Other Direct Costs:** Estimated expenditures for supplies, materials, travel, phone, etc. to support the design, development, and implementation of the MMIS and FA Services functionality enabling the 1115 waiver

Exhibit 22: MMIS and FA Services Budget contains a summary of the budgeted MMIS and FA Services expenditures by cost category and federal fiscal year, reflecting total estimated MMIS and FA Services expenditures of \$526,380 for the period of FFY 2021 through FFY 2022 (see attached MDBT_GA-MMIS-MDBT Project Summary 1115 Waiver – Legacy MMIS Tab).

MMIS and FA Services - 1115 WAIVER	FFY 2021	FFY 2022	TOTAL
STATE			
State Personnel	\$191,913	\$174,467	\$366,380
Other Direct Costs	\$5,000	\$5,000	\$10,000
State Sub-Total	\$196,913	\$179,467	\$376,380
SOFTWARE			
Reporting / Dashboard	\$150,000	\$0	\$150,000
State Sub-Total	\$150,000	\$0	\$150,000
TOTAL	\$346,913	\$179,467	\$526,380

Exhibit 22: MMIS and FA Services Budget

The budget includes expenditures for the design, development, and implementation of MMIS and FA Services functionality required to enable the Georgia Pathways Program (1115 waiver). All costs included in the MMIS and FA Services budget benefit the 1115 waiver. The budget increased by \$150,000 from the prior year to include expenditures in FFY 2021 for software needed to develop required program reporting.



9.2 TPL Services Budget (1115 Waiver) – Updated July 2021

The estimated expenditures to design, develop, and implement the HIPP Program functionality enabling the 1115 waiver include:

- **State Personnel:** Salaries and benefits for the estimated State FTEs required to support the design, development, and implementation of the TPL Services functionality enabling the 1115 waiver
- **Other Direct Costs:** Estimated expenditures for supplies, materials, travel, phone, etc. to support the design, development, and implementation of the TPL Services functionality enabling the 1115 waiver
- **HIPP Program Functionality:** Estimated costs for the TPL Services and PBM Services contractors to design, develop, and implement the HIPP Program functionality enabling the 1115 waiver. The contractors analyzed the 1115 waiver requirements for the HIPP Program to prepare the estimate.

Exhibit 23: TPL Services Budget contains a summary of the budgeted TPL Services expenditures by cost category and federal fiscal year, reflecting total estimated TPL Services expenditures of \$781,929 for the period of FFY 2021 through FFY 2022 (see attached MDBT_GA-MMIS-MDBT Project Summary 1115 Waiver – Legacy TPL Tab).

TPL Services - 1115 WAIVER	FFY 2021	FFY 2022	TOTAL
STATE			
State Personnel	\$144,276	\$80,153	\$224,429
Other Direct Costs	\$5,000	\$5,000	\$10,000
State Sub-Total	\$149,276	\$85,153	\$234,429
CONTRACTED SERVICES			
TPL Services - HIPP Functionality	\$0	\$322,500	\$322,500
PBM Services - HIPP Functionality	\$0	\$225,000	\$225,000
Contracted Services Sub-Total	\$0	\$547,500	\$547,500
Total	\$149,276	\$632,653	\$781,929

Exhibit 23: TPL Services Budget

The budget includes expenditures for the design, development, and implementation of HIPP Program functionality required to enable the Georgia Pathways Program (1115 waiver). All costs included in the TPL Services budget benefit the 1115 waiver. The budget increased by \$255,000 from the prior year, including the design and implementation of PBM modifications to support the implementation of the HIPP functionality for the Pathways Program (\$225,000) and a correction for TPL contractor implementation costs previously categorized as operational costs (\$30,000).

9.3 Consolidated E&E / IES Budget (1115 and 1332 Waivers) – Updated July 2021

Exhibit 24: E&E / IES Consolidated Budget provides the consolidated E&E budget by cost category and federal fiscal year, reflecting total estimated expenditures of \$103,352,159.19 for the period of FFY 2021 through Q1 FFY 2023. These expenditures are for the design, development, and implementation of E&E / IES functionality required to enable the Georgia Pathways Program (1115 waiver) and the Georgia Access Program (1332 waiver).



WAIVER TOTAL BUDGET	FFY21	FFY22	FFY23 1st Q	TOTAL
DDI Vendor Costs				
Amendment 14 - 1115	\$ 18,315,013.00	\$ 8,854,807.00	\$ -	\$ 27,169,820.00
Amendment 14 - 1332	\$ 206,336.00	\$ 6,487,804.00	\$ 102,300.00	\$ 6,796,440.00
Waiver Advisory Services	\$ 3,087,000.00	\$ 5,445,200.00	\$ 217,800.00	\$ 8,750,000.00
Monitoring	\$ 1,000,000.00	\$ 672,000.00	\$ 168,000.00	\$ 1,840,000.00
Software Acquisition	\$ 1,397,339.00	\$ -	\$ -	\$ 1,397,339.00
Software Annual	\$ -	\$ 367,673.00	\$ 383,556.00	\$ 751,229.00
SNET DEV &INT & other environment	\$ -	\$ 272,520.00	\$ -	\$ 272,520.00
M&O (Deloitte)	\$ 728,441.00	\$ 3,644,745.00	\$ 1,459,675.33	\$ 5,832,861.33
1332 non-MA	\$ 598,925.60	\$ 4,582,116.00	\$ 153,558.00	\$ 5,334,599.60
Sub-Total	\$ 25,333,054.60	\$ 30,326,865.00	\$ 2,484,889.33	\$ 58,144,808.93
State Costs				
State Software	\$ 9,866,740.40	\$ 2,241,348.08	\$ 2,241,348.08	\$ 14,349,436.56
GTA GETS Services	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	\$ 900,000.00
Hardware	\$ 867,124.43	\$ 867,124.43	\$ 867,124.43	\$ 2,601,373.29
State Staff	\$ 823,609.00	\$ 823,609.00	\$ 120,931.82	\$ 1,768,149.82
State Other	\$ 20,000.00	\$ 20,000.00	\$ 5,000.00	\$ 45,000.00
State Contractors	\$ 2,911,972.47	\$ 3,600,849.13	\$ 900,212.28	\$ 7,413,033.88
IV&V	\$ 94,560.00	\$ 570,000.00	\$ 92,000.00	\$ 756,560.00
PMO	\$ 1,060,000.00	\$ 2,322,000.00	\$ 570,000.00	\$ 3,952,000.00
OCM	\$ 102,536.00	\$ 2,078,860.00	\$ 434,000.00	\$ 2,615,396.00
Eligibility Staff	\$ 3,459,656.00	\$ 3,459,656.00	\$ 864,914.00	\$ 7,784,226.00
1332 non-MA	\$ 277,413.74	\$ 2,174,778.82	\$ 569,982.14	\$ 3,022,174.72
Sub-Total	\$ 19,783,612.05	\$ 18,458,225.46	\$ 6,965,512.75	\$ 45,207,350.26
IAPD TOTAL	\$ 45,116,666.65	\$ 48,785,090.46	\$ 9,450,402.08	\$ 103,352,159.19

Exhibit 24: E&E / IES Consolidated Budget

Note: The total E&E / IES budget of \$103,352,159.19 is \$8,356,774.30 greater than the total included in the E&E Medicaid Detailed Budget Tables (MDBTs) because \$8,356,774.30 of costs benefit non-Medicaid programs and are excluded from the MDBTs.

In the sections below, a separate E&E / IES budget and overview of included costs are provided for each waiver.

9.3.1 E&E / IES 1115 Waiver Budget (1115 Waiver) – Updated July 2021

The expenditures to design, develop, implement, and operate the E&E / IES functionality enabling the 1115 waiver include:

- **Amendment 14 - 1115:** Costs for the E&E / IES Services contractor to design, develop, and implement the E&E / IES functionality enabling the 1115 waiver. The E&E / IES Services contractor prepared the project pricing by performing a bottom-up level of effort analysis of the new and modified E&E / IES functionality required to enable the 1115 waiver.
- **PMO, IV&V, OCM, Reporting and Monitoring, and Waiver Advisory Services:** The 1115 waiver PMO, IV&V, OCM, and Reporting and Monitoring, and Waiver Advisory



contracted services are allocated at 100 percent to the 1115 waiver budget because the contract value is for activities benefitting the 1115 waiver only.

- **Other Services:** For any services benefitting both the 1115 waiver and the 1332 waiver, the State uses the E&E / IES Services bottom-up level of effort analysis which provides a reliable, accurate cost allocation statistic to distribute these other contracted services costs between the benefitting 1115 and 1332 waiver programs. The analysis determined that 68 percent of the total level of effort is associated with the 1115 waiver and 32 percent is associated with the 1332 waiver.
- **Hardware, Software, and Development Environment:** Costs for the initial acquisition and licenses, as well as annual fees for hardware and software and establishment of the development environment required to design, develop, implement, and operate the E&E / IES functionality enabling the 1115 waiver. The hardware, software, and development environment requirements / specifications were provided to the State by the E&E / IES Services contractor. Initial acquisition and licensing costs are requested at 90 / 10 FFP, while ongoing annual fees are requested at 75 / 25 FFP.
- **M&O (Deloitte):** Costs for the E&E / IES Services contractor to maintain and operate the E&E / IES functionality enabling the 1115 waiver
- **State Staff:** Salaries and benefits for State FTEs required to support the design, development, and implementation of the E&E / IES functionality enabling the 1115 waiver
- **State Other:** Expenditures for supplies, materials, travel, phone, etc. to support the design, development, and implementation of the E&E / IES functionality enabling the 1115 waiver
- **State Contractors:** Costs for contract IT and PM staff augmentation resources required to support the design, development, and implementation of the E&E / IES functionality enabling the 1115 waiver
- **GTA GETS Services:** Costs for Georgia Technology Authority to provide Enterprise Technology support services in support of the design, development, and implementation of the E&E / IES functionality enabling the 1115 waiver
- **Eligibility Staff:** Salaries and benefits for State FTEs required to perform operational activities in support of the 1115 waiver

Exhibit 25: E&E / IES Budget - 1115 Waiver provides the expenditures for the design, development, implementation, and operation of the E&E / IES functionality enabling the 1115 waiver which total \$78,628,234.48 (see attached MDBT_GA-E&E-MDBT Project Summary 1115-1332 Waiver - 1115 Bud tab).



WAIVER TOTAL BUDGET	FFY21	FFY22	FFY23 1st Q	TOTAL
DDI Vendor Costs				
Amendment 14 - 1115	\$ 18,315,013.00	\$ 8,854,807.00	\$ -	\$ 27,169,820.00
Amendment 14 - 1332	\$ -	\$ -	\$ -	\$ -
Waiver Advisory Services	\$ 1,845,000.00	\$ 2,265,200.00	\$ -	\$ 4,110,200.00
Monitoring	\$ 1,000,000.00	\$ 672,000.00	\$ 168,000.00	\$ 1,840,000.00
Software Acquisition	\$ 1,397,339.00	\$ -	\$ -	\$ 1,397,339.00
Software Annual	\$ -	\$ 367,673.00	\$ 383,556.00	\$ 751,229.00
SNET DEV &INT & other environment	\$ -	\$ 272,520.00	\$ -	\$ 272,520.00
M&O (Deloitte)	\$ 728,441.00	\$ 3,644,745.00	\$ 1,459,675.33	\$ 5,832,861.33
Sub-Total	\$ 23,285,793.00	\$ 16,076,945.00	\$ 2,011,231.33	\$ 41,373,969.33
State Costs				
State Software	\$ 9,866,740.40	\$ 2,241,348.08	\$ 2,241,348.08	\$ 14,349,436.56
GTA GETS Services	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	\$ 900,000.00
Hardware	\$ 867,124.43	\$ 867,124.43	\$ 867,124.43	\$ 2,601,373.29
State Staff	\$ 638,378.13	\$ 638,378.13	\$ 93,734.07	\$ 1,370,490.34
State Other	\$ 20,000.00	\$ 20,000.00	\$ 5,000.00	\$ 45,000.00
State Contractors	\$ 2,644,583.44	\$ 3,213,759.62	\$ 803,439.90	\$ 6,661,782.96
IV&V	\$ 94,560.00	\$ 322,000.00	\$ 30,000.00	\$ 446,560.00
PMO	\$ 1,060,000.00	\$ 1,020,000.00	\$ 260,000.00	\$ 2,340,000.00
OCM	\$ 102,536.00	\$ 652,860.00	\$ -	\$ 755,396.00
Eligibility Staff	\$ 3,459,656.00	\$ 3,459,656.00	\$ 864,914.00	\$ 7,784,226.00
Sub-Total	\$ 19,053,578.40	\$ 12,735,126.26	\$ 5,465,560.49	\$ 37,254,265.15
IAPD TOTAL	\$ 42,339,371.40	\$ 28,812,071.26	\$ 7,476,791.82	\$ 78,628,234.48

Exhibit 25: E&E / IES Budget - 1115 Waiver

9.3.2 E&E / IES 1332 Waiver Budget (1332 Waiver) – Updated July 2021

The expenditures to design, develop, and implement the E&E / IES functionality enabling the 1332 waiver include:

- **Amendment 14 – 1332:** Costs for the E&E / IES Services contractor to design, develop, and implement the E&E / IES functionality enabling the 1332 waiver. The E&E / IES Services contractor prepared the estimate by performing a bottom-up level of effort analysis of the new and modified E&E / IES functionality required to enable the 1332 waiver.
- **1332 non-MA:** The design, development, and implementation of the E&E / IES functionality enabling the Georgia Access Program (1332 Waiver) benefits both Medicaid and non-Medicaid programs. The State identified the costs associated with functionality that benefits only non-Medicaid programs using a system development level of effort analysis performed by the E&E / IES Services contractor. The analysis determined 24.42 percent of the level of effort benefits non-Medicaid programs only. The remaining 75.58 percent of the level of effort includes the design, development, and implementation of E&E / IES functionality that benefits both the Medicaid Program and non-Medicaid programs. The costs associated with this functionality are distributed between the benefitting programs using the following population counts:



- › Medicaid Program: Average number of Medicaid and CHIP members during State Fiscal Year 2019 (2,125,961 or 82.0875 percent of the total of both populations)
- › Non-Medicaid Programs (1332 Waiver): Number of consumers who selected an individual plan via the Federally Facilitated Marketplace during Plan Year 2020 Open Enrollment (463,910 or 17.9125 percent of the total of both populations)

The total share of costs benefitting non-Medicaid programs is \$8,356,774.30. A description of the 1332 waiver cost allocation methodology is included in Appendix C. The State will update the population counts used for the 1332 waiver cost allocation in future periods as requested by CMS.

- **PMO, IV&V, OCM, Reporting and Monitoring, and Waiver Advisory Services:** The 1332 waiver PMO, IV&V, OCM, and Waiver Advisory contracted services are allocated at 100 percent to the 1332 waiver budget because the contract value is for activities benefitting the 1332 waiver only.
- **Other Services:** For any services benefitting both the 1115 waiver and the 1332 waiver, the State uses the E&E / IES Services bottom-up level of effort analysis which provides a reliable, accurate cost allocation statistic to distribute these other contracted services costs between the benefitting 1115 and 1332 waiver programs. The analysis determined that 68 percent of the total level of effort is associated with the 1115 waiver and 32 percent is associated with the 1332 waiver.
- **State Staff:** Salaries and benefits for State FTEs required to support the design, development, and implementation of the E&E / IES functionality enabling the 1332 waiver
- **State Contractors:** Costs for contract IT and PM staff augmentation resources required to support the design, development, and implementation of the E&E / IES functionality enabling the 1332 waiver

Exhibit 26: E&E / IES Budget - 1332 Waiver provides the E&E / IES expenditures for the design, development, and implementation of the E&E / IES functionality enabling the 1332 waiver which total \$24,723,924.71 (see attached MDBT_GA-E&E-MDBT Project Summary 1115-1332 Waiver - 1332 Bud tab).

WAIVER TOTAL BUDGET	FFY21	FFY22	FFY23 1st Q	TOTAL
DDI Vendor Costs				
Amendment 14 - 1332	\$ 206,336.00	\$ 6,487,804.00	\$ 102,300.00	\$ 6,796,440.00
Waiver Advisory Services	\$ 1,242,000.00	\$ 3,180,000.00	\$ 217,800.00	\$ 4,639,800.00
1332 non-MA	\$ 598,925.60	\$ 4,582,116.00	\$ 153,558.00	\$ 5,334,599.60
State Costs				
State Staff	\$ 185,230.87	\$ 185,230.87	\$ 27,197.74	\$ 397,659.48
State Contractors	\$ 267,389.04	\$ 387,089.51	\$ 96,772.38	\$ 751,250.92
IV&V	\$ -	\$ 248,000.00	\$ 62,000.00	\$ 310,000.00
PMO	\$ -	\$ 1,302,000.00	\$ 310,000.00	\$ 1,612,000.00
OCM	\$ -	\$ 1,426,000.00	\$ 434,000.00	\$ 1,860,000.00
1332 non-MA	\$ 277,413.74	\$ 2,174,778.82	\$ 569,982.14	\$ 3,022,174.70
Sub-Total	\$ 730,033.65	\$ 5,723,099.20	\$ 1,499,952.26	\$ 7,953,085.11
IAPD TOTAL	\$ 2,777,295.25	\$ 19,973,019.20	\$ 1,973,610.26	\$ 24,723,924.71

Exhibit 26: E&E / IES Budget - 1332 Waiver



SECTION 10 COST ALLOCATION PLAN

In the following section, the project cost allocation is provided below by system (MMIS and FA Services, TPL Services, and E&E / IES) and waiver (1115 waiver and 1332 waiver).

The State estimates the Georgia Pathways Program (1115 waiver) will cost approximately \$1.8 billion over the next five years to implement and operate. The Medicaid federal funding requests included this APD to modify the State's existing Medicaid IT systems to support the Georgia Pathways Program represent approximately 3.4 percent of the overall program cost.

The State estimates the Georgia Access Program (1332 waiver) will cost approximately \$2.5 billion over the next five years to implement and operate. The Medicaid federal funding requests included this APD to modify the State's existing E&E / IES to support the Georgia Access Program represent approximately 0.38 percent of the overall program cost.

10.1 MMIS and FA Services Cost Allocation (1115 Waiver) – Updated July 2021

DCH operates under a Cost Allocation Plan (CAP) approved by Cost Allocation Services located in the Program Support Center of the federal Department of Health and Human Services. DCH's CAP was approved on January 30, 2015.

The CAP describes the methodologies used to identify, measure, and allocate costs incurred in support of benefitting programs. DCH will assign costs associated with Patients First Act Implementation Project activities to unique cost identifiers using the existing federally approved cost allocation mechanisms and systems to identify and capture costs for the project.

Exhibit 27: MMIS and FA Services Cost Allocation provides a summary of the cost allocation for the design, development, and implementation of MMIS and Fiscal Agent Services functionality enabling the Georgia Pathways Program (1115 waiver). The State is requesting Medicaid IT enhanced (90 / 10) funding for these expenditures. Operational funding for the post-implementation period will be requested through the MMIS and FA Services Operational APD.

MMIS and FA Services - 1115 WAIVER	FFY 2021		FFY 2022		TOTAL		TOTAL
	FEDERAL	STATE	FEDERAL	STATE	FEDERAL	STATE	
STATE							
State Personnel	\$172,722	\$19,191	\$157,020	\$17,447	\$329,742	\$36,638	\$366,380
Other Direct Costs	\$4,500	\$500	\$4,500	\$500	\$9,000	\$1,000	\$10,000
State Sub-Total	\$177,222	\$19,691	\$161,520	\$17,947	\$338,742	\$37,638	\$376,380
SOFTWARE							
Reporting	\$135,000	\$15,000	\$0	\$0	\$135,000	\$15,000	\$150,000
Software Sub-Total	\$135,000	\$15,000	\$0	\$0	\$135,000	\$15,000	\$150,000
Total	\$312,222	\$34,691	\$161,520	\$17,947	\$473,742	\$52,638	\$526,380

Exhibit 27: MMIS and FA Services Cost Allocation

Based on the proposed cost allocation, the State's request for federal funding for the period of FFY 2021 through FFY 2022 is \$473,742 including \$312,222 for FFY 2021 and \$161,520 for FFY 2022 (see attached MDBT_GA-MMIS-MDBT Project Summary 1115 Waiver - Legacy MMIS Tab). This is an increase of \$135,000 in FFY 2021 federal funds from the prior year's request.



10.2 TPL Services Cost Allocation (1115 Waiver) – Updated July 2021

DCH operates under a CAP approved by Cost Allocation Services located in the Program Support Center of the federal Department of Health and Human Services. DCH's CAP was approved on January 30, 2015.

The CAP describes the methodologies used to identify, measure, and allocate costs incurred in support of benefitting programs. DCH will assign costs associated with Patients First Act Implementation Project activities to unique cost identifiers using the existing federally approved cost allocation mechanisms and systems to identify and capture costs for the project.

Exhibit 28: TPL Services Cost Allocation provides a summary of the cost allocation for the design, development, and implementation of HIPP Program functionality enabling the Georgia Pathways Program (1115 waiver). The State is requesting Medicaid IT enhanced (90 / 10) funding for these expenditures. Operational funding for the post-implementation period will be requested through the TPL Services and PBM Services Operational APDs.

TPL Services - 1115 WAIVER	FFY 2021		FFY 2022		TOTAL		TOTAL
	FEDERAL	STATE	FEDERAL	STATE	FEDERAL	STATE	
STATE							
State Personnel	\$129,848	\$14,428	\$72,138	\$8,015	\$201,986	\$22,443	\$224,429
Other Direct Costs	\$4,500	\$500	\$4,500	\$500	\$9,000	\$1,000	\$10,000
State Sub-Total	\$134,348	\$14,928	\$76,638	\$8,515	\$210,986	\$23,443	\$234,429
CONTRACTED SERVICES							
TPL Services - HIPP Functionality	\$0	\$0	\$290,250	\$32,250	\$290,250	\$32,250	\$322,500
PBM Services - HIPP Functionality	\$0	\$0	\$202,500	\$22,500	\$202,500	\$22,500	\$225,000
Contracted Services Sub-Total	\$0	\$0	\$492,750	\$54,750	\$492,750	\$54,750	\$547,500
Total	\$134,348	\$14,928	\$569,388	\$63,265	\$703,736	\$78,193	\$781,929

Exhibit 28: TPL Services Cost Allocation

Based on the proposed cost allocation, the State's request for federal funding for the period of FFY 2021 through FFY 2022 is \$703,736, including \$134,348 for FFY 2021 and \$569,388 for FFY 2022 (see attached MDBT_GA-MMIS-MDBT Project Summary 1115 Waiver - Legacy TPL Tab). This is an increase of \$229,500 in FFY 2022 federal funds from the prior year's request.

10.3 E&E / IES Cost Allocation – Updated July 2021

The design, development, implementation, and operation of the E&E / IES functionality enabling the Georgia Pathways Program (1115 Waiver) benefits only the Medicaid Program. One hundred (100) percent of the total costs (\$78,628,234.48) will be charged directly to the Medicaid Program using existing federally approved cost allocation mechanisms and systems to track expenditures.

The design, development, and implementation of the E&E / IES functionality enabling the Georgia Access Program (1332 Waiver) benefits both Medicaid and non-Medicaid programs. The State identified the costs associated with functionality that benefits only non-Medicaid programs using a system development level of effort analysis performed by the E&E / IES Services contractor. The analysis determined 24.42 percent of the level of effort benefits non-



Medicaid programs only. The remaining 75.58 percent of the level of effort includes the design, development, and implementation of E&E / IES functionality that benefits both the Medicaid Program and non-Medicaid programs. The costs associated with this functionality are distributed between the benefitting programs using the following population counts:

- Medicaid Program: Average number of Medicaid and CHIP members during State Fiscal Year 2019 (2,125,961 or 82.0875 percent of the total of both populations)
- Non-Medicaid Programs (1332 Waiver): Number of consumers who selected an individual plan via the Federally Facilitated Marketplace during Plan Year 2020 Open Enrollment (463,910 or 17.9125 percent of the total of both populations)

The total share benefitting non-Medicaid programs is \$8,356,774.30. A description of the 1332 waiver cost allocation methodology is included in Appendix C. The State will update the population counts used for the 1332 waiver cost allocation in future periods as requested by CMS.

Exhibit 29: E&E / IES Cost Distribution provides the overall distribution of the 1115 and 1332 waiver costs by benefitting program. E&E / IES waiver expenditures total \$103,352,159.19, with \$94,995,384.89 allocated to the Medicaid Program and \$8,356,774.30 allocated to non-Medicaid programs. Of the E&E / IES waiver costs allocated to the Medicaid Program, the total federal share is \$82,096,008 including \$39,064,392 in FFY 2021, \$36,114,605 in FFY 2022, and \$6,917,011 in Q1 FFY 2023.

The State's request for federal funding for the period of FFY 2021 through FFY 2022 is \$75,178,997, including \$39,064,392 for FFY 2021 and \$36,114,605 for FFY 2022. This is an increase of \$8,668,932.13 in the E&E funding approved by CMS in the prior year.

The State's application of FFP rates to eligible Medicaid Program E&E / IES costs for the overall project, and separately for the 1115 waiver and 1332 waiver, can be found in the attached file, MDBT_GA-E&E-MDBT Project Summary 1115-1332 Waiver.



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	Distribution %	Total	FFY21			FFY22			FFY23 (1st Q)		
			Total	Federal	State	Total	Federal	State	Total	Federal	State
Medicaid	100.00%	\$ 94,995,384.89	\$ 44,240,327.31	\$ 39,064,391.53	\$ 5,175,935.78	\$ 42,028,195.64	\$ 36,114,605.60	\$ 5,913,590.04	\$ 8,726,861.94	\$ 6,917,010.95	\$ 1,809,851.00
CHIP	0.00%		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
SNAP	0.00%		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TANF	0.00%		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Refugee	0.00%		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Child Support	0.00%		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Child Welfare	0.00%		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
WIC	0.00%		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
CAPS	0.00%		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
* non-distributed		\$ 8,356,774.30	\$ 876,339.34	\$ -	\$ 876,339.34	\$ 6,756,894.82	\$ -	6,756,894.82	\$ 723,540.14	\$ -	\$ 723,540.14
Total	100.00%	\$ 103,352,159.19	\$ 45,116,666.65	\$ 39,064,391.53	\$ 6,052,275.12	\$ 48,785,090.46	\$ 36,114,605.60	\$ 12,670,484.86	\$ 9,450,402.08	\$ 6,917,010.95	\$ 2,533,391.14
* Represents the portion of Waiver 1332 that does not receive a federal match (covered by state funds)											

Exhibit 29: E&E / IES Cost Distribution



SECTION 11 SECURITY, INTERFACE, DISASTER RECOVERY, AND BUSINESS CONTINUITY PLANNING

As shown in Exhibit 30: Security / Interface and Disaster Recovery Requirements, DCH and DHS assure that the agencies intend to comply with the required Security and Disaster Recovery procedures for Medicaid set forth in 45 CFR 95.610(b).

REQUIREMENT	ADDRESSED
Security and Interface	
Departmental HIPAA Business Associate Agreements are signed for all solutions and services involving sharing, storing, or transmitting Electronic Protected Health Information (ePHI) or other sensitive and confidential data.	Yes
Technology Solutions and Services comply with the requirements of the Health Insurance Portability Accountability Act of 1996 ("HIPAA"), the HITECH Act, and all implementing regulations (together, the "HIPAA Privacy and Security Rules").	Yes
Annual Independent HIPAA Security Assessments will be performed for all solutions and services involving sharing, storing, or transmitting Electronic Protected Health Information.	Yes
All sensitive and confidential data used, maintained, transmitted, handled in, or sent by means of data communications channels, electronic devices, computers, computer devices, etc. will only be sent to geographic or virtual areas subject to U.S. Law.	Yes
Approved Contractor/Business Partner Security Plans meet requirements for all Solutions and Services involving sharing, storing, or transmitting Electronic Protected Health Information. Security controls are compliant with the most current version of National Institute of Standards and Technology (NIST), Special Publication 800-53 Federal Computer Security Standards for information with a Data Security Categorization Risk Level of "Moderate" Impact based on the NIST/FIPS 199, Data Security Categorization Standard.	Yes
All stored and transmitted sensitive and confidential data are encrypted utilizing NIST Approved Encryption Protocols.	Yes
All Systems comply with the FIPS 140-2, Security Requirements for Cryptographic Modules Standard as published by NIST.	Yes
All Systems support identity and access management functionality including "separation of duties", the "principal of least privilege", and "role-based access controls" as well as a user security profile that controls access rights to data categories and system functions.	Yes
All systems comply with State Password Standards for length, complexity, aging, and reuse.	Yes
All systems provide standard, secure, and configurable Application Interfaces between all interfacing information sharing entities as defined by the State.	Yes
All systems hosting sensitive and confidential data support applicable security logging and monitoring mechanisms to prevent the loss or unauthorized access, destruction, use, modification, or disclosure of State data.	Yes
All systems hosting sensitive and confidential data comply with Application Session Expiration Requirements as specified by the State.	Yes
All systems hosting sensitive and confidential data include the appropriate security controls and safeguards for preventing, monitoring, and detecting Malware (e.g., Viruses, Worms, Trojans, or other Malicious Program Code).	Yes
All systems hosting sensitive and confidential data include the appropriate security controls and safeguards for preventing, monitoring, and detecting Malware (e.g., Viruses, Worms, Trojans, or other Malicious Program Code).	Yes



REQUIREMENT	ADDRESSED
Disaster Recovery	
The Departments maintain disaster recovery plans and procedures for the involved solutions / systems.	Yes
The Departments maintain and regularly test Disaster Recovery plans. DCH and DHS Disaster Recovery Plans are available at the request of CMS.	Yes
For systems and applications hosted at the State's North Atlanta Data Center (NADC), the schedule for data backups and data recovery testing are contained in the Service Level Agreements with the NADC. If the solution / system is / will be vendor hosted, specific SLAs and disaster recovery and business continuity requirements for the solution / system are / will be included in the vendor(s) contract(s).	Yes

Exhibit 30: Security / Interface and Disaster Recovery Requirements

11.1 Security and Interface Requirements

DCH and DHS maintain documents which provide governance of IT security for the agencies. These documents are available to CMS upon request. Additionally, the agencies have established security and interface requirements consistent with federal and state regulations and policy for contractors to meet or exceed.

11.2 Disaster Recovery and Business Continuity

Contractor(s) must develop and maintain a Disaster Recovery Plans and procedures that meet applicable federal and state regulations and policy for disaster recovery and business continuity. The Disaster Recovery Plans are tested on an annual basis. The schedule for data backups and data recovery testing are reflected in Service Level Agreements and requirements in contracts established with the contractors.



SECTION 12 STANDARDS AND CONDITIONS

The State affirms that the proposed system modifications and enhancements implemented through the Patients First Act Implementation Project will meet the standards and conditions for Medicaid IT listed in 42 CFR Part 433.112(b) required to secure enhanced funding. Several of the standards and conditions have been addressed in Section 11 above. In Exhibit 31: Standards and Conditions for Medicaid IT, the State describes how the remaining standards and conditions are met.

CONDITION & STANDARD	ADDRESSED	HOW ADDRESSED
Modularity – Use of a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces; the separation of business rules from core programming; and the availability of business rules in both human and machine readable formats.	Yes	The IES utilizes a modular, flexible approach to system design, including: - Use of open interfaces and exposed application programming interfaces - Separation of business rules from core programming - Availability of business rules in both human and machine readable formats The State is currently procuring and implementing a modular MES. Once deployed the new MES will provide the required Georgia Pathways and Georgia Access Program. In the meantime, the State will modify and enhance legacy MMIS assets and services to enable the waiver programs.
MITA – Align to and advance increasingly in MITA maturity for business, architecture, and data.	Yes	The system modifications and enhancements will align with MITA maturity principles, automating and enabling new waiver business processes.
Industry Standards – Ensure alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 45 CFR part 170, subpart B: The HIPAA privacy, security and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with Federal civil rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act.	Yes	The State will ensure the system modifications and enhancements designed and developed through this project are aligned with and incorporate: - Applicable industry standards - Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy, and transaction standards - Federal Civil Rights laws prohibiting discrimination against individuals based on race, color, and national origin - Accessibility standards for individuals with disabilities, such as section 508 of the Rehabilitation Act and Title II of the Americans with Disabilities Act - Standards adopted by the Secretary under Section 1104 of the Affordable Care Act



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CONDITION & STANDARD	ADDRESSED	HOW ADDRESSED
		Standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act
Leverage/Reuse – Promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states.	Yes	The State will strive to obtain a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use and authorize others to use software, modifications to software, and documentation that is designed, developed, installed, or improved with enhanced FFP.
Business Results – Support accurate and timely processing of claims, adjudications, and effective communications with providers, beneficiaries, and the public.	Yes	The system modifications and enhancements to be implemented through the project will support accurate and timely processing of waiver program eligibility determination, required reporting, premium calculations, cost effectiveness determinations, renewals, etc. and enable effective communications with beneficiaries and the public.
Reporting – Produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability.	Yes	The system modifications and enhancements include the production of transaction data, reports, and performance information that contribute to waiver program evaluation monitoring. The project will create new and modified reports, supplementing existing reports and data that address this standard and condition.
Interoperability – Support seamless coordination and integration with the Marketplace, the Federal Data Services Hub, and allows interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services as applicable.	Yes	The involved systems are interoperable with state and federal data trading partners to maximize value and minimize burden and costs on Medicaid providers and members. This project will create new interfaces between state systems as well as Georgia's new individual market.
MAGI-Based System Functionality - For E&E systems, deliver acceptable MAGI-based system functionality, demonstrated by performance testing and results based on critical success factors, with limited mitigations and workarounds.	Yes	The State's IES provides the required MAGI-based system functionality. The existing IES MAGI-based functionality will be leveraged/extended to support the new Georgia Pathways Program and Georgia Access Program.
Mitigation Plan - Submit plans that contain strategies for reducing the operational consequences of failure to meet applicable requirements for all major milestones and functionality.	Yes	The Department has assessed the risks and operational consequences of failure to meet requirements for major Patients First Act Implementation Project milestones and functionality. As part of the project's project management processes, the State will maintain a project risk register, identifying risks and mitigation plans.



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CONDITION & STANDARD	ADDRESSED	HOW ADDRESSED
Key Personnel - Identify key state personnel by name, type and time commitment assigned to each project.	Yes	The Department is committed to the success of the Patients First Act Implementation Project and has dedicated state personnel resources to the effort to provide oversight, guidance, and subject matter expertise. The assigned state personnel and time commitment can be found in Section 7 of this document.
Documentation – Include documentation of components and procedures such that the systems could be operated by a variety of contractors or other users.	Yes	The Department will require the IES, TPL Services, and MMIS and FA Services contractors to develop and maintain system documentation and procedures documentation. This requirement can be found in Section 6 of this document and also is/will be included in contractor SOWs.
Minimization of Cost for Operation on an Alternate System - Consider strategies to minimize the costs and difficulty of operating the software on alternate hardware or operating systems.	Yes	The IES will migrate from the state data center to the cloud prior to deployment of the IES modifications and enhancements. This decision was informed by an alternatives analysis performed by the State. Modifications and enhancements to the MMIS will be made in the legacy environment until the State's new ME is deployed. For the State's new MES integration platform and shared services, DCH has considered and chosen options to minimize the costs and difficulty of solution hosting alternatives.
Administration of the State Plan – Allows for more efficient, economical, and effective administration of the state plan	Yes	The Department expects the system modification and enhancements to enable the efficient and effective operation and administration of the Georgia Pathways Program and Georgia Access Program. DCH and DHS business and IT SMEs actively participated in waiver technical design and requirements definition sessions to ensure the system modifications and enhancements result in efficient, effective business operations.

Exhibit 31: Standards and Conditions for Medicaid IT



SECTION 13 REQUIRED FEDERAL ASSURANCES

DCH and DHS assure that the agencies intend to meet the requirements as documented in the federal regulations and policy and procedure cited below:

- Procurement Standards (Competitive/Sole Source)
 - › 45 CFR Part 95 Subpart F §95.615
 - › 45 CFR Part 95, Subpart F § 95.613
 - › 45 CFR Part 95 §75.326
 - › 45 CFR 92.36
 - › State Medicaid Manual (SMM) Part 11
- Access to Systems and Records
 - › 45 CFR Part 95 Subpart F §95.615
 - › 42 CFR Part 433.112(b)(5) – (9)
 - › SMM Section 11267
- Software & Ownership Rights, Federal Licenses, Information Safeguarding, HIPAA Compliance and Progress Reports
 - › 45 CFR Part 95 Subpart F §95.617
 - › 42 CFR Subpart F (Part 431.300-431.307)
 - › 42 CFR Part 164
- Independent Verification & Validation
 - › 45 CFR Part 95.626
- System Costs
 - › 45 CFR 75, Subpart E
- Data Requirements of Quality Improvement Organizations
 - › SSA Title XI, Part B Peer Review of the Utilization and Quality of Health Care Services



SECTION 14 APPENDICES

This section provides additional information or documents incorporated by reference, including:

- Appendix A: Medicaid Detailed Budget Tables
- Appendix B: E&E / IES Budget Quarterly Detail
- Appendix C: Georgia Access Program (1332 Waiver) Cost Allocation
- Appendix D: Requirements Analysis Sessions



14.1 Appendix A: Medicaid Detailed Budget Tables – Updated July 2021

The following MDBT Tables are attached in support of the Patients First Act Implementation Project Implementation APD Budget:

- MDBT_GA-MMIS-MDBT Project Summary 1115 Waiver (Legacy TPL and Legacy MMIS Tabs)
- MDBT_GA-E&E-MDBT Project Summary 1115-1332 Waiver



14.2 Appendix B: E&E / IES Budget Quarterly Detail – Updated July 2021

Exhibit 32: E&E / IES Budget Quarterly Detail provides the consolidated E&E / IES budgeted expenditures by quarter.

WAIVER TOTAL BUDGET	10/1/2020 - 12/31/2020	1/1/2021 - 3/31/2021	4/1/2021 - 6/30/2021	7/1/2021 - 9/30/2021	10/1/2021 - 12/31/2021	1/1/2022 - 3/31/2022	4/1/2022 - 6/30/2022	7/1/2022 - 9/30/2022	10/1/2022 - 12/31/2022	FFY21	FFY22	FFY23 1st Q	TOTAL
	FFY21				FFY22				FFY23				
DDI Vendor Costs													
Amendment 14 - 1115	\$ 6,545,600.00	\$ 4,529,413.00	\$ 4,940,000.00	\$ 2,300,000.00	\$ 2,565,800.00	\$ 1,875,000.00	\$ 3,164,007.00	\$ 1,250,000.00	\$ -	\$ 18,315,013.00	\$ 8,854,807.00	\$ -	\$ 27,169,820.00
Amendment 14 - 1332	\$ -	\$ -	\$ 206,336.00	\$ -	\$ 3,322,704.00	\$ 1,838,300.00	\$ 914,500.00	\$ 412,300.00	\$ 102,300.00	\$ 206,336.00	\$ 6,487,804.00	\$ 102,300.00	\$ 6,796,440.00
Waiver Advisory Services	\$ 771,750.00	\$ 771,750.00	\$ 771,750.00	\$ 771,750.00	\$ 1,361,300.00	\$ 1,361,300.00	\$ 1,361,300.00	\$ 1,361,300.00	\$ 217,800.00	\$ 3,087,000.00	\$ 5,445,200.00	\$ 217,800.00	\$ 8,750,000.00
Monitoring	\$ -	\$ -	\$ -	\$ 1,000,000.00	\$ 168,000.00	\$ 168,000.00	\$ 168,000.00	\$ 168,000.00	\$ 168,000.00	\$ 1,000,000.00	\$ 672,000.00	\$ 168,000.00	\$ 1,840,000.00
Software Acquisition	\$ 1,397,339.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,397,339.00	\$ -	\$ -	\$ 1,397,339.00
Software Annual	\$ -	\$ -	\$ -	\$ -	\$ 367,673.00	\$ -	\$ -	\$ -	\$ 383,556.00	\$ -	\$ 367,673.00	\$ 383,556.00	\$ 751,229.00
SNET DEV & INT & other environment	\$ -	\$ -	\$ -	\$ -	\$ 272,520.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 272,520.00	\$ -	\$ 272,520.00
M&O (Deloitte)	\$ -	\$ -	\$ -	\$ 728,441.00	\$ 728,441.00	\$ 867,191.67	\$ 936,567.00	\$ 1,112,545.33	\$ 1,459,675.33	\$ 728,441.00	\$ 3,644,745.00	\$ 1,459,675.33	\$ 5,832,861.33
1332 non-MA	\$ 78,743.60	\$ 90,858.00	\$ 217,322.00	\$ 212,002.00	\$ 2,127,354.00	\$ 1,338,702.00	\$ 651,358.00	\$ 464,702.00	\$ 153,558.00	\$ 598,925.60	\$ 4,582,116.00	\$ 153,558.00	\$ 5,334,599.60
Sub-Total	\$ 8,793,432.60	\$ 5,392,021.00	\$ 6,135,408.00	\$ 5,012,193.00	\$ 10,913,792.00	\$ 7,448,493.67	\$ 7,195,732.00	\$ 4,768,847.33	\$ 2,484,889.33	\$ 25,333,054.60	\$ 30,326,865.00	\$ 2,484,889.33	\$ 58,144,808.93
State Costs													
State Software	\$ 9,866,740.40	\$ -	\$ -	\$ -	\$ 2,241,348.08	\$ -	\$ -	\$ -	\$ 2,241,348.08	\$ 9,866,740.40	\$ 2,241,348.08	\$ 2,241,348.08	\$ 14,349,436.56
GTA GETS Services	\$ 75,000.00	\$ 75,000.00	\$ 75,000.00	\$ 75,000.00	\$ 75,000.00	\$ 75,000.00	\$ 75,000.00	\$ 75,000.00	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	\$ 900,000.00
Hardware	\$ 867,124.43	\$ -	\$ -	\$ -	\$ 867,124.43	\$ -	\$ -	\$ -	\$ 867,124.43	\$ 867,124.43	\$ 867,124.43	\$ 867,124.43	\$ 2,601,373.29
State Staff	\$ 205,902.25	\$ 205,902.25	\$ 205,902.25	\$ 205,902.25	\$ 205,902.25	\$ 205,902.25	\$ 205,902.25	\$ 205,902.25	\$ 120,931.82	\$ 823,609.00	\$ 823,609.00	\$ 120,931.82	\$ 1,768,149.82
State Other	\$ 5,000.00	\$ 5,000.00	\$ 5,000.00	\$ 5,000.00	\$ 5,000.00	\$ 5,000.00	\$ 5,000.00	\$ 5,000.00	\$ 5,000.00	\$ 20,000.00	\$ 20,000.00	\$ 5,000.00	\$ 45,000.00
State Contractors	\$ 382,888.32	\$ 728,659.59	\$ 900,212.28	\$ 900,212.28	\$ 900,212.28	\$ 900,212.28	\$ 900,212.28	\$ 900,212.28	\$ 900,212.28	\$ 2,911,972.47	\$ 3,600,849.13	\$ 900,212.28	\$ 7,413,033.88
IV&V	\$ -	\$ -	\$ -	\$ 94,560.00	\$ 159,800.00	\$ 125,400.00	\$ 139,400.00	\$ 145,400.00	\$ 92,000.00	\$ 94,560.00	\$ 570,000.00	\$ 92,000.00	\$ 756,560.00
PMO	\$ -	\$ -	\$ -	\$ 1,060,000.00	\$ 612,000.00	\$ 550,000.00	\$ 580,000.00	\$ 580,000.00	\$ 570,000.00	\$ 1,060,000.00	\$ 2,322,000.00	\$ 570,000.00	\$ 3,952,000.00
OCM	\$ -	\$ -	\$ -	\$ 102,536.00	\$ 379,030.00	\$ 738,330.00	\$ 485,000.00	\$ 476,500.00	\$ 434,000.00	\$ 102,536.00	\$ 2,078,860.00	\$ 434,000.00	\$ 2,615,396.00
Eligibility Staff	\$ 864,914.00	\$ 864,914.00	\$ 864,914.00	\$ 864,914.00	\$ 864,914.00	\$ 864,914.00	\$ 864,914.00	\$ 864,914.00	\$ 864,914.00	\$ 3,459,656.00	\$ 3,459,656.00	\$ 864,914.00	\$ 7,784,226.00
1332 non-MA	\$ 37,977.03	\$ 64,047.31	\$ 87,694.71	\$ 87,694.71	\$ 406,894.71	\$ 589,294.71	\$ 589,294.71	\$ 589,294.71	\$ 569,982.14	\$ 277,413.74	\$ 2,174,778.82	\$ 569,982.14	\$ 3,022,174.72
Sub-Total	\$ 12,305,546.42	\$ 1,943,523.15	\$ 2,138,723.24	\$ 3,395,819.24	\$ 6,717,225.75	\$ 4,054,053.24	\$ 3,844,723.24	\$ 3,842,223.24	\$ 6,965,512.75	\$ 19,783,612.05	\$ 18,458,225.46	\$ 6,965,512.75	\$ 45,207,350.26
IAPD TOTAL	\$ 21,098,979.02	\$ 7,335,544.15	\$ 8,274,131.24	\$ 8,408,012.24	\$ 17,631,017.75	\$ 11,502,546.91	\$ 11,040,455.24	\$ 8,611,070.58	\$ 9,450,402.08	\$ 45,116,666.65	\$ 48,785,090.46	\$ 9,450,402.08	\$ 103,352,159.19

Exhibit 32: E&E / IES Budget Quarterly Detail



14.3 Appendix C: Georgia Access Program (1332 Waiver) Cost Allocation

Described below is the Georgia Access Program (1332 Waiver) cost allocation methodology. The State will update the population counts used for the 1332 waiver cost allocation in future periods as requested by CMS.

- **Step One:** The design, development, and implementation of the E&E / IES functionality enabling the Georgia Access Program (1332 Waiver) benefits both Medicaid and non-Medicaid programs. The State identified the costs associated with functionality that benefits only non-Medicaid programs using a system development level of effort analysis performed by the E&E / IES Services contractor. The analysis determined 24.42 percent of the level of effort benefits non-Medicaid programs only. The remaining 75.58 percent of the level of effort includes the design, development, and implementation of E&E / IES functionality that benefits both the Medicaid Program and non-Medicaid programs.
- **Step Two:** Distribute 24.42 percent of the costs associated with the E&E / IES functionality identified in Step One directly to the Georgia Access Model (1332 Waiver) non-Medicaid Programs.
- **Step Three:** Distribute the remaining 75.58 percent of the costs associated with the E&E / IES functionality between the two benefitting programs (Medicaid and non-Medicaid / Georgia Access Model) using the following statistics:

- › Estimated Georgia Access Model (1332 Waiver) Population

Definition: Number of consumers who selected an individual plan via the Federally Facilitated Marketplace during Plan Year 2020 Open Enrollment

Statistic: 463,910 (17.9125 percent of the total of both populations)

- › Medicaid and CHIP Population

Definition: Average number of Medicaid and CHIP members during State Fiscal Year 2019 (July 2018 – June 2019)

Statistic: 2,125,961 (82.0875 percent of the total of both populations)

The total population of the benefitting programs is 2,589,871. The Medicaid Program represents 82.0875 percent of the total benefitting population. The Georgia Access Model represents 17.9125 percent of the total benefitting population.

- **Step Four:** Apply a 90 (federal) / 10 (state) FFP rate to the costs benefitting the Medicaid Program. Apply 0 (federal) / 100 (state) FFP rate to the costs benefitting the Georgia Access Model (1332 Waiver) / non-Medicaid Programs.



14.4 Appendix D: Requirements Analysis Sessions – Updated July 2021

Waiver Technical Design Sessions were conducted by the State that included key business and IT subject matter experts from DHS and DCH. Exhibit 33: Waiver Technical Design Sessions lists the session dates and participants.

SESSION	STATE PARTICIPANTS	
Technical Design Meetings – Round 1 Dates: 2/18/2020, 2/25/2020, 3/3/2020, 3/10/2020, 3/17/2020	Lisa Bessent Ryan Loke Sonja Allen-Smith Tanisha Lankford Jon Anderson Christan Scarsella Bradly Green Stefanie Ashlaw Lynnette Rhodes Brian Dowd Yvonne Greene Venu Gurram Joe Hood Matt Jarrard Lisa Walker Kellee Richards Joyce Wilson	Jonathan Duttweiler Shawn Green Anika Washington Daphanie Calliste Tina Hawkins Waverly Wesson Jamie Howgate Michelle Prescott Shawnzia Thomas Zainab Muhammad-Only Audrey Wynter Jayshree Sawant Lavinia Luca Dennis James Marisol Owens Matt Krull Catherine Ivy
Technical Design Meetings – Round 2 Dates: 6/8/2020, 6/16/2020	Matt Jarrard Joyce Wilson Stefanie Ashlaw Dennis James Marisol Owens Jon Anderson Kelvin Holloway Randall Solomon Zainab Muhammad-Only Shawnzia Thomas	Blake Fulenwider Matt Krull Lavinia Luca Lynnette Rhodes Brian Dowd Catherine Ivy Yvonne Greene Anika Washington Carla Willis
TPL Meetings Dates: 2/5/2020, 2/24/2020, 3/4/2020, 3/24/2020, 4/2/2020, 4/9/2020, 4/14/2020, 4/22/2020, 5/6/2020, 5/11/2020, 5/18/2020, 5/20/2020, 5/20/2020, 6/23/2020, 7/1/2020, 7/30/2020, 8/5/2020, 8/7/2020	Lavinia Luca Marisol Owens Shawn Green	Dennis James Sonja Allen-Smith

Exhibit 33: Waiver Technical Design Sessions

Waiver Policy Review Sessions were conducted by the State to prepare for requirements definition sessions. Exhibit 34: Waiver Review Sessions lists the session dates and participants.



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SESSION	STATE PARTICIPANTS	
Waiver Policy Review Sessions – Georgia Pathways Program Dates: 8/18/20, 8/21/20	Jon Anderson Ametria Baker Shannon Bennett Debbie Bodney Carla Fairley Mashonda Fortune Sharon Fullwood Toni Gay Bradly Green Yvonne Greene Sushil Jain Scherie Jeffries Rich Kim Tanisha Lankford Lavinia Luca Tracy White Stefanie Ashlaw	Wesley Merritt Zainab Muhammad-Only Jan Prescott Tamika Pyron Paul Rayapudi Brian Roth Teresa Sampson Rajasekher Satyaneni Jayshree Sawant Christan Scarsella Mohandas Sundareswaran Aditya Vasireddy Sreeji Vijayan Anika Washington Kathy Weiss
Waiver Policy Review Sessions – Georgia Access Program Dates: 8/19/20	Jon Anderson Stefanie Ashlaw Debbie Bodney Mashonda Fortune Blake Fulenwider Sharon Fullwood Toni Gay Bradly Green Yvonne Greene Sushil Jain Scherie Jeffries Matthew Krull Tanisha Lankford Anika Washington Kathy Weiss Tracy White	Lavinia Luca Wesley Merritt Zainab Muhammad-Only Jan Prescott Tamika Pyron Paul Rayapudi Brian Roth Teresa Sampson Rajasekher Satyaneni Jayshree Sawant Christan Scarsella Mohandas Sundareswaran Aditya Vasireddy Sreeji Vijayan

Exhibit 34: Waiver Review Sessions

Requirements Definition Sessions were conducted by the State to develop a preliminary set of high-level requirements for the Georgia Pathways Program Implementation Project. Exhibit 35: Requirements Definition Sessions lists the session dates and participants.



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SESSION	STATE PARTICIPANTS	
Requirements Definition Session 1 Date: 8/24/20	Tanisha Lankford Christan Scarsella Bradly Green Yvonne Greene Mona Jackson Tanisha Lankford Jan Prescott Paul Rayapudi Alvin Riggs Venkat Krishnan Rajasekher Satyaneni Jayshree Sawant Sreeji Vijayan Mohandas Sundareswaran	Zainab Muhammad-Only Jayshree Sawant Lavinia Luca Wesley Merritt Mashonda Fortune Tamika Pyron Brian Roth Teresa Sampson Debbie Bodney Sushil Jain Kathy Weiss Anika Washington Aditya Vasireddy
Requirements Definition Session 2 Date: 8/25/20	Debbie Bodney Tanisha Lankford Christan Scarsella Bradly Green Yvonne Greene Sushil Jain Tracy White Jan Prescott Wesley Merritt Lavinia Luca Mona Jackson Anika Washington	Tamika Pyron Zainab Muhammad-Only Paul Rayapudi Brian Roth Teresa Sampson Rajasekher Satyaneni Jayshree Sawant Aditya Vasireddy Sreeji Vijayan Kathy Weiss Mashonda Fortune Tamesha Wallace
Requirements Definition Session 3 Date: 8/26/20	Tanisha Lankford Jon Anderson Christan Scarsella Bradly Green Stefanie Ashlaw Yvonne Greene Sushil Jain Scherie Jeffries Jan Prescott Wesley Merritt Lavinia Luca	Tamika Pyron Zainab Muhammad-Only Paul Rayapudi Brian Roth Teresa Sampson Rajasekher Satyaneni Jayshree Sawant Aditya Vasireddy Sreeji Vijayan Kathy Weiss



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SESSION	STATE PARTICIPANTS	
Requirements Definition Session 4 Date: 8/27/20	Jon Anderson Christan Scarsella Bradly Green Yvonne Greene Sushil Jain Scherie Jeffries Jan Prescott Wesley Merritt Jayshree Sawant Lavinia Luca Shannon Bennett	Tamika Pyron Anika Washington Paul Rayapudi Brian Roth Aditya Vasireddy Sreeji Vijayan Kathy Weiss Mashonda Fortune Alvin Riggs Mohandas Sundareswaran Tamesha Wallace

Exhibit 35: Requirements Definition Sessions

The Joint Application Requirements sessions and Joint Application Design sessions that were held or are planned by the State including key business and IT subject matter experts from DHS and DCH are described in Exhibit 36: JAR / JAD Sessions.

RELEASE	SESSION DATE	TOPICS
1	10/9/20, 10/14/20, 10/20/20	Gateway – Worker Portal
1	10/7/20, 10/13/20, 10/16/20, 10/23/21, 11/30/20, 12/2/20	Gateway - Customer Portal
1	10/21/20, 10/27/20, 10/28/20, 11/17/20	Gateway - Eligibility
1	10/30/20, 11/4/20	Gateway - Support Functions
1	11/3/20, 11/6/20, 11/13/20, 11/24/20, 12/1/20	Gateway - Notices
1	11/10/20, 12/4/20	Gateway – Interfaces (GVRA, Education)
1	11/18/20, 11/20/20	Gateway - Reasonable Modifications
1	12/2/20	Gateway - Renewals
1	12/15/20, 1/8/21, 1/15/21, 1/26/21	Gateway – Reporting
1	10/15/20, 10/16/20, 10/22/20, 10/28/20, 10/29/20, 11/4/20, 11/5/20, 11/11/20, 11/12/20, 11/18/20, 11/19/20, 12/2/20, 12/3/20	GAMMIS
2	2/16/21	Gateway - Board of Regents (BOR) Integration for Qualifying Activities
2	1/27/21, 3/16/21	Gateway - Renewals



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RELEASE	SESSION DATE	TOPICS
2	2/9/21, 2/23/21, 2/24/21, 3/2/21, 3/9/21	Gateway - HIPP
2	3/30/21, 4/6/21, 4/15/21, 4/26/21	Gateway - Audit
2	3/23/21, 4/13/21	Gateway - Reporting
2	3/3/21, 4/19/21	Gateway/GAMMIS - Interfaces
2	3/17/21	Gateway/GAMMIS/HMS - Interfaces
2	2/11/21, 2/19/21, 2/23/21, 2/26/21, 3/2/21, 3/9/21, 3/11/21, 3/18/21, 3/23/21, 3/25/21, 3/30/21, 4/1/21, 4/6/21, 4/8/21, 4/13/21, 4/15/21, 4/27/21, 5/4/21, 5/6/21, 5/11/21, 5/18/21, 5/25/21, 6/1/21, 6/8/21, 6/29/21, 7/9/21, 7/20/21	GAMMIS - HIPP
2	1/6/21, 1/13/21, 1/20/21, 1/27/21, 1/13/21, 2/3/21, 2/10/21, 2/17/21, 2/25/21, 3/4/21, 3/10/21, 3/17/21, 3/24/21, 3/31/21, 4/7/21, 4/14/21, 4/21/21, 4/28/21, 5/5/21	HMS/DCH – TPL Workgroup Sessions
3	Aug 2021 – Nov 2021 (TBD)	Gateway
3	Oct 2021 – Nov 2021 (TBD)	MRA Vendor
3	Aug 2021 – Nov 2021 (TBD)	GAMMIS

Exhibit 36: JAR / JAD Sessions

Exhibit 10

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 2/7/2020**Subject:** Eligibility

Invitees: **CMS:** Hawkins, Etta (CMS/CMCS); Payne, Dina P. (CMS/OC); Pak, William (CMS/CMCS); Porcher, Tara L. (CMS/CMCS); Dubois, Anna M. (CMS/CMCS); Wigfall, Cheryl (CMS/CMCS); Shaw, Shante L. (CMS/CMCS); Jensen, Kirsten (CMS/CMCS); Tillman-Boyd, Sabrina (CMS/CMCS); Miller, Frederick J. (CMS/CMCS); Fraser, Terri (CMS/CMCS); Holt, Kathryn (CMS/CMCS); Crystal, Frances C. (CMS/CMCS); Casart, Andrea J. (CMS/CMCS)

DCH: Fulenwider, Blake; Dowd, Brian; Ivy, Catherine Taylor, Brenda; Harris, Nicole; Rhodes, Lynnette; Wilson, Joyce; Jarrard, Matt; Butler, Marvis; Luca, Lavinia; Greene, Yvonne; Wesson, Waverly; Krull, Matthew; Washington, Anika

State: Loke, Ryan

Deloitte: Horn, Wade; FitzPatrick, Timothy; Burke, Jeff Andrew; Hardy, Jim; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; Betlach, Tom

#	Topic / Question from CMS	From	State Response:	Action Item
1	Community Engagement Suspension If an individual is suspended for non-compliance for the Community Engagement (CE) requirements, does the State require that person to complete a new application to be re-enrolled?	Dina	- The State intends to model a similar approach to the Exchange model with a 3-month grace period. - If an individual fails to comply, they will be suspended for 3 months prior to disenrollment. - A new application will not be required for reinstatement while an individual is in the 3-month suspension. - Good Cause exceptions will apply for a limited time.	None
2	Re-enrollment Process After Suspension If an individual is suspended, how would they start the re-enrollment process to lift the suspension?	Dina	- Once an individual provides evidence of meeting the CE threshold or pays their premium, that would trigger the system to lift the suspension. - This program is prospective, and would follow the first of the month. - The State is in the process of determining the exact triggers and timing of suspensions and reinstatements. Follow-up provided on 2/12/20: The State is looking to mirror either ACA-type processes for the individual market or the existing state processes for CHIP.	CMS will follow up at a later time for more detail
3	Re-enrollment Process After Suspension What will be the process if an individual is suspended due to a change in circumstance and is now eligible for State Plan coverage?	Dina	- The individual would report the change to Medicaid eligibility staff and provide documentation of the change. When the eligibility rules are run, the system would return the category of coverage the individual is eligible for. - Georgia has an integrated eligibility system with a cascading rule logic to identify which level of assistance an individual qualifies for.	None
4	Deviations from Current Application Processes Is the state proposing that the program would deviate from current Medicaid application processes?	Shannon	- No. Participants would follow the same processes for submitting applications with the addition of CE and premiums as requirements for eligibility.	None

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

5	Duplicate Application During Suspension What happens if an individual is suspended, but doesn't realize they are suspended, and submits a new application? Does the State capture new data (i.e. income) in a second application?	Shannon	- There is a master client index in the State's eligibility system. If an individual applies, it would match to an existing active case. - The State will take this question back to their Eligibility leads to confirm the process used by Gateway to handle this today. Follow-up provided on 2/12/20: The State's Integrated Eligibility system, Georgia Gateway, requires that individuals submitting applications online must first create a user account. The system does not allow individuals to submit a duplicate application for Medical Assistance if they already have an active case. They are instead given the option to submit a change to their existing case. Currently, Georgia Gateway only has a "suspended" determination status for the AMN Spenddown categories of assistance in months for which the individual does not meet spenddown criteria. If an individual submits a second application via another mode (e.g. paper), the eligibility worker must review and register the application within Georgia Gateway. If the individual already has an existing active Medicaid case, the new application is scanned in to the document imaging system, and the worker reviews the application for new information to then process the change on the case.	State will follow up with additional detail by 2/14
6	Eligibility Determination Prior to Termination Is the State planning to follow its current process for this population of assessing eligibility for other categories of assistance prior to termination after suspension?	Shannon	- Yes. The State's intent is to model current process. This would include notices generated and sent to the individual during the suspension period and running them through the rules engine prior to termination.	None
7	Waiver of Retroactive Coverage, and Hospital Presumptive Eligibility Will the State confirm the population included on the waiver of retroactive coverage and hospital presumptive eligibility?	Shannon	- The State is not proposing to waive retroactive coverage and hospital presumptive eligibility for any existing Medicaid eligible population, including those eligible as a parent caretaker today. These would only apply to the new Pathways population added through this waiver.	None
8	Benefit Package for New Population Is the State intending to mirror all policies in the State Plan adult group for the currently ineligible adults?	Martin	- The benefit package would be modeled under the State Plan, with the exception of NEMT.	None
9	Eligibility Criteria for New Population Is the State intending to apply other eligibility criteria that are part of the State Plan group to the proposed group? (i.e. individual cannot be eligible for Medicare or children who are eligible for CHIP)	Martin	- The State would apply those additional tests. - If an individual is a parent or caretaker, they would be eligible for enrollment into this waiver and the child would be eligible for CHIP by virtue of household income. The children will go into their respective category under children's Medicaid.	None
10	Incarcerated Population How will the State think about incarceration in the context of this population?	Jen	- Georgia has a policy that when someone becomes incarcerated, their Medicaid is suspended. They are only eligible for coverage for a hospital stay for 2 or more days. - The services they receive are covered by the Department of Corrections. - The State intends to treat Pathways population the same.	None

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

#	Topic / Question from Georgia	Question by:	CMS Response:	Follow-up:
1	Topic Schedule Does CMS have a schedule of topics they'd like to discuss over the next couple of months?	Blake	- CMS will send topics ahead of the Friday calls so that the State can get subject experts on the phone.	None
2	Deliverables Post Approval What is the typical list of deliverables due to CMS post waiver approval and the timeline?	Blake	- Review the list of deliverables and timelines in South Carolina's STCs.	None

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date: 2/14/2020****Subject: Community Engagement Requirements**

Invitees: **CMS:** Hawkins, Etta (CMS/CMCS); Payne, Dina P. (CMS/OC); Pak, William (CMS/CMCS); Porcher, Tara L. (CMS/CMCS); Dubois, Anna M. (CMS/CMCS); Wigfall, Cheryl (CMS/CMCS); Shaw, Shante L. (CMS/CMCS); Jensen, Kirsten (CMS/CMCS); Tillman-Boyd, Sabrina (CMS/CMCS); Miller, Frederick J. (CMS/CMCS); Fraser, Terri (CMS/CMCS); Holt, Kathryn (CMS/CMCS); Crystal, Frances C. (CMS/CMCS); Casart, Andrea J. (CMS/CMCS); Chesnick, Matt (CMS Baltimore); Ross, Heather (CMS Baltimore); Lovejoy, Karen (CMS Baltimore); Pack, William (CMS Georgia);

DCH: Fulenwider, Blake; Dowd, Brian; Ivy, Catherine Taylor, Brenda; Harris, Nicole; Rhodes, Lynnette; Wilson, Joyce; Jarrard, Matt; Butler, Marvis; Luca, Lavinia; Greene, Yvonne; Wesson, Waverly; Krull, Matthew; Washington, Anika

State: Loke, Ryan

Deloitte: Horn, Wade; FitzPatrick, Timothy; Burke, Jeff Andrew; Hardy, Jim; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; Betlach, Tom

#	Topic / Question from CMS	From	State Response:	Action Item
1	Community Engagement Requirements What population will be subject to the Community Engagement (CE) requirement?	Dina	- The opportunity to enroll in Medicaid through Georgia Pathways will be limited to the “new adult population” which includes parent caretakers above the current Medicaid threshold today (approximately 35% FPL) and childless adults who are not currently eligible for Medicaid up to 100% of the FPL. - The pathways approach will not apply to any existing categories of eligibility today. - The State does not consider the CE aspect as a “requirement,” but rather as a pathway to Medicaid coverage that will be made available to otherwise ineligible populations if these individuals elect to participate in the pathway.	None
2	Hour and Activities Reporting How will the State have individuals report their completed hours and through which channels (online, telephone, mail)?	Dina	- The State is looking to leverage technology as much as possible to minimize the burden on both individuals and staff. For example, the State is looking at how to leverage wage data already available from interfaces with the Dept of Labor through its existing Integrated Eligibility System (IES). - The State also envisions allowing individuals to report via multiple channels. For example, the State is considering leveraging a web-based application to allow individuals to submit pictures of paystubs and for individuals to be able to report hours at their local County DFCS office. - Once an enrollee successfully documents compliance with the minimum requirements for six months, they would no longer have to report monthly . The individual would then be re-validated upon annual redetermination and has an obligation to report any change in circumstance such as changes in employment status or income. - The State has a desire to make this process as simple as possible using electronic options, while also recognizing some individuals will not be able to meet these channels (e.g., individuals not receiving a formal payroll).	None

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3	Self-Employment Does the State propose utilizing similar channels for individuals who are self-employed?	Dina	- The State is in the process of determining the details for how self-employed individuals would report their hours and activities. - The State would not require revalidation every month for full-time enrollment in an institution of Higher Learning. These individuals would provide documentation that they are enrolled and would not need to re-enter matriculation information on a monthly basis, but rather on a periodic basis such as each semester.	CMS will follow up at a later time for more detail
4	Hour and Activities Reporting What are the audit processes mentioned in the waiver that will be used to verify CE?	Dina	- In order to minimize the burden, the State is considering random spot audits for compliance and quality assurance. - The State is considering system triggers to identify where further validation may be required. For example, if there are fluctuations in income with wage data through the DOL interface, it would alert a caseworker to review the case and ask questions of an enrollee to verify compliance. - At annual recertification, there will be verification of income and employment/ CE .	None
5	Cost Sharing and Non-Payment of Premiums Page 9 of the waiver indicates that an individual may be liable for all incurred capitation payments. How would an individual be notified of non-payment, and what are the timeline or consequences for non-payment?	Dina	- The State is in the process of determining the details of the timeframes and notifications and is working to compare similar policies such as CHIP for this situation. - The State envisions that if it is identified that cap payments have been made while an individual should not have been covered due to a change in circumstance or fraud, then that individual would pay back those payments. Payment would be due upon receipt of an initial notice, and past dues would need to be satisfied prior to re-enrollment into Pathways. - All appeals rights would be available to the individual.	CMS will follow up at a later time for more detail
6	TANF and SNAP Work Requirements Will the State automatically consider individuals enrolled in and compliant with TANF or SNAP work requirements? If individuals are exempt from TANF or SNAP work requirements, will they individuals also be exempt from the Pathways work requirements?	Dina	- It depends on which activity under TANF is being satisfied. There are some TANF categories that are not qualifying activities under Pathways, such as individually directed job search or work readiness. - The State does not have any categorical exemptions in the Pathways approach. Rather, everyone under 100% of FPL who are otherwise ineligible for Medicaid would be afforded the opportunity to enroll in Medicaid by participating in one of the pathways. - Good cause exceptions will be provided for individuals whose participation in a pathway is temporarily interrupted by circumstances such as temporary illness, the birth or adoption of a child. - The State would like to reiterate that these are not requirements that would remove someone from the program, but rather the new Pathways program allows a new population to become eligible for coverage by participating in one of the pathways.	None
7	Disability/Reasonable Modification How will the State ensure that individuals with disabilities are not denied access to Medicaid for inability to meet the CE requirement? Will the State consider putting mechanisms in place to ensure		- The State has discussed this point and considered it throughout the comment period. - The waiver does not include any categorically exempted populations. - Individuals with disabilities may become eligible through Pathways, or, depending on circumstances, are eligible under several other categories of assistance in the State that are available to them today.	None

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	reasonable modifications are available for individuals who need them?		- There are two parts to the question: - The first is making reasonable accommodations through the application process - The second is an exemption process in terms of giving a pathway - <i>Regarding the application process</i>, the State will continue to follow the law to make sure that the Pathways application has reasonable modifications, and be accessible for individuals with disabilities, such as for those who are hearing impaired or visually impaired. For example, the State provides services for individuals who may need larger print font or for individuals who need assistance to fill out the application. - <i>Regarding the Pathways for Coverage</i>: Pathways is not restricted only to employment. It encompasses community service, training, and education. In these programs there are statutes that accommodate people with disabilities. - In addition, if an individual is incapable of doing work or community service, this person should qualify for SSI; in this case they would most likely be eligible for Medicaid under traditional Medicaid.	
8	Exemptions To confirm: there will not be a blanket exemption. Will an individual not be exempt because they should already be receiving coverage through SSI?	Matt/ Dina	- There is a distinction between people who have a disability and those who are incapable of performing daily activities. The latter group is likely eligible for SSI and would not need to go through a Pathways approach as they are likely eligible for traditional Medicaid. - There are programs available to help individuals who are disabled to get engaged in community activities, and the State hopes they avail themselves of these supports, should they want to gain coverage under the Pathways approach.	None
9	Medically Frail Individuals How will the State address individuals determined to be Medically Frail?	Dina	- The State does not envision having categories of people who will be exempt. - Through Pathways, the State is creating a new eligibility group which is a group not covered absent the waiver. This program is not taking anyone out of coverage. - If an individual is incapable of working, they would likely be eligible for coverage through traditional Medicaid.	None
10	Medically Frail Individuals For an individual who is medically frail, what if they cannot meet the CE but have resources above the standard Medicaid?	Matt	- Unless these individuals meet a pathways hours/enrollment threshold, they are not going to qualify for coverage under the waiver. If, due to their medical condition they are unable to participate in any of the pathways, they would most likely be eligible to enroll in traditional Medicaid.	None
11	Medically Frail Individuals The terminology medically frail is a term of art. We need to think about those individuals who are otherwise eligible but have some reason why they cannot participate. What would happen to them? There are potential concerns about expanding coverage of eligibility that may be discriminatory.	Anika	- The State understands this issue and will provide additional detail on how individuals with disabilities gain access to coverage today. - There are other categories of Medicaid assistance that serve individuals with disabilities. The State is creating a very distinct eligibility pathway for individuals who are not otherwise eligible for enrollment in Medicaid.	State will provide more information to CMS
12	Good Cause Exception	Dina	- The State would like to reserve the right to review a good cause exception to ensure that it fits under the broader vision for the Pathways program. The	None

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	Will the State have a pre-defined list of “Other” Good Cause exceptions, or will this be determined on case-by-case basis?		exceptions that will most likely qualify will be defined so that there is a general understanding of what meets the Good Cause exception requirement. - The State is still refining this list and defining the duration of the Short-Term Exception.	
13	Volume of Individuals Not Eligible/Losing Coverage Due to CE Requirement Is there an estimate of the number or percentage of individuals that may not be eligible or lose coverage due to the CE requirements? For example, SC and UT provide loss estimates and assumptions.	Dina	- No one who is currently eligible for Medicaid will lose coverage under the Georgia Pathways approach. Rather, the Georgia Pathways approach provides an opportunity for those who are otherwise ineligible for Medicaid to obtain coverage. Hence, there will only be a net gain in Medicaid enrollment through the Pathways approach and never a net loss. - The State has estimates for the number of individuals expected to apply and gain coverage through the Pathways program based on other states who expanded with a CE component experienced. The State will provide additional detail on the net gain. The Georgia Pathways approach will operate similar to the work requirement in the SNAP program, in which those who are ineligible for SNAP benefits because they have exhausted their benefit limit can earn additional SNAP benefits by satisfying its work requirement. - Once Pathway enrollees reach 100% of the FPL, they move into the individual market. This is the goal of the program: as people are getting better jobs and making more money, their income reaches above 100% and they transition to commercial coverage. Follow-up Provided on 2/19/2020 - Georgia Pathways provides individuals who are otherwise ineligible for Medicaid an opportunity to enroll in Medicaid by working or volunteering for 80 hours per month or matriculating in and institution of higher learning, such as college or vocational education. This approach will provide access to affordable health care coverage to Georgian’s below 100% FPL who are otherwise ineligible for Medicaid coverage. The State’s 1115 Waiver does not propose any changes to its existing Medicaid programs. Any enrollment in the Pathway Program will be net new enrollment in the Medicaid program. - To project enrollment into the new Pathways Program, the State looked at state demographic data and uptake data from Medicaid expansion states. The State’s enrollment projections account for an initial growth in enrollment as the program is rolled out. It also assumes that a portion of participants will transition out of the program when their incomes exceeds 100% FPL, at which point they would transition to purchasing insurance in the individual market with subsidy assistance. - Since Pathways participants are required to demonstrate compliance with the eligibility requirements prior to gaining access to Medicaid, the State does not anticipate churn on and off of this program to be any greater than what is experienced by the traditional Medicaid programs.	State to provide additional detail on the net gain.
14	Work Support Programs	Dina	- The State is not envisioning using Medicaid funds to pay for transportation or childcare. However, there are several other programs available outside of Medicaid today, such as the Child Care Development Block Grant, existing	None

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	Has the State considered any work support programs such as transportation or childcare through Medicaid or other programs?		workforce development, and the option to use TANF funds, that could be used to provide child care for those participating one of the pathways.	
15	Initial Eligibility Determination of CE Requirement What is the process for reviewing whether an individual is meeting CE hours and is determined eligible prior to the application date? How would an individual show proof of new employment?	Dina	- The State is in the process of determining the details of the initial determination and verification for meeting the CE requirement. - The State anticipates that there are a number of individuals who are already meeting the requirement. These individuals would provide paystubs or some other verification, such as evidence that they are matriculating in an education or training program, and be enrolled. Members who have to pay a premium would be enrolled the first of the month following their premium payment.	CMS will follow up at a later time for more detail
16	Annual Redetermination and CE Requirement How will the CE reporting interact with the annual redetermination process? Will the state continue to check data sources first before reaching out to the beneficiary to provide?	Dina	- The State is in the process of determining the details of redetermination. - The State will aim to make redetermination as simple and easy for the beneficiary as possibly by leveraging all available information.	CMS will follow up at a later time for more detail

#	Topic / Question from Georgia	Question by:	CMS Response:	Follow-up:
1	Topic Schedule Is there a discussion topic for next week?	Tom	- Unless there are additional questions or feedback on the topic of Community Engagement, CMS would like to discuss premiums and cost sharing.	None

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 2/21/2020**Subject:** Cost Sharing

Attendees: **CMS:** Payne, Dina P. (CMS/OC); Pak, William (CMS/CMCS); Porcher, Tara L. (CMS/CMCS); Fraser, Terri (CMS/CMCS); Rossi, Heather (CMS Baltimore); Height, Melissa; Shaw, Shante L. (CMS/CMCS); Holt, Kathryn (CMS/CMCS); Crystal, Frances C. (CMS/CMCS); Casart, Andrea J. (CMS/CMCS); Chesnick, Matt (CMS Baltimore); Lovejoy, Karen (CMS Baltimore)

DCH: Fulenwider, Blake; Dowd, Brian; Rhodes, Lynnette; Wilson, Joyce; Jarrard, Matt; Butler, Marvis; Luca, Lavinia; Greene, Yvonne; Wesson, Waverly; Krull, Matthew; Gurram, Venu

Deloitte: Horn, Wade; FitzPatrick, Timothy; Burke, Jeff; Hardy, Jim; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; Betlach, Tom

#	Topic / Question from CMS	From	State Response	Action Item
1	Premium Assistance Page 2 of the waiver states that every low-income individual in the expansion population will be eligible to either enroll in Pathways or purchase insurance through the FFE. Will the State include state health plans as part of premium assistance?	Mario	- The State is targeting a population at or below 100% FPL for Medicaid eligibility through the new Pathways program. The State will subsidize ESI for the subset of this eligible population for whom ESI is available and cost effective to the state. Follow-up Provided 2/26/2020 - The waiver application reference on page 2 to the FFE is in regards to the fact that low income individuals above 100% FPL have access to affordable commercial market insurance through government subsidies in the individual marketplace. The State of Georgia submitted both an 1115 and 1332 waiver in December 2019 to improve access to affordable healthcare coverage in the State for individuals below and above 100% FPL.	
2	Current Voluntary HIPP Program What cost sharing is currently covered by the State's voluntary HIPP program?	Mario	- Cost sharing and other out of pocket expenses are covered. Follow-Up Provided 2/26/2020 - Currently under HIPP, cost sharing and other out of pocket expenses are paid directly to the provider through the TPL process when the HIPP beneficiary sees a provider in the employer's carrier's network who is also a Medicaid provider.	
3	Emerging CMS Provisions on Cost Sharing that Impact the Mandatory HIPP Program How will payment be effectuated for coinsurance and deductibles under the mandatory HIPP program? What is the mechanism to provide these payments to members?	Mario/Melissa	- CMS explained there are emerging provisions which will not allow the beneficiary to pay out of pocket for expenses. - The State can open its Medicaid network to allow premium assistance members to see any provider, on a case by case, or more broadly. - The State can enter into individual contracts with providers for a specific incident of care. The State would enter into a contract to become a Medicaid provider for the patient responsibility of the claim. - The State can obtain a freedom of choice waiver to restrict access to only providers who are both in the private network and Medicaid. - The State's proposed plan is to reimburse HIPP individuals for out of pocket expenses but will need to evaluate its options after reviewing the guidance.	CMS will provide further information on cost-sharing payment options

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			- For option 1, it would be difficult for the State to align Medicaid and commercial market networks. - The State's intention in the mandatory HIPP program is to utilize the commercial plans' provider network uniformly. - CMS has not issued guidance yet but will send additional information on the options.	
4	1115(a)2 Authority Is the population an expenditure authority population under 1115(a)(2) authority?	Melissa	- Yes, the population is under 1115 (a)(2) authority. - CMS Response: - There is more flexibility under (a)(2) than under <i>the three options that were mentioned</i>. However, the State will have to prove that Medicaid objectives are being met. - In working with another state, there has been difficulty with the General Counsel pushing back on this meeting Medicaid objectives. - If Georgia wants to try the "shoe box" option to make advanced payments to providers, which is harder than the three options mentioned, then the State needs to provide data that beneficiaries are benefitting from this approach. - State Response: - The State would make the case that the Medicaid objectives are being met. Part of the argument is sustainability of the Medicaid program, which the Court has said can be an argument of advancing the program.	
5	Premium Payment Reimbursement How does the State intend to provide a payment to the beneficiary for premium payment under premium assistance in this demonstration?	Mario	The intention with pathways is to have a premium payment paid on behalf of the HIPP member directly to the employer. - CMS Response : - Premium payment made directly to the employer is compliant with CMS policy.	
6	Wraparound Benefits What is the State's rationale for not providing wrap benefits and in what ways is this compliant with Medicaid? <i>The waiver states that the State will not provide wrap-around benefits to members in the HIPP program. Generally, States are required to provide a wrap, with services covered in the State's Medicaid plan but not covered by the ESI.</i>	Mario	- The State is proposing to waive the wrap benefit requirements for the Pathways population with access to ESI because it meets ACA requirements. It is assumed that individuals below the FPL who have an offer of ESI that is cost effective will likely be employed by larger employers; in this case, those core requirements (such as QHPs and affordability) are going to be met. - CMS Response: - CMS has never approved this before. This would be a new ask before General Counsel. The State would be required to prove that the Medicaid objectives are met. - State Response - The State would argue it does meet the objectives of Medicaid. The waiver's objective is to offer coverage to individuals who do not have access to coverage today. Sustainability of the overall program is also an important objective for Medicaid. The State would like the opportunity to pursue this for the Pathways population to see what avenues may exist for a population that otherwise would not have coverage.	CMS will follow up with next steps for wraparound

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7	Cost Effectiveness Calculation How does the State plan to account for additional costs to the State of personnel working with the HIPP program to determine eligibility, within its cost effectiveness calculation?	Mario	- A third-party vendor administers HIPP currently. Third party resources will be leveraged for the mandatory HIPP program. - One state employee manages the HIPP program today; the current administrative cost of the program is relatively small. - The State envisions a minimal increase in State staff and adapting the arrangement with the vendor in order to implement the mandatory HIPP program. - The State will need to follow up with the vendor on its cost effectiveness calculation to confirm whether administrative costs are included Follow-Up Provided 2/26/2020 - The State confirmed that administrative costs are part of the calculation.	The State will follow up on cost effectiveness after discussing with its vendor												
8	Premium Assessment and Pre-payment How will State conduct the premium assessment? Will pre-payment be required?	Terri	- Premiums will be required for a subset of the total Pathways population from 50-100% of FPL. The premiums required by this subset are as follows: <table><tr><th>Percent of the FPL</th><th>Monthly Single</th><th>Monthly Spouse</th><th>Tobacco Surcharge</th></tr><tr><td>50% - 84%</td><td>\$7.00</td><td>\$4.00</td><td>\$3.00</td></tr><tr><td>85% -100%</td><td>\$11.00</td><td>\$7.00</td><td>\$5.00</td></tr></table> - Premiums would not apply to any currently eligible category of assistance in Medicaid or anyone enrolled in the mandatory HIPP program. - The State is also waiving the premium requirement for those enrolled in vocational education programs of highly sought-after trades through the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant programs. - Pre-payment will be required. Coverage will not begin before the initial payment is received, mirroring the commercial model of insurance. - CMS Response: - Because there is a pre-payment requirement for the first month, if the individual misses that first month payment, are they are not enrolled? - State Response: - Yes. That is correct. They are not enrolled until they make their first premium payment.	Percent of the FPL	Monthly Single	Monthly Spouse	Tobacco Surcharge	50% - 84%	\$7.00	\$4.00	\$3.00	85% -100%	\$11.00	\$7.00	\$5.00	
Percent of the FPL	Monthly Single	Monthly Spouse	Tobacco Surcharge													
50% - 84%	\$7.00	\$4.00	\$3.00													
85% -100%	\$11.00	\$7.00	\$5.00													
9	Adverse Action for Missed Premiums When does adverse action occur for missed premiums?	Terri	- The State proposed a process in the waiver based on what happens in the individual market today with premium payments - Recently, the State has had additional conversations about aligning the policy for ongoing Pathways premium payments with the current process in place for its CHIP program (Peach Care for Kids) - As written in the waiver, an individual would be suspended month 1 after missing a premium payment but not terminated from the program until the end of month 3 of o premium payment (90 days).	The State will provide the premium timeline outlining this process												

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			- If an individual is terminated due to non-payment at the end of the 90 days, there is no lock-out period for re-applying. - From a policy standpoint, the State's goal is to encourage the behavior of making a monthly contribution in order to prepare individuals for the commercial market. - The State is creating a timeline that helps lay out these timeframes and can make available to CMS once finalized. - CMS Response: - There are still some additional questions around the penalties with premiums. For example, what happens if the individual is suspended for not meeting the community engagement requirement? What are the consequences and interactions with the premium requirement?	
11	Tobacco Surcharge Is there an opportunity for a smoker to appeal the tobacco surcharge?	Terri	- The State envisions assessing the tobacco surcharge based on self-attestation at the enrollment process. Nicotine screening will not be required in advance of enrollment. - If an individual self-attests to being a smoker, the tobacco surcharge will be applied. - Enrollment in a smoking cessation program will be rewarded through the Member Rewards Account. If an individual completes a smoking cessation programs and attests to no longer smoking, the surcharge is listed. - In terms of an appeal, if the individual is not participating in smoking cessation or other qualified health improvement activities, and they attest that are smoking, there would be no grounds for appeal of a tobacco surcharge.	

#	Topic / Question from Georgia	Question by:	CMS Response:	Follow-up:
1	N/A			

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 2/28/2020**Subject:** Cost Sharing and Premiums (Continued)**Attendees:** **CMS:** Payne, Dina P. (CMS/OC); Fraser, Terri (CMS/CMCS); Rossi, Heather (CMS Baltimore); Height, Melissa; Shaw, Shante L. (CMS/CMCS); Chesnick, Matt (CMS Baltimore); Middlebrooks, Sandra**DCH:** Fulenwider, Blake; Rhodes, Lynnette; Wilson, Joyce; Luca, Lavinia; Greene, Yvonne; Krull, Matthew;**Deloitte:** Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; Betlach, Tom

#	Topic / Question from CMS	From	State Response	Action Item
1	Initial Premium Payment Timeline [Reference to Initial Premium Payment Timeline provided on 2/26/20] If the individual is deemed eligible in February, can they make a payment prior to March in the scenario outlined in the initial premium payment timeline?	Matt	- The State is working through the logistics of the premium payment timelines. In this specific scenario, if the individual is determined eligible on February 15 and receives the notice within 15 days, they would not have enough time to make the payment for March coverage. - The State is considering whether an individual can make their first premium payment during application; however, the State needs to consider the operational consequences of this and the need to make refunds if an individual is not determined eligible.	
2	Initial Premium Payment Timeline [Reference to Initial Premium Payment Timeline provided on 2/26/20] If an individual misses the payment cut-off date of the 23 rd of the month, would their coverage begin later than the first of the following month? For example: If the March 23 rd date is missed, would their start date be later than April 1?	Terri	- That is correct. If payment comes after the 23rd, coverage would begin on the first of the next month. In this scenario, that would be May 1st. - The State currently needs 7 days from an operational standpoint with its CHIP program to process the received payment for coverage the following month.	
3	Initial Premium Payment Timeline [Reference to Initial Premium Payment Timeline provided on 2/26/20] If the individual misses the next payment date in April, and has a grace period, will there be an additional period to make up the past premium?	Terri	- The timeline shared with CMS is only regarding initial enrollment. - The State is still working through the details of the suspension timeline and exploring the possibility of aligning it with the current CHIP process. - There will likely be a grace period as mentioned. - The State will provide a timeline for ongoing payments for the group next week.	State to provide ongoing premium payment timeline next week
4	Initial Premium Payment Timeline [Reference to Initial Premium Payment Timeline provided on 2/26/20] If an individual wanted coverage on the 1 st of the following month and missed the 23 rd deadline, is there	Melissa	- At this time, there is no intent for the State to provide retroactive coverage for the Pathways population. - The 23rd is the operational deadline by which the payment can be processed for coverage to begin the following month. If the State can operationally push this cut-off date to later in the month, the State will consider this.	

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	a way they can get retroactive coverage? For example: If two premiums were paid.			
5	Pathways Contract What is the Pathways contract that an individual is required to sign before coverage begins?	Melissa	- The contract is an acknowledgement that the individual has an obligation to pay a premium and comply with the hours and activities reporting to maintain their eligibility in the program.	
6	Initial Premium Payment The individual has 90 days to pay a premium before their case is closed. If an individual never makes a premium payment, is there a notice to inform them that they must pay, or their case is closed?	Melissa	- The State has not determined the details of the entire noticing process, but there would be a notice informing a member that if they do not pay their premium by a certain date, their case will be closed and they will need to reapply. The initial eligibility notice would also include this information. - CMS Follow-up: • There is an interest in understanding this process. CMS will follow up at a later time to understand additional noticing.	CMS will follow up at a later time about noticing
7	Initial Eligibility Determination What happens if the State processes the application later than expected? For example, if it takes longer than 60 days in this scenario, is there a way for the individual to pay previous premiums so their coverage can start sooner?	Sandra	- The State has not built in any provisions to include retroactive coverage. - Coverage would begin from the first of the month following the initial premium payment.	
8	Cost Sharing – 5% Limit The population that the State will cover will be subject to copayments. Does the State confirm that any combination of premiums and copayments is subject to the 5% limit?	Terri	- The State confirms awareness of the 5% limit and the proposed approach is in compliance. - CMS Follow-up: • There is a possibility that members subject to premiums (50-100%) will reach the cap quickly given the \$30 non-emergency use of the ED.	
9	Cost Sharing – 5% Limit Can the State explain how they currently comply with tracking that members do not exceed the 5% cost sharing limit?	Terri	- The State can look into the specifics of tracking the 5% cap and will follow up at a later time. - The State has not submitted any SPAs recently related to cost sharing.	State to follow up with information on tracking the 5% limit
10	Member Rewards Account How will copayments be tracked through the Healthy Rewards Accounts?	Terri	- Copayments will be paid directly out of the Member Rewards Account. - Copayments are managed centrally, not at a point of service, by looking at utilization based on encounter data. - The provider bills the full amount for the service and does not experience a deduction for the copayment. The rate assumptions for the CMOs will be that there are no copays. The copayments are transferred from the Member Rewards Account to the State. - CMS Follow-up: • Will the State or a vendor will oversee this account? - State Follow-up: • The State expects to contract with a third party to administer the account.	CMS will continue with further questions on the Member Rewards Account

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11	Non-emergent Use of the ED Copay There are a number of requirements related to non-emergent ED copays around screening being conducted by a medical professional, notice requirements that the hospital needs to supply at point of service (informing that could be subject to copayment, what that amount is, alternative providers, and other items). Will the same standards still apply with regards to this increased non-emergent ED copay? Has the State worked with the hospitals on this increase?		- The State currently has a similar copay in a lesser amount. The same standards would apply with regards to the increased copay. - Hospitals are aware of the increased copay as written in the waiver. There have not been any individual discussions yet. - CMS Follow-up: • Will hospitals follow the same procedure to ensure a visit constitutes a true non-emergency? Will the State make a reduction to the provider in the reimbursement paid? - State Follow-up: • The State envisions following the same process used today. • If someone presents with an emergent condition, then this copayment will not apply. This is specifically designed to reduce the likelihood of individuals making the ED a primary care clinic. • Providers will continue to receive their full rate and will not experience a copay reduction. Copays will be transferred from the Member Rewards Account to the State based on encounter data. If there are insufficient funds, then the account will go negative.	
12	Non-emergent ED Copay Has the State considered implementing a grace period before the initial copayment is assessed?	Dina	- State has not proposed or discussed this at this point.	
13	Non-emergent ED Copay Other than the copayment, is there any consequence for nonpayment on behalf of beneficiary?	Terri	- There is no other consequence for nonpayment. - The Member Rewards Account would be able to accrue a negative balance. For example, if an individual has \$20 in the Account and has a \$30 copayment, their Account would balance out to -\$10. - Subsequent premium payments or points will offset the negative balance on that account. - CMS Follow-up: • Once the State provides more detail on the Member Rewards Account, there is interest in knowing how the negative balance will occur as relates to capping CSR limits at 5%.	
14	Non-emergent ED Copay Has the State found that the current non-emergent ED copay is not deterring individuals from use?	Melissa	- The copay amount is currently nominal. Most copayments are a few dollars (\$2 - \$5). - The State has not done any specific analysis. However, anecdotally, the State has heard frequently about the issue from providers. - The Pathways model aims to prepare individuals for entry into the commercial market once they income-out of Medicaid eligibility above 100%. This is part of education process that is in line with the State's goals with Pathways. - The State has also considered the experience of other states, particularly Oregon, which experienced a 40% increase in their utilization after expansion. The State is operating with the understanding that increased ED use could be a problem. The State is trying to encourage people to seek care at the right setting, including primary care.	State to follow up regarding the current non-emergent ED copay amount

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			- CMS Follow-up: • Has the State monitored or discussed with hospitals how this is working now? - State Follow-up: • The State has not directly discussed this issue with hospitals.	
15	Cost Sharing – 5% Limit Are the non-emergent ED copays, in addition to premiums and the tobacco surcharge, all part of the 5% cap?	Terri	- This is correct.	
16	Recoupment On page 14, the State noted that it may recoup cap payment for the months the individual would be suspended. How would this process work?	Terri	- The State would like to defer this topic to next week as it is still working through details of the post-enrollment premium process in the event that an individual is suspended.	CMS will follow up at a later time about the post-enrollment process
17	Post-Medicaid Expenses On page 17, the State discussed post-Medicaid expenses. Can the State share more information about the process for any premium contributions still in the Rewards Account, if an individual is no longer eligible for Medicaid?	Terri	- The State is using the concept of a portable account. If a balance remains in the Member Rewards Account, an individual will have that account available after leaving Medicaid to use for qualified health care expenses. These expenses mirror what are allowable while the individual is enrolled in Pathways, such as over the counter drugs, eye glasses, and dental expenses. - The State's goal is to provide an incentive for individuals to be cost-conscious consumers and to save money. The State's goal is also to smooth a transition as an individual moves out of Medicaid into commercial coverage, where they face a higher copayment structure, and greater out of pocket exposure. - CMS Follow-up: • What is the advantage of doing this and not directly reimbursing the beneficiary? The CMS preference is that funds be made available back to the beneficiary. - State Follow-up: • The dollars are designated for the use of qualified healthcare expenditures. One of the advantages to the individual would be the tax treatment of the dollars in that account. - CMS Follow-up: • Did the State base this on other states that have Member Rewards Accounts? - State Follow-up: • The State is not sure if another state has implemented this exact model. In building the account, the State looked at what has been approved in other states (such as in Michigan, Arizona, and Indiana), but is not certain specifically on whether post-membership dollars have been used in this way.	CMS will follow up internally on how rewards accounts have been designed in other states

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			- <i>CMS Follow-up:</i> CMS will need to connect with other colleagues on how novel or precedential this is, and if it needs consideration.	

#	Topic / Question from Georgia	Question by:	CMS Response:	Follow-up:
1	Discussion topic next week	N/A	Next week's conversation will continue with questions regarding cost sharing, premium suspensions, and other items related to premiums.	N/A

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 3/6/2020**Subject:** Premiums, Premium Assistance, and Community Engagement**Attendees:** **CMS:** Payne, Dina P. (CMS/OC); Pak, William (CMS/CMCS); Porcher, Tara L. (CMS/CMCS); Fraser, Terri (CMS/CMCS); Height, Melissa; Shaw, Shante L. (CMS/CMCS); Lovejoy, Shannon; Sheer, Jenn**DCH:** Fulenwider, Blake; Rhodes, Lynnette; Wilson, Joyce; Greene, Yvonne; Butler, Marvis; Wesson, Waverly; Jarrard, Matt; Ashlaw, Stefanie; Dowd, Brian; Ivy, Catherine**Deloitte:** Horn, Wade; Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; Betlach, Tom; McCarthy, John

#	Topic / Question from CMS	From	State Response	Action Item
1	Effective Date of Coverage How will the effective date of coverage be set for individuals subject to premiums? [Reference to "Initial and Ongoing Premium Timeline" Document, shared 3/5/2020]	Shannon	- Individuals who become newly eligible under Georgia Pathways will begin coverage on the first of the month following their initial premium payment. - Premium payment must be received by the 23rd of a previous month for coverage to begin on the first of the following month. This deadline has been established to allow for enough time to process premium payments. - No retroactive coverage will be provided for individuals in Pathways.	
2	Effective Date of Coverage How will the effective date of coverage be set for individuals not subject to premiums?	Shannon	- If an individual is below 50% of FPL, no premium is required. - Coverage for this group will begin the first day of the month following the determination of eligibility. - CMS Follow-up: • If a person applies on the first of the month, and determination is completed on the 15th, would coverage for individuals not subject to premiums begin the first of the following month? - State Response: • Correct. In the example timeline provided, and individual determined eligible on February 15 who does not owe premiums would start their coverage on March 1.	
3	Effective Date of Coverage If an individual is not required to pay a premium, will they still need to select a CMO and sign the Pathways contract, in order to receive coverage? <i>(In the initial premium timeline document provided, three items must be completed in order for coverage to begin: Premium payment, CMO selection, and Signed Pathways contract.)</i>	Terri	- Correct. - The State is having ongoing discussion to determine whether auto-assignment, or the ability to choose auto-assignment, will be options for individuals in Pathways. - The intent for the State is to mirror the commercial market in which a plan is selected for enrollment through shopping and comparing prior to coverage. - The State recognizes that the selection may be less important to some individuals. For this reason, we are considering including the option for an individual to select auto-assignment. In this case, the existing auto-assignment algorithm will be utilized for CMO assignment. - CMS Follow-up:	CMS will follow-up with Managed Care colleagues

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			- If the State is interested in expediting enrollment and eligibility, CMS may assist with thinking through additional flexibilities. - A follow-up may be necessary with Managed Care colleagues on the proposed process.	
4	Premium Payment Timeline Can the State confirm they are aiming to align proposed premium processes to existing CHIP processes?	Terri	Correct. The State is aiming to align the premium process for Pathways to the existing premium process for CHIP as much as possible.	
5	Community Engagement Timeline Can the State provide an overview of the Community Engagement timelines? [Reference to “Community Engagement Timelines” Document, shared 3/5/2020]	Dina	Initial CE Reporting – First Six Months of Pathways - When entering Pathways, an individual will need to be engaged in a qualifying activity prior to entering the program to show compliance. - For the first six months of Pathways, documentation must be provided to show that the hours and activities threshold is being met. - Following the six consecutive months of compliance, the individual will not be required to report monthly. As stated in the Pathways contract, the individual will be required to report any change in circumstance, which is consistent with the current Medicaid program. - Random audits will be conducted on an ongoing basis in order to ensure Pathways members remain compliant with the program. - For redetermination each year, the member will need to report and document meeting the hours and activities threshold. CE Suspension – No Engagement - If the hours and activities threshold is not met, the individual will enter a 90-day suspension period. - If the hours and activities threshold is not met at the end of the 90-day period, they will be terminated. - While an individual is in suspension, the CMO capitation rate is not paid and claims are not paid; providers will see these individuals as not enrolled. CE Suspension – Re-engagement - If the individual comes back into compliance during the suspension period, they will be reinstated starting the first of the month following reporting. CMS Follow-up: - Can the State confirm that suspension is not considered a lock-out, and that once hours and activities requirement are met the suspension status will be lifted? State Response: - Correct. There is no lock-out proposed at any stage for Pathways members. CMS Follow-up: - Can the State confirm the effective date of reinstatement, once an individual comes back into compliance with Community Engagement?	

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			- State Response: • The first of the next calendar month, following the individual's report to the State that they are in compliance. • The State is using a deadline of the 23rd of the calendar month for operational reasons and in order to align deadlines that are in place for premium payment each month. - CMS Follow-up: • Can the State confirm that in order for an individual to regain coverage, they will need to pay next month's premium payment and report CE? - State Response: • Correct.	
6	Community Engagement Suspension If an individual is suspended for Community Engagement, a claim is denied from a provider during suspension, and coverage is restored for the next month, is there any way to get the past claim covered?	Melissa	- There is no retroactive reinstatement of coverage. Coverage would be prospective following their reinstatement. - Providers will know that an individual is in suspension. - From a system perspective, a provider will see an individual as not eligible to receive services while they are suspended.	
7	Community Engagement Reporting and Documentation Will self-attestation qualify for the Community Engagement reporting and documentation requirement?	Melissa	- Where possible, the State would like to leverage existing interfaces (such as through the Georgia Department of Labor) that collect payment data for individuals in Pathways. In this case, automated verification would take place. - In the case where automation is not possible, such as in the case of self-employment or cash-based workers, there may be a need for actual reporting/documentation that the requirement is met. - The State wants to ease the burden of reporting as much as possible and is looking into technology options that allow for this, such as a mobile application to easily submit a pay stub.	
8	Suspension Noticing At what point will the State send a notice to the individual to inform them that they are in a suspension period due to not meeting the hours and activities threshold? [Reference to "Community Engagement Timelines" Document, shared 3/5/2020]	Jen	- From the 23rd to the end of a month in which a premium payment or CE documentation is not received, a notice will be generated to inform the beneficiary that they are in suspension. - The State envisions there would be a recurring notice in place that is triggered on the 23rd of each following month while the individual remains in suspension, including if the individual will soon be subject to final termination. - This process will be aligned with federal rules and regulations for noticing requirements, which the State currently adheres to with existing noticing. - CMS Follow-up: • Can the State confirm that the member will get an initial notice and following notices to remind them and update them on the status? - State Follow-up: • Correct. The State will follow up at a later time with a timeline that includes the notices that will be provided for suspensions, premium payments, and terminations.	State to provide a timeline of notices provided across the Pathways program in a future discussion
9	Good Cause Exception Is there a hardship exemption for Community Engagement?	Melissa	- There are short-term, good cause exceptions. An individual may be excused for a short period of time, but not on an ongoing basis.	

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			- A member needs to be in the program and have previously met the hours and activities threshold. In this case, if an event takes place, they will be excused from Community Engagement for a set time. - CMS Follow-up: • What is the noticing timeline around these exceptions? - State Follow-up: • This would be part of the explanation that goes out to all of the Pathways eligible individuals. This information would be included with the requirements about the program, as well as in the contract.	
10	Good Cause Exception If an individual has cancer (or another serious illness) while not already in Georgia Pathways and is unable to work because of current illness, does this individual have the opportunity to apply?	Jen	- There are other programs in the State that can assist these individuals. - The State has not included any categorical exemptions. The short-term exceptions apply to individuals who have already qualified for Pathways coverage. - The State has compiled a list of programs that are available to certain individuals, such as individuals with disabilities, which was shared earlier today with CMS. - CMS Follow-up: • There might not be a pathway to Medicaid coverage for someone who is ill in a way that prevents them from performing Community Engagement activities but may not be sick enough to be on SSA. - State Follow-up: • The State can provide additional information on state funded programs for individuals who fall into this category.	State to provide additional details on current resources available for individuals with Cancer or Other Defined Illness
11	Good Cause Exception Has the State defined other kinds of exceptions that will be approved within reason? For example, if an individual is injured in an accident and is no longer able to drive.	Melissa	- In this example, the individual would receive a Good Cause exception. - The State cannot contemplate every distinct scenario that would prevent an individual from meeting the hours and activities threshold but will take into account various cases where an individual is prevented from working. - The State is not expanding Medicaid into the currently ineligible population. The State is providing pathways to coverage for the currently ineligible population. - Absent this waiver, 100% of this population in Georgia will not have access to Medicaid coverage. With this waiver, a good percentage of the currently ineligible population will be able to enter a pathway and get Medicaid. - The State has other resources available to for individuals who are ill or may not be able to meet the requirements for Pathways. - CMS Follow-up: • While a State program may provide assistance to an individual who would be barred from applying for Pathways due to not meeting Community Engagement requirements, they are not provided the same coverage or protections under those programs. • The concern is that someone's condition would have to improve before they can get on a pathway. - State Follow-up: • Is the concern primarily a policy one or legal concern? - CMS Follow-up:	

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			There might be both policy and legal concerns. In terms of a policy concern, this could be an equity issue, where an individual who is ill is treated less favorably than an individual who is able-bodied.	

#	Topic	Raised by:	CMS Response:	Follow-up:
1	Budget Neutrality	Dina	CMS acknowledged receipt of the requested Budget Neutrality document.	N/A
2	Discussion topic next week	Dina	Next week's conversation will continue with follow-up questions on premiums and community engagement. If the State has any additional topics, they will be provided on Monday or Tuesday.	N/A

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 3/13/2020**Subject:** Premiums/Cost Sharing, Tobacco Surcharge, Fraud/Abuse

Attendees: **CMS:** Payne, Dina P. (CMS/OC); Height, Melissa; Shaw, Shante L. (CMS/CMCS); Sheer, Jenn; Gibson, Alexis; Nora, Lorraine; Davis, Lavie; Rodriguez, Matt; Hawkins, Etta;
DCH: Fulenwider, Blake; Greene, Yvonne; Butler, Marvis; Dowd, Brian
Deloitte: Horn, Wade; Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; McCarthy, John

#	Topic / Question from CMS	From	State Response	Action Item
1	MCO Selection Individuals are required to complete a number of actions prior to enrollment, including CMO selection and premium payment. Will individuals be “on hold” from benefits until all actions are completed?	Alexis	- This is correct. An individual would be “on-hold” until they signed their contract, selected a CMO, and made a premium payment. Once this payment is received, they would be enrolled on the first of the next month. - It is still an open question as to whether the State will pursue auto-enrollment or allow for an active selection. Currently, the State allows for “passive enrollment”, in which all MCO-eligible members are auto-assigned and then allowed 90 days to make an active change. CMS Follow-up: - From the Managed Care perspective, there is no problem with the State’s auto-assignment process. Expenditure authority would be required if the State was not intending to allow for 90 days to change plans. State Follow-up: - The State is considering allowing consumers to shop for their plans to make an active plan selection, pay their premium, and then be eligible for coverage to begin the first of the next month in order to mirror the experience in the commercial market. Individuals could still select to be auto assigned. The State has not made a definitive decision on the process. - Does CMS see any concerns with this approach? CMS Follow-up: - This is the first time hearing about this concept. It makes sense to allow for beneficiaries to have the best plan possible. This may be a little more difficult to do. We are assuming the State has an algorithm that would handle the population that does not make an active choice. - Would the individual work with an enrollment broker? State Follow-up: - The State’s enrollment broker (MAXIUMS) can assist consumers as part of a point of entry. The individual can work with a particular MCO or compare value-added benefits. DCH provides information through eligibility workers to assist with this a well.	CMS will follow-up internally to discuss the State’s proposed MCO selection process

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			- Regardless of whether an individual is auto-enrolled or makes an active choice, they would have 90 days to make a change. - The State also anticipates that a beneficiary will have the option to actively choose to be auto-enrolled.	
2	MCO Selection Is there a reason why the State wants individuals to make an active choice? Is it because so many people who are auto-assigned end up changing plans?	Alexis	- The State's goal is to mirror the commercial market and help prepare members for the commercial market as they move up the economic ladder. The State would like to test whether providing this assistance will help individuals to move on to subsidized or employer-sponsored coverage.	
3	Enrollment If an individual does not pay their initial premium, what happens to them?	Andrea	- They must pay a premium within 90 days of eligibility determination or start over and reapply. - There would be noticing regarding what the individual is required to do once determined eligible for Pathways.	
4	Noticing Can you talk through the sequencing of notices that are sent regarding a member's eligibility determination?	Alexis	- A notice is generated by the integrated eligibility system when an individual is determined eligible. - The State envisions the notice will include information on the required next steps, including MCO selection and paying the first month's premium (if applicable). - Enrollment may take place starting the first of the month following completion of these steps.	
5	Noticing Is the State able to provide a timeline that lays out when notices for failure to provide Community Engagement will be sent, and provide information on the notices?	Dina	- The State would like to come back to that question next weeks. We are currently in internal discussions on noticing.	State will provide more information on notices next week (3/20)
6	Suspension for Failure to Remit Premium On page 14 of the application there is an indication that capitation payment will be recouped for the month when the individual will be suspended. How will the State operationalize this process? Will the individual be notified prior to the recoupment process?	Dina	- Since the waiver was submitted, a different approach has been taken to align the suspension process with the State's current process for CHIP. In the waiver, capitation payments would be made to CMOs and claims would be pended during suspension. Since then, the decision has been made that there will be a 2-month grace period prior to suspension in which the capitation rate is still paid, and claims are paid and not pended. - There will be no need to recoup payments in this proposed approach. CMS Follow-up: - Is it correct that the intended policy will be that failure to pay a premium could trigger a loss of benefit? Will there be advanced notice of an individual's suspension? State Follow-up: - Individuals will be notified on or around the 23rd of the preceding month when premium payments are due. This allows for processing time to ensure payments clear. If payments are not posted, a notice will be generated to notify that premium payment has not been made in month 1. If payments are not issued, there would be a secondary notice in month 2. In month 3, a third notice would explain that if no action is taken, they are subject to termination.	

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			- There will be multiple notices, with individuals given at least ten days notice prior to suspension.	
7	Suspension for Failure to Remit Premium Can the State confirm that the two-month grace period that previously involved recoupment will no longer apply? In the revised process, once the suspension is triggered, there will be no more payment made to the CMO.	Terri	- The member has a grace period for 2 months. If they continue not to make their premium payments after the 2 months grace period, they enter a suspension period and will be disenrolled from the MCO. There will not be any capitation rates paid to their MCO, or claims paid while in suspension. Therefore, there would be no need to recoup. - The member is still receiving benefits during a grace period, even though they are not paying a premium.	
8	Suspension for Failure to Remit Premium If a person is suspended and ultimately disenrolled, is there recoupment at that time? Is the premium a collectable debt by the State?	Alexis	- The State has determined that the level of effort and cost to pursue premiums owed is not worth it. - During the grace period, the individual will have the ability to pay a missed premium. During suspension, a member may pay a premium to get back into Pathways. In addition, at time of redetermination, past debts are forgiven.	
9	Tobacco Surcharge How will individuals be assessed for the tobacco surcharge? Once assessed, will there be an opportunity for the individual to be re-assessed outside of the appeal process?	Dina	- The State has posed a tiered tobacco surcharge. This surcharge would be identified as a question asked during the eligibility determination process. - These fees will be added to the monthly premium requirement. - If someone believes they are being charged incorrectly, they have the option to appeal. - If someone engages successfully in tobacco cessation, they have the opportunity to have the fee lifted. There are ways for people to get out of this charge, once they demonstrate that they are doing smoking cessation. CMS Follow-up: - Is there a minimum number of smoking cessation classes required to lift the surcharge? State Follow-up: - There would need to be more than one, but this has not been detailed yet. This would be written into the operations plan.	
10	Fraud/Abuse Page 9 of the application indicates that if a member does not report changes in employment status in a timely manner, the member will be liable for capitation payments on their behalf. What is the process envisioned for this recoupment?	Dina	- The obligation shifts from active to passive reporting after 6 consecutive months of reporting. After 6 months of monthly reporting, the member is obligated to report a change in community engagement participation. The State will validate this through random audits to check if a member has become non-compliant. - The obligation would be placed on the member to make those capitation payments back to the State because they were incorrectly paid on their behalf. CMS Follow-up: - What is the State's current practice if a beneficiary fails to timely report a change in circumstance (e.g., if a member reports their job was lost one month prior)? State Follow-up: - The State may seek to recoup this payment and has the option to take that approach but has never done this. CMS Follow-up:	

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			- CMS is in the process of working through guidance on various beneficiary penalties. CMS had a goal of releasing this in mid-summer, but we have a delay with COVID-19. - Recoupment from beneficiaries under a state plan or under an 1115 is not allowable. Beneficiaries have due process rights by Medicaid, the Constitution, and Case Law, that prohibit recoupment from beneficiaries. - When money is recouped from beneficiaries back to a point in time, this serves as a retroactive termination of benefits. State Follow-up: - In the past, the State may have a member determined not eligible to receive benefits for a variety of reasons. That individual may appeal the denial, reduction of services, or termination or suspension. If the State's decision is upheld, they can go back and recover from the beneficiary to the extent that those services were rendered. - Is CMS saying that the State does not have the authority to do that? CMS Follow-up: - The distinction here is a difference between recovering for benefits provided between date of action and hearing. 42 CFR 431230 B allows for recovery from the beneficiary. - If an individual calls the State in March to claim job lost in February, the State will need to treat this as a change in circumstance and redetermine eligibility prospectively. If they are longer eligible for Medicaid, 10 days of advanced notice is required from the date of redetermination to inform the individual they are no longer eligible for Medicaid. - The State cannot recoup the prior month capitation payment.	
11	Member Rewards Accounts How does the State envision tracking the 5% cost sharing cap for the Member Rewards Account?	Dina	- The State requests to follow up on this topic during next week's discussion.	State will provide more information on 5% tracking for the Member Rewards Account next week, on 3/20

#	Topic	Raised by:	CMS Response:	Follow-up:
1	Acknowledgement of Receipt of Resource Document for Individuals with Cancer and other conditions	Dina	• CMS would like to table discussions related to this document until next week. • CMS will share additional resources for future conversations around this topic.	CMS will share additional resources on 3/16 for discussion on 3/20

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Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 3/20/2020**Subject:** Noticing and Cost Sharing**Attendees:** **CMS:** Payne, Dina P. (CMS/OC); Chesnick, Matthew; Ross, Heather; Height, Melissa; Sheer, Jenn; Gibson, Alexis; Pak, William; Nora, Lorraine; Davis, Lavie; Rodriguez, Matt; Hawkins, Etta; King, Serge; Moss, Allen**DCH:** Fulenwider, Blake; Butler, Marvis; Dowd, Brian; Middlebrooks Sandra; Rhodes, Lynnette; Krull, Matthew; Ashlaw, Stefanie; Luca, Lavinia**Deloitte:** Horn, Wade; Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; McCarthy, John

#	Topic / Question from CMS	From	State Response	Action Item
1	Notices Timeline (Premiums) What is the sequence and timing of notices during suspension for premium payment?	Dina	[Reference to 1115 Waiver Notices Document Sent 3/20 – Slide 6] - Members will receive ample notice regarding outstanding amounts that are due which clearly state the consequences for non-payment. - If a payment is missed on the 7th of the month, a notice is sent on the 8th of the month (“First Notice of Incomplete Payment”); this first notice provides information that a grace period and suspension will follow if non-payment continues, indicating effective dates of each. - If no payment is made, the member will enter a grace period for premium payment. If a payment is again missed on the 7th of the month, a second notice is sent on the 8th of the month (“Second Notice of Incomplete Payment”); this second notice provides information about the grace period and that suspension will follow if non-payment continues. - If no payment is made, the member will remain in a grace period for premium payment. If a payment is again missed on the 7th of the month, a third notice is sent on the 8th of the month (“Third Notice of Incomplete Payment”); this third notice provides information about the grace period and that suspension will follow if non-payment continues. - If no payment is made, the member will receive a final suspension notice is sent 14 days in advance on the 24th of the month indicating the member will move in to suspension at the start of the next month.	
2	Notices Timeline (Premiums) Will all notices indicate the effective suspension date? In this example, will information that suspension will be effective on 9/1 be included on the notices sent on 8/8 and 8/24?	Jenn	- Correct. In this scenario, the notices sent on 8/8 and 8/24 will state that if an individual fails to make a payment, suspension will take place on 9/1.	
3	Notices Timeline (Premiums) How is the ten-day adverse action notice incorporated in this timeline?	Matt	- Georgia provides 14 days of notice before adverse action. Each monthly reminder on a missed premium payment will notify individuals of the effective suspension date. This gives members effectively 3 months of noticing prior to suspension.	

			- In this example, the 8/8 notice serves as the “final” warning that this is the last month that they will receive coverage if they don’t pay by the 23rd. - On 11/16 in this example, there are 14 days of notice provided in advance of adverse action, prior to termination on 12/1.	
4	Notices Timeline (Community Engagement) What is the sequence and timing of notices during suspension for Community Engagement (CE)?		[Reference to 1115 Waiver Notices Document Sent 3/20 – Slide 8] - The timelines are aligned as much as possible between CE and premium payment. The big difference is that individuals do not get a grace period for CE if they fail to report timely. They can always request a good cause exception if they are unable to meet the CE requirement in a given month. - In the case of CE, if an individual fails to report, they go into a suspension. - In this scenario, the individual gets a notice on the 8th if they did not report. This notice will include information that they will go in to suspension on 7/1 if they do not report by the 23rd of the month. - On the 24th of the month, if the individual fails to report, they will get a notice saying that they are suspended starting on 7/1. - Similar to the situation for premiums, a member would also be sent a termination notice 14 days in advance of their termination date if they did not report CE during suspension. [Reference to 1115 Waiver Notices Document Sent 3/20 – Slide 9] - If an individual is non-compliant on both CE and premiums, the suspension notice received provides information on non-compliance due to both areas. - CE compliance takes priority over premium payment. In the scenario, the individual will enter suspension immediately due to their CE non-compliance (instead of entering a second month of grace period due to premium non-compliance). CMS Follow-up: - If an individual is enrolled and has failed to report CE, what is the consequence? State Follow-up: - There is no grace period for failing to report CE in the waiver. They will receive notices that they will be suspended at the end of the month if they fail to comply. There is a grace period provided for missed premium payment. - The due date for both premium payment and CE reporting is the 7th of each month; notices will be sent on the 8th of each month to indicate any form of non-compliance. CMS Follow-up: - If an individual participating in Pathways fails to meet the activities threshold in June, on June 1 a letter will indicate failure to meet requirements. Will that letter indicate that they have until the 23rd to report? State Follow-up: - The deadline for reporting will be the 7th of each month. In this scenario, the member needs to report their May hours by June 7. - If not reported by June 7, the notice is sent on June 8, indicating that the member will need to meet the required hours and activities by June 23, and	

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			that failure to meet the requirements by that time will result in suspension effectuated on July 1. - Individuals may opt to get paper or electronic notices.	
5	Notices Timeline (Community Engagement) What would happen if an individual doesn't report CE and submits a Good Cause exception, and this exception is rejected? Or if the individual submitted self-attestation that work was done, but not the required documentation? Is there extra time for compliance in these circumstances?	Melissa	- If attestation is submitted without documentation, the individual will still receive the notice on 6/8 that they failed to provide supporting documentation as required; this notice will inform the individual of what is outstanding and they have until the 23rd to submit. - For a Good Cause exception, the individual will have the entire month to file an exception. Once the State makes the review and determination, they will receive a notice from the State indicating the result of the exception. CMS Follow-up: - Are there appeal rights for the denial? State Follow-up: - As per current State processes, the individual will have hearing and appeal rights. This language is currently included on all of the State's denial notices. - In addition, there is no lock-out period in Georgia Pathways. An individual can reapply immediately after being terminated.	
6	Community Engagement and Redetermination If an individual fails to meet CE requirements at the end of their certification, will an individual be able to submit their renewal?	Melissa	- Individuals would need to be in compliance but there is nuance in this circumstance because individuals can submit their renewal 45 days in advance of their end date. Individuals receive their renewal packet 45 days prior to the renewal deadline. - The individual would need to indicate they are in compliance and submit CE documentation at the time of renewal in order to successfully complete their renewal process. CMS Follow-up: - Are the renewal packets pre-populated with the individual's information? State Follow-up: - When the renewal is filled out using the online portal, much of the information is pre-populated. - The State needs to confirm whether the paper renewal forms which are mailed are also pre-populated. State Update Provided 3/25/2020: - When a customer submits a renewal via their online account, their information is auto-populated and displays when they are completing their program renewal(s). At this point, the customer can indicate a change to an existing/most recent record, make additions, or indicate no change to existing information. - When a customer submits a renewal via paper form, they may request that a pre-populated form be mailed to them. CMS Follow-up: - How will the State handle Exparte redeterminations before mailing out renewal packets? State Update Provided 3/25/2020: - The State intends to follow CMS guidance on Exparte redetermination.	The State will provide more details on renewals [Provided 3/25 in Minutes]

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7	5% Cost Sharing Tracking How will the State track the 5% cost sharing limit for the Pathways population? How will the State provide reimbursement for cost sharing when the limit is reached?	Dina	- By the nature of how the program is structured, it is not possible for an individual to incur an out of pocket expense above the 5% limit. - The only true out of pocket expense for an individual in Pathways is the premium, which is set at or below 2%. - Individuals between 0-50% FPL will not pay premiums. - Premiums for individuals between 50-100% are set at or below 2%, including the tobacco surcharge. - Copays are deducted on the back end from the Member Rewards Account (MRA) which is funded through the individual's premium payments and accrued health behavior points. - There is no consequence if the MRA goes negative.	
8	5% Cost Sharing Tracking Will the \$30 Non-emergent Hospital Copay stay within the 5% due to the nature of the copay being deducted from this account, which is credited by premiums?	Terri	- Correct. - When the hospital bills for this service, they are paid the full contracted amount from the CMO. When the State receives the Encounter data from the visit, then the MRA is debited to reflect this activity. CMS Follow-up: - To confirm, if a beneficiary makes a premium payment, this goes into an MRA. If this person goes to the ER, no copayment is required at the point of service. This copay will be billed at a later date against the money paid into the MRA from the member's paid premiums. State Follow-up: - Correct. This payment will be made from the balance in the MRA, which is composed of both premiums and rewards incurred as part of the healthy behavior activities. - This account can go negative with no consequence to the member. For example, if an MRA has a \$10 account balance, and is charged \$30 for an ER visit, the account will be - \$20. There is no recoupment from the state. CMS Follow-up: - Is there any action expected from the beneficiary at renewal to continue enrollment if there is a negative balance? State Follow-up: - No. There will be no impact of having a negative balance at renewal. CMS Follow-up: - So if I am an individual who goes to the ER a lot, and my copayments exceed the value of the MRA, then there would be no consequence to me because the MRA can sustain a negative balance and there is no recoupment from the State? State Follow-up: - Correct. There is no financial consequence to the individual. The only thing the individual can't do is to use points for the uses identified in the waiver.	
9	Non-Emergent Use of ER If an individual visits the ER and is identified as using the ER for non-emergent reasons, and the hospital is paid the full amount, how will the State know that the visit itself qualified as emergent or non-emergent use?	Melissa	- This would be captured in the diagnosis code attached to the claim. For example, in some cases an earache is non-emergent. There would be a set of diagnosis codes received by the state and considered non-emergent. - If the provider indicates that this was in fact a serious situation, this could be handled in the claims and appeals process.	State will provide information on how an individual is informed of

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			CMS Follow-up: - If an individual has an earache, the doctor codes it this way, and treatment is received, would there be a claims appeals process? State Follow-up: - How the hospital gets paid is determined by the CMO payment policy and its contracted rates. The State will review the encounter data and make the determination whether it was emergent and apply the copayment to the MRA as appropriate. State Follow-up: - For the application to the MRA, would the hospital have specific notes on what the individual came in with and the determination of emergent? Normally, the individual is counseled at the hospital on the consequence of a non-emergent use. - If they are not getting charged at the hospital, it is important that they know what is happening and what they are getting charged with. CMS Follow-up: - The State will follow up on the open question regarding counseling and education when a member is presenting to the ER for non-emergent reasons.	non-emergent use next week, 3/27

#	Topic	Raised by:	Response:	Follow-up:
1	Disability Resource documents will be reviewed as the first topic of discussion on the agenda for next week's call, on 3/27	Dina	N/A	N/A

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Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 3/27/2020**Subject:** CE Exceptions/Disability Resources; CE Redetermination Renewal; Non-Emergent ED Copay Overview

Attendees: **CMS:** Payne, Dina P. (CMS/OC); Chesnick, Matthew; Ross, Heather; Height, Melissa; Nora, Lorraine; Davis, Lavie; Rodriguez, Matt; Hawkins, Etta; King, Serge
DCH: Butler, Marvis; Middlebrooks, Sandra; Rhodes, Lynnette; Krull, Matthew; Ashlaw, Stefanie; Luca, Lavinia; Wilson, Joyce; Greene, Yvonne; Ivy, Catherine
Deloitte: Horn, Wade; Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; McCarthy, John; Betlach, Tom

#	Topic / Question from CMS	From	State Response	Action Item
1	Community Engagement and Redetermination Can the State confirm the process in place when a customer fills out their renewal? <i>Our understanding from materials provided is that when a customer submits a renewal, their information will be auto-populated and displayed. At that point, the customer can indicate a change or no change in their information. Additionally, when this is done via paper, they may request that a pre-populated form be mailed to them.</i>	Dina	- This is correct. The Customer Portal is very dynamic. Existing case data will be pre-populated in the renewal form when the individuals begins their renewal process online. - The individual also has the option to contact the agency and ask for a pre-populated form, and the agency will mail that to them. CMS Follow-up: - The State indicated that it intends to follow CMS guidance with respect to Exparte renewals. Is there any additional information the State wants to provide? State Follow-up: - There is nothing further to add to this.	
2	Non-emergent ED Copay Can the State explain the process outlined for informing members of the Non-emergent ED Copay?	Dina	[Reference to “Copay Flow Non-Emergent ED” document sent on 3/26/2020] - For the Pathways Medicaid population, no copay will be made by the individual at the point of service in the ED. - The hospital bills the CMO for the visit and the hospital is paid according to the contract. There is no deduction on the payment to the hospital. - When the CMO sends the Encounter data, the State will look for CPT code #99281, which is the least intensive. This code will be used as a proxy for a non-emergent ED visit. The State will debit the Member Rewards Account (MRA) for the copayment. - A notice will be sent to the member, noting that the visit was identified as non-emergent and stating that the member will have appeal rights to indicate the emergent nature of the visit. - This process will also be outlined in the contract that the individual signs when they enter the Pathways program, providing advanced notice on non-emergent use of the ED. CMS Follow-up: - Is there a process where the hospital is talking to the patient and telling them that the visit is non-emergent, and that they have the option to seek care elsewhere?	CMS will share the cited statute regarding Non-Emergent ED Use with the State

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			State Follow-up: - This process would be up to the individual hospital and the CMO. CMS Follow-up: - If counseling is not received at the hospital and the appeal is made on the basis that counseling was never provided for non-emergent ED use, would the individual win the appeal? State Follow-up: - That would certainly be taken into consideration. CMS Follow-up: - CMS has some concerns about this process, because this is not the way that they envision copays being implemented within the statute. CMS will need to circle back to leadership. State Follow-up: - Can CMS share the specific federal statute cited? CMS Follow-up: - Melissa will provide the statute to Dina to share with the State.	
3	Good Cause Exceptions/Exemptions Will there be opportunities for individuals who are unable to even qualify for or be eligible for the demonstration to receive an exemption or exception to participation? <i>We have some additional questions regarding the exemptions. Our understanding is that individuals would need to be participating in the hours and activities threshold before they can submit a good cause exception. We are requesting clarity on whether there will be opportunities for individuals who would not qualify or be eligible to receive an exemption.</i>	Dina	[Reference to “Georgia Resources for Individuals with Cancer” and “Georgia Resources for Individuals with Disabilities” re-circulated on 3/26/2020] - It is important to keep in mind that Georgia is taking a fundamentally different approach to CE requirements compared to other waivers that CMS has approved. The State is not expanding Medicaid. Today in Georgia, 100% of those persons who are below 100% of the FPL and not eligible for Traditional Medicaid have no access to Medicaid today in the State. - This waiver is designed to provide to those persons currently ineligible for Traditional Medicaid, a means of accessing Medicaid through work, volunteering or enrolling in an institution of higher learning. Without the waiver, 100% of the people in this group are ineligible for Medicaid. - The State is not proposing to provide categorical exemptions for several reasons. - There are many persons with disabilities or cancer who are able to still volunteer, work, or attend an institution of higher learning. If a person with one of these conditions is able to work and chooses not to, they will be treated the same as everyone else. They would not have access to Medicaid through the Pathways model. - For persons with disabilities, it is important to note that many people want to work and be engaged. The Georgia Vocational Rehabilitation Agency (GVRA) operates programs that assists these individuals. GVRA staff have expressed excitement about the Pathways approach and the opportunities it provides to their participants. - For individuals with disabilities that prevents them from being able to work or engage in activity, it is important to note that there are opportunities for coverage through Traditional Medicaid. There are 21 different ABD categories in the State today. The State’s current definition of ABD is either that there is a verified disability record (physical, mental, or blind disability	

			with acceptable verification) or that the individual receives SSI, Railroad Retirement, or Retirement, Survivors, and Disability Insurance (RSDI). - Two particular categories to highlight here are the HCBS waivers. The State's New Options Waiver (NOW) and the Comprehensive Supports Waiver Program (COMP) offer home-and community-based services for people with intellectual disabilities (ID) or developmental disabilities (DD). - For individuals with cancer, there are a number of existing programs in Georgia such as Medicaid coverage for women with breast or cervical cancer under 250% of the FPL. There is also a separate program under the Department of Public Health that provides services to those diagnosed with Cancer who are under 250% of the FPL. - The good cause exceptions are meant for people who satisfy the requirement and suddenly face an unexpected circumstance. There is a time-limited exception for these cases so that their Medicaid is not disrupted. - If the individual who has an exception is permanently unable to engage in activities because of a new disability or diagnosis, then there are other categories of Medicaid or programs that the individual would transition to. - The difficulty with the categorical exemption is that it assumes that everyone in those categories is unable to engage, and that is not true. There are other State resources and programs available for those under 100% FPL who are unable to work, volunteer, or attend an institution of higher learning. CMS Follow-up: - To reiterate, individuals who would not qualify for Pathways would be eligible to receive benefits and coverage through another State-offered service or program. State Follow-up: - That's correct. For example, if someone applied, and it was found out that that individual has cervical or breast cancer, they would be able to receive coverage through that category of Medicaid.	
4	SUD Treatment If a Georgia resident with income under 100% of the FPL is receiving SUD treatment, is the State considering any potential exemptions or exceptions for this individual?	Dina	- A best practice in SUD treatment is to combine treatment with other kinds of activities to help keep people busy and create structure in their lives. - The Department of Behavioral Health and Developmental Disabilities (DBHDD) provides resources and programs for individuals who are uninsured or underinsured who have substance use disorders. CMS Follow-up: - Are individuals in this program receiving Medicaid due to their participation? State Follow-up: - Individuals would not necessarily receive Medicaid because of their SUD participation. DBHDD does serve some individuals on Medicaid. CMS Follow-up: - For individuals in outpatient treatment, are you planning to align with those programs so the individual can participate in qualifying activities?	State will provide information on resources available to individuals with SUD

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			State Follow-up: - That is correct. There are several programs such as job readiness or community service activities that are typically required as part of outpatient SUD programs that would align with Pathways. - There are also other programs throughout Georgia that help individuals get engaged in activities that align with Pathways, such as community service requirements through the Georgia Accountability Court program.	
5	Medically Frail What are the State's intentions around individuals who are medically frail? Could these individuals be eligible by participation in another pathway in order to receive coverage?	Dina	- The State would take the same approach. There are a lot of people who are medically frail who still attend work, school, or volunteer. The intention is not to have categorical exemptions from the CE requirement because not everyone in that category is unable to engage. CMS Follow-up: - CMS has not approved a state waiver to date that does not have a standard exception for the medically frail or assurance of an exemption for individuals who have SUD or are undergoing mental health treatment. - CMS will need to better understand the existing avenues within the State and what services and options exist for these population to position. Additional information on these areas is appreciated. State Follow-up: - This waiver request is fundamentally different from every other CE waiver that has been approved by CMS. In every other case, states expanded and then carved out certain populations and required them to meet an additional standard. - This waiver does not expand Medicaid to everybody. It provides an opportunity for a new category of assistance for new population to receive Medicaid. - Many people in the categories discussed will be able to participate. Those who cannot participate in Pathways will be able to seek assistance from other existing State programs. CMS Follow-up: - CMS is working on an initial draft of Special Terms and Conditions. Once additional information is received from the State, CMS will share these with the State to ensure it is characterized accurately. A preliminary document will be shared in coming weeks to clarify various aspects of the proposal. - Any additional information on available resources will be appreciated.	State will provide information on resources available to individuals who are Medically Frail
6	Cancer State Aid To be eligible under this program, will an individual have to have received a Medicaid denial?	Matt	- When an individual is at a participating facility, they are counseled. If the individual is eligible for Medicaid, they are counseled to apply. - The State does not believe they need to be officially denied for Medicaid to receive CSA support but will confirm.	State will follow-up on Cancer State Aid question regarding Medicaid denial
7	Cancer State Aid	Matt	- The State will double check whether MAGI methodology is used.	State will follow-up on Cancer State Aid question

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	The individual needs to be under 250% of the FPL to participate. Is this based on the MAGI methodology?			regarding MAGI methodology
8	Cancer State Aid Are there waiting lists for these programs?	Dina	- There is an appropriation that the State makes each year for these programs. There sometimes is a waiting list at the end of the year if they run up against the budget cap. There is not one currently. - Typically, 250-300 people are enrolled at any given point in time. Participants are admitted on a rolling basis. - There is a tiered category based on need to assess where someone is in their cancer progression. CMS Follow-up: - How many people typically apply and are denied? State Follow-up: - The State will need to follow up for additional information on application volume from the program.	State will follow-up on Cancer State Aid question regarding application volume

#	Topic	Raised by:	Response:	Follow-up:
1	Next week's call will address Budget Neutrality worksheet. CMS Monitoring colleagues will also provide a high-level overview of the Monitoring and Evaluation Process for the State.	Dina	N/A	4/3/2020
2	Draft STC document is being prepared and may be provided in the next two weeks.	Matthew	CMS will follow-up with leadership team regarding the tentative date for approval and next steps. The internal date set was mid-summer; Dina needs to ensure this date is still accurate. This waiver is still a priority for CMS.	4/3/2020

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Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 4/10/2020**Subject:** Cost sharing wrap option and Pre-suspension notice content**Attendees:** CMS: Payne, Dina P. (CMS/OC); Ross, Heather; Heitt, Melissa; Davis, Lovie; Hawkins, Etta; Shaw, Shante; O'Connor, Sarah; Ma, Allen; Crystal, Frances; Porcher, Tara; Ramsey, Mario**DCH:** Fulenwider, Blake; Krull, Matthew; Butler, Marvis; Middlebrooks, Sandra; Rhodes, Lynnette; Luca, Lavinia; Wilson, Joyce; Greene, Yvonne; Ivy, Catherine; Dowd, Brian**Deloitte:** Horn, Wade; Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; McCarthy, John; Betlach, Tom; Leef, Justin***NOTE*** This first portion of this call was dedicated to review of the State's COVID-19 Request. That conversation is not captured within these notes.

#	Topic / Question from CMS	From	State Response	Action Item
1	Cost Sharing Wrap Options Is the State prepared to discuss the options previously shared? [Reference to "Premium Assistance Payment Language 2.24.20" Document Circulated on 3/31/20]	Dina	- Regarding premiums payments for ESI, the State is moving in the direction of making advanced payments to Pathways members. The details of this process are still being developed. - Regarding the cost sharing wrap, the State has reviewed and discussed these options and believes they are going to be administratively complex to implement. Can CMS share examples from other states on how they have implemented these four options? It would be helpful for Georgia to speak with other states regarding their experience. - The State is most interested in exploring the third option ("Freedom of Choice Waiver") but it would be difficult to do an analysis of network adequacy for commercial health plans. - The State's current cost-sharing proposal is to have TPL handle dually enrolled individuals, so that individuals do not have out of pocket expenses if they see a Medicaid provider in the employer plan's network. If an individual goes to see a provider that was not in Medicaid, then a reimbursement would need to be made. CMS Follow-up: - CMS can provide a few state examples for each of these options. - Only one state is using the "Freedom of Choice Waiver" option and they have been working on getting this process for 2-3 years. The process has been very complex for them. - CMS acknowledges the complexity of conducting a network adequacy analysis, but there would be no option to waive this component. State Follow-up: - What is the willingness of CMS to adapt these four options? Is there an ability for the State to propose an option that is more administratively feasible? CMS Follow-up:	CMS will provide a list of states using each of the four cost sharing examples

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			- A proposed variation to the four options would need to be considered before a definitive answer can be provided. - Because a(2) authority is being used, it is possible that there is more flexibility. CMS will need to consider the specific proposal and modification.	
2	Copays and Non-Emergent ED Appeals The State would like to follow up on this topic from last week.	N/A	- The State acknowledges receipt of regulatory guidance on this matter. - The State wants to clarify that if a member receives a notice regarding a copay for non-emergent use of the ED, and wants to appeal the decision because they were not counseled at the hospital on non-emergent use, this would be grounds for a successful appeal. - In addition, the State wants to reiterate that this is not an out of pocket charge, all copays are deductions from the Member Rewards Account. CMS Follow-up: - This will be considered in CMS's review. To confirm, the MRA is funded by premium charges? State Follow-up: - It is funded both by premiums paid and earned healthy behavior points. - There is no out of pocket consequence for an account going negative.	
3	Pre-Suspension Notice Content In the example provided, notices occur on the 8 th of the month prior to Premium or CE suspension. Do these earlier notices include the specific date of action when suspension would occur if an individual fails to pay a premium or report CE hours? [Reference to "1115 Waiver Notices_CMS 03-20-2020_vF" Document Circulated on 3/20/20]	Jennifer	- That is correct. The first notice sent on the 8th of the month when someone fails to pay a premium or report CE would include language of potential adverse selection, including information on dates of suspension if failure to comply. - The intention is to make sure that the individual has sufficient notice and opportunity to come in to compliance prior to suspension. - The State wants to reiterate that in the first month of a missed premium, an individual enters a grace period (with no loss of coverage).	

#	Topic	Raised by:	Response:	Follow-up:
1	Discussion of exempted population will take place during next week's call, on 4/10	Dina	The State will share documentation mid-week next week regarding resources available for individuals with SUD and considered Medically Frail, as well as provide follow-up responses for the questions on the Cancer State Aid program	N/A

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Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 4/17/2020**Subject:** Review of Budget Neutrality and Monitory & Evaluation Deliverables**Attendees:** CMS: Payne, Dina P.; Hawkins, Etta; Ross, Heather; Ma, Allen; Shaw, Shante; Chesnick, Matt

DCH: Fulenwider, Blake; Krull, Matthew; Luca, Lavinia; Dowd, Brian; Wilson, Joyce; Holloway, Kelvin; Willis, Carla

Deloitte: Horn, Wade; Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; McCarthy, John; Betlach, Tom; Gordon, Darin; Fitzpatrick, Tim

#	Topic / Question from CMS	From	State Response	Action Item
1	Budget Neutrality [Reference to Document “Georgia 1115 Waiver Submission Model” Circulated on 4/17] The WW and WOW calculations were derived using 2017 base PMPM. Can you give us an overview of why you chose to use 2017 data and whether those are based on projected or actual math?	Dina	- All of the historical data used is actual data and is based on encounter data. - Data from 2017 was used because the analysis started in June 2019. At that time, 2017 had well over one year of run-out, whereas 2018 only had five months. - Additionally, there was a large eligibility system change in 2017 and 2018 that impacted how eligibility was cascading for different population groups. In 2018, the Low-income Medicaid (LIM) population experienced a much larger growth rate (11%) than was experienced in prior years from 2015 – 2017 which was less than 5% annually. - We used 2017 and prior years because it was more stable than 2018 from both a member months perspective and claims perspective which is why it was used.	
2	Budget Neutrality Does the Base PMPM GF Medicaid (YRS 45+M) & (YRS 45+F) population data include individuals 64+?	Dina	- Yes; however the number of individuals over 64 in this data is minimal and would not impact PMPMs. - The total population is 1.5 million member months and 232,618 individuals. - Only .03% (or 60-70 total individuals) of the LIM base population are under 19 or older than 64, so the impact is immaterial. CMS Follow-up: - Please provide this information in writing after the discussion.	State will provide budget neutrality responses in writing [Responses provided in Meeting Minutes]
3	Budget Neutrality Can you explain the growth factors incorporated in this document?	Dina	- We realize that we as a nation are now going through a period of extreme unemployment. But by the time the waiver starts in July 2021, employment will hopefully pick back up. We are not ignoring this impact but don't want to change assumptions at this time. - Growth factors represent a growing number of Georgians meeting the community engagement requirements. There are several assumptions driving enrollment, such as Georgia's uninsured population size (this has been historically declining), the general population increase over time (at 2% which is the majority of the change), those meeting the community engagement requirements, and program effectiveness encouraging growth in community engagement.	

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			- We applied a growth rate assumption of expected new enrollees meeting the Pathway requirements each year. - The assumption for working growth factor is increasing from 2% in DY1 to 4% by DY5. - Further, external forces, such as current economic conditions, could drive the base uninsured population up or down, given workforce opportunities, etc. - A normal churn is expected with this program, as well as program growth due to encouragement of the program.	
4	Budget Neutrality Can you explain the population shift adjustment incorporated in this document?	Dina	- The population shift adjusts the distribution of the different Medicaid eligibility groups from the LIM population in the historical data to the population distribution we saw from other similar populations eligible for Pathways. - We believe that the population eligible for Pathways will be more reflective of expansion populations in other states. - We used a study by the Society of Actuaries that looked at expansion population distributions for the 21-44 and 44+ age groups. - We also assessed statistics provided for Idaho, Washington, and Ohio on their expansion populations. - The “assumed distribution” uses these different resources to estimate the population mix from both an age and a gender perspective. We applied that to the Georgia LIM Medicaid eligibility groups. - The population shift adjustment factor is applied to reflect the reweighting of the 2017 PMPMs using this “assumed distribution.” CMS Follow-up: - Additional questions may be provided via email.	
5	Monitoring and Evaluation The CMS M&E Team will provide a high-level overview of demonstration deliverables in order for the State to understand post-approval deliverables Are there any initial questions upfront?	M&E Team	- The State has an existing 1115 waiver, so this is not entirely new to us. However, that is for a target population with limited benefits. - As we look at a broader scale waiver, what differences should we anticipate in terms of reporting? CMS Follow-up: - There are some similarities in terms of the reporting timelines. - However, given the scope of the eligibility and coverage policies encompassing premiums and community engagement, there are more rigorous reporting requirements. This applies both to monitoring and evaluation. - There is a set of metrics CMS has developed that states should be monitoring. - There are also more rigorous expectations of developing an evaluation design. Different from the Family Planning waiver, this is a first-time implementation, and there are pre and post baselines required. - If the State plans and thinks through these items early enough, there is opportunity to effectively evaluate the program.	
6	Monitoring and Evaluation	M&E Team	[Reference to Document “Georgia’s Section 1115 E&C Demonstration-ME Overview” Circulated on 4/17]	CMS will share examples of

The CMS M&E Team provided an overview of key deliverables and timeline.	Slide 4: - CMS has guidance on various metrics that could be used and how evaluation information should be captured. This information will also be laid out with clear expectations provided in the STCs. - The Implementation Plan is due 90 days after the approval. The State should start thinking about this from now. There are a lot of system and support service changes that need to be in place. Between approval and implementation, having a gap in time is better for states and gives them time to implement. Keep in mind there will likely be at least one if not two revisions of the Implementation Plan. - If the implementation plan is submitted earlier, CMS can give feedback sooner (however, not before approval). The sooner CMS can provide reaction to the Implementation Plan, the sooner this feedback can be considered for program implementation by the state. - The Monitoring Protocol document is new, which has not been seen for Family Planning. This is due 150 days after completeness determination of the Implementation Plan because what is going to be monitored will be settled in the Implementation Plan. - The Monitoring reports are at same frequency as for the Family Planning waiver: quarterly, 60 days after each demonstration quarter, and annually, 90 days after each demonstration year. This means there will be three quarterly reports and one annual report (in the fourth quarter). - The Evaluation Design is due 180 days after demonstration approval. The state will need to provide two Evaluation reports. - An interim report is due 12 months prior to end of approval period, or with the renewal application. Typically, the interim report captures for the first three years of the demonstration period. - The summative report is due 18 months after the end of the approval period to ensure data validation and surveys are properly completed. Slide 6: - There is guidance available on the Implementation Plan, including plan topics. If the State would like to see more documentation, CMS can provide in order to guide the Implementation Plan Slide 7: - There are specific documents to be used for the Monitoring Protocol which need to be followed. - There is similarity between the Monitoring Protocol and the Monitoring Report Templates. They are two separate docs for reporting and protocol phases. Slide 7: - There are 80 required metrics across various eligibility and coverage metric modules.	approved evaluation designs with the State

			- “Module 1” applies to all demonstrations (including metrics on enrollment, coverage, access to care, etc). These are not defined by states, but there is structured guidance on how states report on these metrics. - “Modules 2-6” vary across demonstrations. Slide 11: - The Technical Specifications Manual document is not publicly available. CMS will require the state to read through certain terms, and the state needs to acknowledge agreement to terms and the manual is sent. - This document is something that the state will get access to through email. - Many of the other documents are available on Medicaid.gov. Slide 12: - CMS has specific guidance on eligibility and coverage policy areas, including individual appendices for each of the policy areas. - There is a master narrative document that lays out the approach that states should be pursuing in terms of methodology, data sources, rigor and robustness of evaluation. - There are individual appendices devoted to each policy area. - States have flexibility in the evaluation as there may be a goal or objective that is nuanced compared to other states. However, states are required to cover core policy expectations. Slide 13: - States that have independent evaluators onboarded sooner allows to plan for implementation to occur in conversation with them. States could think about random assignment (to use an RCT), or use groupings by age group or other characteristics, which will help get causal effects of how a policy leads to certain outcomes. - States with the strongest evaluation design had solid relationships with independent evaluators before approval. That said, CMS recognizes that this is not always feasible. - This guidance document allows for modification, but this guidance comes from alignment with STCs. This will help move the process faster to approval of evaluation design. - CMS encourages states to get familiar with these requirements because this will help for planning. Slide 14: - We are always available to answer any questions or provide information using the mailbox 1115MonitoringAndEvaluation@cms.hhs.gov State follow-up: - Is there any state with a design document that CMS has a strong preference for which has already been approved that the State can model after? CMS follow-up: - We are very close to approving a couple of designs that have solid evaluation designs. CMS will see if this can be shared publicly because some of these are held up in the courts.	

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#	Topic	Raised by:	Response:	Follow-up:
1	Next Week Agenda	Dina	- CMS will provide agenda items early next week as they are still working out additional items internally	

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Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 5/1/2020**Subject:** HIPP Cost-sharing Wrap Approach**Attendees:** CMS: Payne, Dina P.; Hawkins, Etta; Ramsey, Mario; Ross, Heather; Heights, Melissa

DCH: Fulenwider, Blake; Krull, Matthew; Luca, Lavinia; Dowd, Brian; Wilson, Joyce; Middlebrooks, Sandra; Ashlaw, Stefanie; Rhodes, Lynnette

Deloitte: Horn, Wade; Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; McCarthy, John; Betlach, Tom; Fitzpatrick, Tim

#	Topic / Question from CMS	From	State Response	Action Item
1	HIPP Cost-sharing Wrap Approach [Reference to Document “GA Pathways_Proposed Cost Share for HIPP” Circulated on 4/20] Can the State provide an overview of the proposed approach for the mandatory HIPP cost-sharing wrap?	Dina	Overview of Document “GA Pathways_Proposed Cost Share for HIPP” Circulated on 4/20 Slide 2: - The State has developed a process in consultation with its HIPP vendor in order to make advanced payments for premiums for the mandatory HIPP population of Georgia Pathways. - The State has also developed a process to address cost-sharing. This process addresses cost-sharing with both Medicaid and Non-Medicaid providers. - o For Medicaid providers, the current TPL process will be leveraged in which the State makes copayments directly to the provider. - o For Non-Medicaid providers, the beneficiary can notify the State of an upcoming appointment to receive advanced payment. In addition, the beneficiary will have access to a letter that can be shared with the provider at point of service to outline how the provider will receive payment for services. Slide 3: <i>Provider both in the Employer’s Health Insurance (ESI) Network and Medicaid:</i> - In the initial HIPP enrollment notice, members will be encouraged to seek a Medicaid provider within their network. - The current process of providing payment to the provider will follow. If a member obtains care from a provider that is both a Medicaid participating provider and participating in the ESI network, Medicaid pays after the ESI plan and other third-party resources are exhausted, up to the Medicaid negotiated rate <i>Provider in the ESI Network but not Medicaid:</i> - If a member seeks care from a non-Medicaid enrolled provider, they will have various options available to them, which include: 1. The member may request an advance of the cost-share if the amount is known, if the request is made at least thirty (30) calendar days before payment is due;	

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			2. The member may download or request a letter to give to the provider at the point of service which includes instructions on how the copay will be paid; 3. The member may provide information to the provider on enrollment into the Medicaid network. Slide 4 - The process of receiving an advance of the cost-share will work as follows: - o The member will submit a bill, invoice or other document demonstrating the member's liability to the Department of Community Health (DCH) at least thirty calendar days before payment is due. DCH will pay the HIPP member and/or ESI provider prospectively for the member's cost-sharing obligations when the necessary information is submitted. - o DCH may, at its discretion, pay cost-sharing obligations if the member submits a bill less than thirty calendar days before payment is due. - In addition, the member can download or request a letter to share with the provider at the time of service that will advise how the TPL vendor will work with the provider to secure payment for services usually collected at the time of service. The letter will also provide instructions for joining the Medicaid network. - o If the provider is requiring the member to submit payment at the point-of-service, the member can share this information so that the provider can contact the Georgia Pathways HIPP department. - o In this case, a caseworker will work with the provider to have a bill sent to the HIPP department for reimbursement. - The State believes that this proposal is consistent with CMS' desire to ensure the member does not go out of pocket. The State has also worked to ensure that this is a process that can be implemented with current resources. CMS Follow-up: - CMS approves of this approach for the cost-sharing wrap and appreciates that the State has put thought into developing this process.	
2	Advance Premium Payment What is the State's proposed approach for providing advance premium payments to its mandatory HIPP members?	Mario	- The State has a process flow with a timeline that lays out how this process would work. The State can forward this documentation for CMS' information. CMS Follow-up: - CMS will review this documentation and may follow-up via email or in an upcoming call if there are any questions about the proposed approach.	State will provide documentation on advance premium payment timeline early next week

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#	Topic	Raised by:	Response:	Follow-up:
1	Update on Draft STCs	Blake	- Internal work is still ongoing and additional feedback from leadership is still required. The original timeline has not changed.	CMS will share an update early next week
2	Providing Examples of Implementation Plan and Evaluation Design	Sadie	- Dina will share general M&E design guidance which has been provided by M&E colleagues. - CMS can share specific examples from other states in the near future once they are publicized.	CMS will share an update early next week

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Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 6/12/2020**Subject:** STCs Draft Content Outline Review**Attendees:** CMS: Payne, Dina P.; Kostasich, Jennifer; Shaw, Shante; Ma, Allen**DCH:** Fulenwider, Blake; Krull, Matthew; Luca, Lavinia; Dowd, Brian; Rhodes, Lynnette; Wilson, Joyce**Deloitte:** Horn, Wade; Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; McCarthy, John; Betlach, Tom; Fitzpatrick, Tim

The notes below do not capture the full, detailed walk-through of the State's proposed modifications to the draft STCs but rather capture the discussion areas/questions from the conversation when reviewing the document entitled "GA 1115 CONTENT OUTLINE" sent to CMS on 6/9/20.

#	Topic / Question from CMS	From	State Response	Action Item
1	120 Hours of Qualifying Activities Good Cause Exception The inclusion of a maximum of 120 hours of good cause exception is a new detail that the state has included. Can the state provide an overview of how this will work for a beneficiary?	Dina	- The state has clarified the definition of temporary good cause exception and further defined how it will operationalize it. To reiterate, this is not an exemption, it is a time-limited exception for those in the program. - By translating the exception from months into hours, there is greater flexibility for the beneficiary. For example, if the beneficiary was only able to complete 70 hours in a month because they were in the hospital for a couple of days, they would only need to use 10 hours of their good cause exception to supplement the 70, in order to reach 80. In this proposed approach, the member can spread the good cause hours over more months as needed, which provides more flexibility to the member.	
2	Reasonable Modification for Qualifying Activities The state has provided additional information in STC 27.d.i on how a beneficiary can request a reasonable modification. Can the state provide more information on how the process will work to rerun Medicaid eligibility for other classes of assistance in this circumstance?	Dina/ Jennifer	- When an individual applies for the Pathways program, the State's integrated eligibility system will cascade them through all existing Medicaid eligibility groups before they are determined eligible for Pathways. - Similarly, when an individual is terminated from Pathways, the system will first check to see if they are eligible for another category of assistance prior to termination. - If an individual who is enrolled in Pathways requests a reasonable modification in order to meeting the Qualifying Activities, the State will work with that individual to identify potential options. - If the individual does not accept the State's proposed modifications, they would first be run for eligibility for other categories of assistance prior to termination from the Pathways program. - In addition, at termination from Pathways, this individual will have full appeal rights. CMS Follow-up: - To confirm understanding: An individual will initially go through the cascade to see if they may qualify for another class of assistance outside of the demonstration. If the individual ultimately enters Pathways, and later needs	

			a reasonable modification, they can request this through the good cause exception process. Prior to termination, the State will rerun Medicaid eligibility to determine if the individual is eligible for another category. State Follow-up: - The State confirms this is correct. In addition, if a beneficiary cannot meet the Qualifying Activities threshold, even given reasonable modification, they would likely be eligible for another class of assistance such as ABD. CMS Follow-up: - Can the State expand further upon which modifications would not be feasible? State Follow-up: - The State could envision a situation in which a beneficiary has become severely disabled, without the opportunity to meet the Qualifying Activities threshold. In this circumstance, they would likely be eligible for another Medicaid category under ABD. - The State has also included the provision that should the beneficiary not accept the modification, eligibility will be rerun prior to termination. The State believes that most beneficiaries will be able to reach a modification and may complete a certain number of Qualifying Activity hours. - Given this, a beneficiary will only be disenrolled if they do not accept the modification, or if not eligible for another class of assistance. In this case, they have appeal rights.	
3	CMO Assignment If an individual does not pro-actively choose a CMO in the application process and is auto-assigned, is there a potential for their enrollment to be delayed?	Jennifer	- No, enrollment will not be delayed if an individual does not make a CMO selection. - As a condition of eligibility and enrollment, an individual will need to select a CMO within their application or they will be auto-assigned if they do not make a choice. They will also be required to pay their first month's premium, if applicable, for Pathways coverage to begin the following month.	
4	Premium Assessment How will the premium be assessed for a household with more than one individual? For example: In a household where one individual is employed with income above the 50% of the FPL, while another individual does not have a premium requirement, will only one individual pay the premium?	Jennifer	- The State confirms this is correct; premium amounts will be assessed at the individual level based on MAGI income eligibility rules.	
5	Member Rewards Account (MRA) Do beneficiaries below 50% of the FPL have the same rights and access to the MRA as those above 50% of the FPL?	Dina	- The State confirms this is correct. Members below 50% of the FPL will accrue funds in their account by completing healthy behaviors similar to those above 50%. - The only difference between those below and above 50% of the FPL is that members above 50% FPL are required to pay premiums and that amount will also be credited to their accounts. Member under 50% do not have a	

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			premium requirement; their account will only accrue value through the completion of healthy rewards incentives.	
6	Member Rewards Account (MRA) If there are households with two individuals, will each have their own separate account?	Dina	- That is correct. Each individual will have their own account.	
7	Premiums Can the state explain the difference between the 90-day period for the initial premium payment and the two-month grace period on an ongoing basis?	Dina	- Grace periods apply to individuals who are already enrolled in Pathways and who miss a premium payment. A beneficiary is granted a two-month grace period to make up missed payment, before entering a 90-day suspension period in which their CMO capitation rate is not paid and they are no longer covered. If they make a payment during that 90-day suspended period, they will be prospectively placed back in pathways. - The 90-day time period for initial premium payment is applicable <i>before</i> an individual enters Pathways. After someone is determined eligible for Pathways, the State will leave a case open for up to 90 days to allow an individual to make a payment in order to begin coverage. The State will send reminder notices to individuals who are determined eligible but have not submitted a premium payment. At the end of that 90 days, if they have failed to make a payment the case will be closed, and the individual will have to reapply for medical assistance. CMS follow-up: - Prior to suspension, does a beneficiary need to make up all missed payments in order to exit the grace period? State follow-up: - No, the individual needs to only make one payment in order to avoid suspension if they have accrued two months of grace periods for two missed premium payments. - It may be helpful to think of it as a “counter” in order to conceptualize how the grace periods work. A beneficiary may have two missed premium payments, so two months of grace period. As soon as a beneficiary accrues a third missed premium payment, they enter the 90-day suspension period. - The beneficiary can back-pay missed premium payments in order to reduce the count of missed premiums. - The counter will reset at each redetermination period and the member is not held responsible for any past due premium amount.	State to send premium payment timelines that illustrate grace and suspension periods
8	Post-Medicaid Expenses for the MRA The state indicates there will be a run-out period for a beneficiary’s remaining balance to be used. How will this be operationalized?	Jennifer	- The State has not fully defined the details of this process but plans to include within its operational plan. - The MRA is envisioned to work in a similar way to an HSA, as a transactional service run by a third-party administrator with funds available for defined, acceptable expenses during a run-out period. - The full list of acceptable expenses is still being defined, but will include the ability to pay premiums if the individual transitions above 100% of the FPL and enrolls in commercial coverage.	State to share additional details related to it currenting thinking on the MRA and run-out period

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#	Topic	Raised by:	Response:	Follow-up:
1	Premium Grace Periods and Suspensions	Jennifer	- State to send premium payment timelines that illustrate grace and suspension periods	Week of 6/15
2	MRA Run-Out Period	Jennifer	- State to share additional details related to it currenting thinking on the MRA and run-out period	Week of 6/15
3	Next Steps	Dina	- CMS will provide with agenda items and next steps for the upcoming discussion early next week.	Week of 6/15

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 6/19/2020**Subject:** STCs Draft Content Outline Review #2**Attendees:** CMS: Payne, Dina P.; Hawkins, Etta; Shaw, Shante; Taylor, Julian; Ross, Heather

DCH: Fulenwider, Blake; Krull, Matthew; Luca, Lavinia; Dowd, Brian; Wilson, Joyce; Ashlaw, Stefanie; Butler, Marvis; Ivy, Catherine

Deloitte: Horn, Wade; Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; McCarthy, John; Betlach, Tom; Fitzpatrick, Tim

#	Topic / Question from CMS	From	State Response	Action Item
1	Run-Out Period for MRA The information submitted by the state on the MRA shows that the state is considering a 90-day timeframe for a run-out period. Has this timeframe been confirmed, or is this still under development?	Dina	Reference to document “GA 1115 Waiver MRA Transitions” shared with CMS 6/17 - The state issued an RFI to get a better understanding of what potential MRA vendors can do from an operational standpoint. The idea conceptually is to have a 90-day run-out period. There may be variations or constraints from the industry that the state is not aware of. - As documented in the materials shared, there are different scenarios anticipated. If an individual transfers to another class of assistance, they will maintain their account for as long as they are enrolled in Medicaid. - The state does not have a confirmed run-out period at this time but will develop this detail in operational plans for the program.	
2	Reasonable Modifications When an individual requests a reasonable modification, what are the options available for reasonable modification? Are the options limited to the 120 hours of good cause exception?	Dina	- The modification for an individual with a disability is separate from Good Cause and not part of the 120 hours. - The state envisions that other accommodations will be provided apart from a potential reduction in hours. - When an individual applies for Medical Assistance, the state will run the application through the existing cascade to determine if the individual is eligible under traditional Medicaid. This includes assessing them under ABD and various disability categories that exist. If the individual is eligible under traditional Medicaid, they will be enrolled. - If an individual is not eligible under traditional categories of Medicaid, then the individual will be considered for Pathways. - If at this point the individual states they are unable to meet the qualifying activities due to a disability, a referral will be made to other state programs, for example to the Georgia Vocational Rehabilitation Agency (GVRA) which works with individuals with disabilities to help them gain employment. - If the individual participates in a qualifying program and meets the activities as determined by the qualifying program, the individual may be eligible for coverage in Pathways. The rehabilitation services provided by GVRA, for example, will help the individual seek activities that they can do without accommodations, or work with them to find accommodations to enable the person to work, volunteer, or participate in educational activities.	State to follow up with written information on the process for reasonable modifications

			- There are other kinds of accommodation that an employer or supervisor may make to enable an individual with a disability to be able to participate in Pathways. CMS Follow-up: - Can the process on verification of the disability be clarified, if SSI/SSDI is not required? State Follow-up: - This depends on the eligibility category and the individual's circumstance. It could be a physician's determination that states that the person cannot meet the activities of daily living. CMS Follow-up: - To clarify, other accommodations provided by the state will include referral to GVRA, where the individual will work with a rehabilitation counselor to help the individual prepare for employment. When this individual is referred to GVRA, can the state confirm that they will not be receiving Medicaid at this point? State Follow-up - If they are participating in the GVRA to the extent that the agency is satisfied, the state envisions that the individual would be enrolled under Pathways into Medicaid. - However, to be clear, there are individuals who may be participating in GVRA programs who may not meet the rehabilitation requirements. - One scenario is if an individual applies and is not eligible for ABD, a referral will be made to GVRA. If the individual engages with GVRA to the extent that the rehabilitation services deems complete, this will count for Pathways Medicaid. - Another scenario is if someone applies and they are already working. Once enrolled in Pathways, something can happen that creates a disability which the individual did not have at the time of application. At this point, they can apply for a short-term, good cause exception for that temporary disability (of which 120 hours each year are allowable). A referral to GVRA will be made in the event that the temporary disability becomes more serious and the individual is in need of rehabilitation services. CMS Follow-up: - We are clear on what happens at the point of application. CMS would like a clearer understanding of what happens if an individual becomes involved in an accident, or if their circumstances require that they are unable to participate in the 80-hour activities threshold in order to understand what those modifications look like.	

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			- Our understanding is that they can request a good cause exception up to a maximum of 120 hours; if this is not a reasonable ask, then the individual may also be referred to the GVRA for additional resources and support. - CMS would appreciate if the state can summarize and sharing the information on the process for reasonable modification in writing to assist in finalizing the STC documents.	
3	Disability Definition Why would someone who did not qualify for traditional Medicaid, and then later states that they have a disability when considered for Pathways, not have been able to go through the traditional Medicaid route? Is there a reason for differentiation in disability for traditional Medicaid and for Pathways?	Heather	- The state believes very few people will fall into this group. - The state anticipates that most individuals with a disability that prevents them from begin able to engage in a qualifying activity will be picked up in ABD category of assistance, as the definition of disability is that the individual cannot perform activities of daily living. - There may be a small handful of people with a disability that prevents them from participating in employment, community service, or education, who would not qualify under traditional Medicaid. - If an individual did not disclose information on their initial application that would potentially qualify them for ABD, but then the state discovers this new information while under consideration for Pathways, the state would rerun eligibility for consideration of ABD Medicaid prior to approval for Pathways. CMS Follow-up: - CMS would like to reiterate the request that the State provide as much information as possible on the points made. We are trying to work to identify all of the protections and guardrails for anyone who is going through the process. We need to be able to say what the process is and that no one is going to fall through the cracks. We want to be able to clarify to CMS leadership that the State of Georgia has protections and guardrails in place.	
4	State Assurances If an individual is enrolled in a TANF program in Georgia that requires employment participation to receive TANF benefits, are they precluded from participating in the demonstration? Or, may they participate in Pathways and have their TANF employment requirements transfer over?	Dina	- There is not a perfect alignment between the requirements of TANF and the qualifying activities of Georgia Pathways. - If the individual is doing supportive employment under TANF for 20 hours each week, these 20 hours will count towards Pathways hours. - There are some activities that don't align between the programs; therefore, it does not mean that someone enrolled in TANF will be automatically enrolled in Pathways. - While there is an individual requirement in TANF of 20 or 30 hours each week, not everybody needs to be doing this at any point in time. The state is only held accountable for the work participation rate in TANF. CMS Follow-up: - To clarify, there will be a small segment of individuals for whom the program does not align. But without this alignment, there would not be a duplication of requirements between the program.	State to follow up with information in writing on the process discussed regarding TANF

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			State Follow-up: - That is correct. If 20 hours a week is done in TANF for an activity that meets the Pathways criteria, those hours will count for Pathways.	
5	Georgia Disability Definition Can the state provide its definition of disability in writing?	Heather	- The state will include this in the follow-up materials from today's call.	State to follow up with definition of disability used in Georgia

Additional Discussion Questions from the State and CMS

#	Additional Question/Topic	Raised by:	Response:	Follow-up:
1	Does CMS have a timeframe for the other sections on report requirements, evaluation criteria, and budget neutrality? What is the overall timeframe for approval?	Tom	- CMS is still working towards the original timeframe, keeping in mind that additional information is required from the state. - As soon as this information can be provided and submitted for the expanded internal CMS Georgia team to review, then these additional elements can be shared with our expanded team and we can circle back with a more definitive answer.	Dina will follow-up on timelines on the week of 6/22
2	Does CMS have a timeframe on progress with federal partners, OMB and others, in terms of clearance?	Tom	- We are still working through COVID priorities. This demonstration is still a priority for CMS. - CMS needs additional information from Federal partners and will give a more definitive timeline as soon as possible. - CMS is still working towards the end of July target approval timeline.	
3	Information for Demonstration Evaluation	Dina	- Evaluation information is available online and the evaluation team is available to discuss in an ad hoc call or discuss in a future call. - The Evaluation team be holding live webinar events to review monitoring metrics. The next version of technical specifications will be released in late summer.	

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 6/26/2020**Subject:** STCs Draft Content Outline Review #3**Attendees:** CMS: Payne, Dina P.; Hawkins, Etta; Taylor, Julian; Ross, Heather; Ma, Allen

DCH: Fulenwider, Blake; Rhodes, Lynnette; Krull, Matthew; Luca, Lavinia; Dowd, Brian; Ashlaw, Stefanie

Deloitte: Horn, Wade; Burke, Jeff; Conrad, Sadie; Adams, Kiersten; Collas, Ariana Areti; McCarthy, John; Betlach, Tom; Gordon, Darin; Fitzpatrick, Tim

#	Topic / Question from CMS	From	State Response	Action Item
1	Individuals with Disabilities Can the State provide an overview on the latest information shared regarding individuals with disabilities?	Dina	Reference to document “GA 1115 Waiver Opportunities for Healthcare Coverage for Those with Disabilities” shared with CMS on 6/25 - This document outlines the State’s proposed approach for reasonable modifications for individuals who identify as having disabilities. - What is included in this document regarding the proposed process aligns with the proposed STC modifications provided yesterday. - The first two pages of this document summarizes information previously provided to CMS related to the different Medicaid classes of assistance available in the State today for ABD. - Following this, the document provides more details on the existing state processes related to verification of disabilities for ABD. - The State then outlines the proposed new processes for Pathways by which an individual with disabilities will receive accommodations at application or once enrolled - At application, an individual may be referred to other state programs, such as the Georgia Vocational Rehabilitation Agency (GVRA), as an accommodation for their enrollment into Pathways. If the individual provides verification of participation with one of these programs, they will be enrolled in Pathways. - Once enrolled, the State will accommodate reasonable modifications requests made by the beneficiary. These may include an adjustment in hours, adjustments for accommodation, or referrals to other state programs such as GVRA. CMS Follow-up: - The third paragraph on page 1 indicates that a range of accommodations will be provided, including virtual options. Is this open to all demonstration participations, or relegated to individuals with disabilities? State Follow-up: - The virtual opportunities exist for all Pathways participants, and includes education and work from home.	

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#	Topic / Question from CMS	From	State Response	Action Item
			- In addition, in the case that someone is disabled and engaged in on-site employment that requires a modification, then making that work virtual may be part of the accommodation they are provided for by their employer.	
2	Updated Budget Neutrality Model Can the State provide an overview of the changes reflected in the Budget Neutrality model?	Dina	Reference to document “GA 1115 Waiver Submission Model Unlocked” shared with CMS 6/25 - Three small updates were made to the Budget Neutrality model. - First, we modified the health insurer fee since it was repealed by Congress. Since it will not be in place going forward, we removed it from the model. - Second, Georgia’s Department of Insurance has a premium tax that is applied to all insurance premiums, which includes managed care rates. Those taxes are 2.25 state and 2.5% county and municipal. These taxes will be applied to the capitation rate and have been included to the model (Column L). - Third, since the unemployment rate in the State has increased due to COVID, it may impact the number of people seeking healthcare coverage through Pathways. We applied a 10% increase to the projected number of people enrolled in Pathways across all five demonstration years (Column T). CMS Follow-up: - In addition to the increase in enrollment due to unemployment numbers, can you clarify if any other updates were made based on the impact of the pandemic? State Follow-up: - No other changes were made based on the pandemic, such as changes to the PMPM. Only the enrollment projections have been modified. CMS Follow-up: - CMS may have additional questions after a full analysis of the documents which will be shared early next week.	
3	Document on Disabilities Is the information provided in the documents related to disabilities memorialized elsewhere, or is this information somewhere in the guidelines?	Heather	Reference to document “GA 1115 Waiver Opportunities for Healthcare Coverage for Those with Disabilities” shared with CMS on 6/25 - The document prepared for this conversation was compiled using various sources. - The information related to the State’s current ABD classes of assistance and processes came from the State’s existing Policy Manuals. - The processes proposed for specifically Pathways and modifications for individuals with disabilities is new information shared in these documents and these processes are also reflected in the State’s edits proposed in the draft STCs.	

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Additional Discussion Questions From State and CMS

#	Topic	Raised by:	Response:	Follow-up:
1	Timeline What does the timeline look like for approval?	Wade	- CMS is working internally to finalize the approval process to provide a definitive date. Follow-up will be provided next week.	
2	Revised STCs Does CMS have any comments on the revisions made to the STCs provided by the State?	Jim	- CMS clarifies that these are not the actual STCs but an outline of information. The STCs require leadership approval before officially being shared. - CMS did not have any additional questions regarding the latest edits sent by the State.	
3	HIPP Contact The State has been working through some of the operational issues for the Mandatory HIPP Program in the case that an advanced payment is made for a service and the service is not rendered. Can the State provide a contact from the California HIPP Program in order to discuss?	Jim	- Dina/Heather will reach out to the California Mandatory HIPP team to provide a POC and request additional information on this topic.	Dina/Heather to follow-up with California for Mandatory HIPP POC
4	Next Meeting Given that next Friday is a holiday, does the State want to meet another day next week or defer to the following week?	Dina	- CMS will follow-up on Monday to verify whether another call will be held next week and with any questions from analysis of these documents. Based on initial review of the documents, a meeting may not be necessary. - CMS may come back with additional questions or discussion to be able to develop internal documents and tools that will be put together to share within leadership in CMS in order to ensure alignment before sharing full STCs with the State.	Dina to follow-up to confirm if a meeting is needed next week and share any additional questions

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 7/10/2020**Subject:** STCs Discussion #4 (Reasonable Accommodations)**Attendees:** CMS: Payne, Dina P.; Hawkins, Etta; Taylor, Julian; Ross, Heather; Shaw, Shane; Chesnick, Matthew; Cash, Judith

DCH: Fulenwider, Blake; Rhodes, Lynnette; Krull, Matthew; Luca, Lavinia; Dowd, Brian

Deloitte: Burke, Jeff; Conrad, Sadie; Collas, Ariana Areti; McCarthy, John; Betlach, Tom; Gordon, Darin; Fitzpatrick, Tim

#	Topic / Question from CMS	From	State Response	Action Item
1	Reasonable Accommodation for Pathways Applicants [Reference to document “GA 1115 Waiver Opportunities for Healthcare Coverage for Those with Disabilities” shared with CMS on 6/25] Can the State provide clarifications regarding accommodations provided to individuals with disabilities who apply for Pathways? <i>CMS would like to ensure provisions proposed for individuals with disabilities are offered at application, to ensure full compliance with the ADA and mitigate potential legal risk to both CMS and to the State. In reviewing the document provided, CMS understands that different provisions are provided for applicants to Pathways compared to beneficiaries already enrolled in the program.</i>	Dina/ Judith	- Meeting the qualifying activities requirement is a core tenet of the waiver. Therefore, the state would like to maintain this provision as robustly as possible upfront in the program, while ensuring that reasonable accommodations are made to allow persons with disabilities to participate in the program. - For someone to be determined eligible for Pathways, they will cascade through all other classes of assistance (COAs) under the current Medicaid program prior to being considered for Pathways. If someone meets the level of disability that qualifies them for another COA, they will be enrolled in Traditional Medicaid. In addition, an individual enrolled in Pathways will move into another COA if their circumstances change and they are eligible for traditional Medicaid. - The Pathways waiver is not designed to be exclusionary. In Georgia today, without Pathways, if someone does not meet the level of disability required for ABD Medicaid and if an individual is a childless adult in Georgia, they will not qualify for any other COA. They are left without options today. - Pathways provides an opportunity for people who can meet the qualifying activities threshold to earn their eligibility into Pathways initially, and on an ongoing basis. - The State has focused on how to partner with different state agencies to provide referrals for individuals who wish to participate in Pathways but may need additional support, such as with the Georgia Vocational Rehabilitation Agency (GVRA) which specializes in helping those with disabilities gain employment. - The State also envisions that other reasonable accommodations, such as virtual education or online training also provide opportunities and increased access for individuals who have disabilities may require reasonable accommodations in order to participate in Pathways. State follow-up: - Can CMS provide additional clarification on the opening comments regarding CMS’ understanding of accommodations the State intends to provide to individuals who are enrolled versus applying for Pathways.	

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

#	Topic / Question from CMS	From	State Response	Action Item
			CMS follow-up: - From reviewing the provided document, CMS understands that the State is taking a different approach for accommodations for individuals who apply, compared to individuals who are enrolled in Pathways. - CMS understands that an individual who applies and meets the qualifying activities threshold at application, and who later develops a condition, will receive accommodations that may include alternative reporting channels, or a reduction in the number of hours, in addition to referrals. - CMS requires clarification on what happens if an applicant applies for Pathways and has a condition which prevents them from completing the activities, but who for example, can be successful in working 10 hours per week, or for an individual who needs an alternative mechanism for submitting hours. - Because this person is subject to the rights appropriated in the ADA, CMS wants to make sure there is the same accommodations provided at application. - If the State is intending on making these same accommodations at application, then the State needs to provide clarity on this, and this needs to be included in the STCs. State follow-up: - CMS' overview of what we proposed for individuals enrolled in Pathways is accurate. There are two reasonable accommodation approaches for an individual enrolled in Pathways. - o If an individual is unable to conduct the qualifying activities due to a temporary impairment, then a short-term Good Cause Exception to meeting the hours and activities threshold will apply. - o If there are individuals who are unable to meet qualifying activities on a more permanent basis, the State will consider other reasonable accommodations such as referrals to other agencies	
2	Reasonable Accommodation for Pathways Applicants What kind of accommodation would the State envision making to a Pathways applicant who for example, has chronic back pain, and a clear inability to be successful for 80 hours/month of community engagement (CE)? <i>CMS recognizes that the Pathways approach differs from other CE demonstrations as it expands coverage to individuals who have no other pathway.</i>	Judith	- The State would like to know to what level of detail reasonable accommodations need to be addressed in the STCs. - Some of the operational aspects have already been laid out for CMS. The State has been working through this issue in a real-time basis and would like more clarity on the level to which this needs to be defined in the STCs. CMS follow-up: - CMS needs to see the policy commitment in the STCs that the State is making for reasonable modifications for individuals with disabilities. CMS recognizes this is a work in progress and that applicant by applicant decisions will need to be made in many circumstances. - CMS sets out policy parameters in the STCs and will work with the State to follow-up on the Implementation Plan and operational details.	

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

#	Topic / Question from CMS	From	State Response	Action Item
			- At this time for the purposes of the STCs, CMS requires the policy commitment that where an individual presents with a request based on a disabling condition, the State will consider reasonable accommodations at applications, including some examples, such as a reduction in hours or an alternative to the reporting requirement, as the State has already outlined for beneficiaries already in the program. State follow-up: - The State has expressed the policy commitment that there will be reasonable accommodations provided at the frontend of the process for Pathways. - If the document shared does not reflect this commitment, then it can be updated to lay this out.	
3	Referral to Vocational Rehabilitation If a new applicant does not meet the qualifying hours threshold, is the process that the individual will be referred to another agency or organization to do an assessment and development of a recommendation for an accommodation? In addition to this, is there an opportunity to do training to meet the hours?	Jenn	- With the GVRA Vocational Rehabilitation (VR) Program, when someone comes in and has a disability, the individual works with a counselor to assess their needs to help with job readiness, training, and to develop a plan. That plan, for example, may say that someone only participates 10 hours each week or indicate some other reasonable accommodation that would allow that individual to participate in Georgia Pathways. - GVRA then gets someone engaged with community partners to conduct the training and job readiness activities with the goal to obtain employment. - The State envisions that so long as the individual fully complies with the requirements of the program, that individual will be deemed to be in compliance with the eligibility requirements for Georgia Pathways without regard for the number of hours that individual is actually engaged each week/month. - To be able to enroll in Pathways, the individual needs to show they are meeting the requirements laid out in the Work Plan. CMS follow-up: - Does the State envision that the VR Program will share the individual's Work Plan with the State, and the individual would then be able to apply and gain coverage? State follow-up: - Correct. Once a referral is made, and an individual shows engagement in the VR Program within the 90-day period after an initial eligibility determination, then they will be considered for Pathways without needing to submit a new application for Medical Assistance. This allows for a quicker process rather than having to reapply for Pathways. CMS follow-up:	State to provide CMS with additional information on accommodations provided to individuals who report a disability at application for Pathways week of 7/13/2020

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#	Topic / Question from CMS	From	State Response	Action Item
			- Does the State expect that if the modified 10 hours/week are met, then this determination will be in place until it is determined that an accommodation is not required? State follow-up: - Correct. The State would match GVRA's assessment. If hours are re-assessed by GVRA, then the State would likewise re-adjust the individual's hours threshold on an ongoing basis. CMS follow-up: - Is this the same process envisioned for individuals enrolled who become disabled? State follow-up: - Correct. The State has mirrored the same referral process. CMS follow-up: - It would be helpful for the State to add the additional information under the proposed operationalization of the referrals for individuals who report a disability at application, including that individuals with disabilities will be referred to GVRA. Additional context around the assessment and referral provision will be helpful.	
4	GVRA Capacity Does the State feel comfortable that GVRA is adequately resourced? Has the State engaged with this agency?	Judith	- The State has engaged with GVRA. Much like DFCS, which is the agency that performs Medicaid determinations within the state, in there will be a need with approval of this waiver for additional resources to handle the case volume. There is infrastructure in place to scale with volume. CMS follow-up: - Is there commitment from executive and legislative branches to make these resources available? State follow-up: - The State is working with the Office of Planning and Budget. The Governor is fully committed to the waiver.	
5	Appeal Rights Did the State submit language in the STCs Outline that if a beneficiary declines the proposed reasonable modification then coverage will be terminated subject to appeal rights?	Dina	- Correct. The State will maintain all appeal rights currently in place for an adverse action, at application and at point of enrollment.	

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Additional Discussion Topics/Questions from State and CMS

#	Topic	Raised by:	Notes:	Follow-up:
1	Next Steps	Judith	- CMS is working continuing to work through the preparation of all required documents. - STCs will need to go through multiple rounds of review with partners. - Because the Pathways approach is a new approach that has not been used, additional questions will certainly come up.	

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 7/17/2020**Subject:** STCs Discussion #5 (Reasonable Accommodations and Member Rewards Account)**Attendees:** CMS: Payne, Dina P.; Hawkins, Etta; Taylor, Julian; Shaw, Shante

DCH: Fulenwider, Blake; Rhodes, Lynnette; Krull, Matthew; Luca, Lavinia; Dowd, Brian; Ashlaw, Stefanie

Deloitte: Burke, Jeff; Conrad, Sadie; Collas, Ariana Areti; Adams, Kiersten; McCarthy, John; Betlach, Tom; Gordon, Darin; Fitzpatrick, Tim; Horn, Wade

#	Topic / Question from CMS	From	State Response	Action Item
1	Reasonable Accommodations [Reference to updated version of document “GA 1115 Waiver Opportunities for Healthcare Coverage for Those with Disabilities” shared with CMS on 7/15] Can the State provide an overview of the updated write-up on accommodations provided to individuals with disabilities who apply for Pathways?	Dina	- The State made several updates to the document originally provided to CMS on 6/25/2020 on reasonable accommodations. - The introduction clarifies that the State intends to offer reasonable accommodations both at application for Pathways and for beneficiaries enrolled in Pathways. - Additional information was added that if an individual indicates that they have a disability and is under consideration for Pathways but does not meet the qualifying activities threshold, the State would provide a referral to the Georgia Vocational Rehabilitation Agency (GVRA) as an accommodation. - o If the individual accepts the referral, and meets GVRA’s program requirements, they will be determined eligible for Pathways. - o As long as the individual is actively engaged and meeting the requirements of the referral program, they will be considered in compliance with the Pathways hours/activities threshold. - In addition to referrals, reasonable accommodations will be offered on a case-by-case basis based on the needs of the individual, such as offering reasonable accommodations for reporting hours if the individual is unable to use technology. - Additional information was added regarding GVRA’s intake process. - o GVRA has an application process to assess the disability and level of support an individual requires. - o The agency then creates a customized work plan - referred to as an ‘Individualized Plan for Employment’ (IPE) - to help the individual meet their needs and work goals. - o While in the program, individuals may get services from a provider network for job readiness, interviewing skills, and more. - No changes were made to the rest of the document for individuals already enrolled in Pathways. CMS Follow-up:	

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#	Topic / Question from CMS	From	State Response	Action Item
			- To clarify our understand, reasonable accommodation provisions will be available to all applicants with disabilities at the time of application, and the specific accommodation will be determined on a case-by-case basis. State Follow-up: - Correct. Specifically, if an individual with a disability does not meet the qualifying hours and activities threshold and needs support to do so, then a referral will be provided to GVRA to help connect that individual to opportunities. CMS Follow-up: - To confirm the process, GVRA completes the assessment and creates the IPE. If it is determined that the individual requires a referral to another partnering agency, GVRA has the ability to do this referral. State Follow-up: - That is correct. GVRA partners with various community providers to provide the services that the individual may need. - For example, if an individual needs support for interview skills development, they will work with community providers if GVRA is not able to provide those services directly. It is more of a partnership model than a referral.	
2	Member Rewards Account At the time that an individual's income reaches 100% of the FPL and they transition out of the demonstration, if they are uninsured, would they still have access to the balance of the funds in the MRA?	Dina	- The State's hope is that individuals would move from Pathways coverage into the individual market or to employer sponsored insurance and use the remaining balance in their MRA to help pay for their portion of the premium. There will also be a run out period to use the balance, and the State envisions that the individual would still be able to use funds for approved health expenses but is still working through the operational details. - Does CMS have thoughts or guidance? CMS Follow-up: - Indiana allows individuals who are uninsured to maintain access to the funds in the account. This is something that the State might want to consider. - CMS will share information from Indiana for with the State.	CMS will share information from Indiana on account transitions for uninsured individuals
3	Member Rewards Account Can the State provide additional details on how the monies will flow in and out of the account? CMS anticipates being asked about individuals who transition away from the demonstration and have access to the account. Currently, the language provided by the State stipulates that individuals will have the option to utilize monies for State-approved funds. Does the State have plans to align the State-approved funds to Medicaid-approved funds?	Dina	- The plan is to limit the use of the funds, similar to the way this is done with an HSA or FSA. The State can be more specific in terms of what those approvable expenses would be, but is currently working through the operational details of the program. The State anticipates expenses like medical services, supplies, and pharmaceuticals would be allowed. - The State is also working on a funds flow as it relates to the MRA; this will be shared in the near future. CMS Follow-up: - CMS received questions on the use of Medicaid funds for individuals who are no longer eligible for Medicaid. It would be helpful if the State could provide	State will provide information on the flow of funds for the MRA

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#	Topic / Question from CMS	From	State Response	Action Item
			additional details to help make the argument to approve this mechanism based on how it's proposed.	
4	Member Rewards Account Has the State modeled the estimated amount of State contribution to the MRA?	Dina	- The State can provide modeling on the MRA. There is an assumption of an annual cap where a member could not accrue more than a certain amount every year. CMS Follow-up: - In other states, they anticipated providing funds that don't exceed \$500 dollars. It would be helpful to receive more information to determine the level of expenditures the State may need. This is in anticipation of questions from our partners.	State will provide MRA modeling and information about the annual cap on the account
5	Member Rewards Account For individuals no longer enrolled in the demonstration, will the incentive points that they have earned be available during the run-off period?	Dina	- It depends on why the individual loses access to the account. If they lose access due to suspension for non-compliance, the account is frozen. If they never come back into compliance and are terminated, those dollars will not be available to them. - If the individual moves to another Medicaid category of assistance, or transitions off Pathways due to being over income, then they will continue to have access to their balance for a set period of time, but they cannot accrue additional points.	

Additional Discussion Topics/Questions from State and CMS

#	Topic	Raised by:	Notes:	Follow-up:
1	Budget Neutrality	Tim	- The State is working through updates to the Budget Neutrality with some assumptions on increased enrollment by individuals with disabilities currently in GVRA's programs. - The State will share updates next week for discussion on Friday.	State will send CMS an updated Budget Neutrality modeling
2	Demonstration Year	Tim	- The State's waiver demonstration years are based on implementation dates, with DY1 starting on July 1, 2021. We want to confirm there are no concerns with that. CMS Follow-up: - This is fine. Many states come in with that same scenario	

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 7/24/2020**Subject:** STCs Discussion #6 (Budget Neutrality and Member Rewards Account)**Attendees:** CMS: Payne, Dina P.; Hawkins, Etta; Ross, Heather**DCH:** Fulenwider, Blake; Rhodes, Lynnette; Luca, Lavinia; Dowd, Brian; Ashlaw, Stefanie;**Deloitte:** Burke, Jeff; Conrad, Sadie; Collas, Ariana Areti; Adams, Kiersten; McCarthy, John; Betlach, Tom; Gordon, Darin; Fitzpatrick, Tim**Note:** This document reflects the discussion that took place between the State and CMS, and notes where content has changed due to decisions made following the meeting.

#	Topic / Question from CMS	From	State Response	Action Item
1	Member Rewards Account When an individual leaves Medicaid and transitions to commercial coverage, are the monies the individual has access to during the run-off period comprised of the remaining MRA balance? <i>CMS wants to ensure an accurate understanding of how the State proposes to provide post-Medicaid expenses to individuals who have transitioned from the demonstration to commercial insurance.</i>	Dina	- Correct. They have access to their MRA which includes premiums they previously paid and any dollars accrued from healthy behavior incentives completed while enrolled in Pathways. The State has envisioned that this balance would be available to the individual for use during a 90-day runout period. CMS Follow-up: - Regarding budget neutrality, do the monies that the individual has access to post-Medicaid include any federal dollars? State Follow-up: - The money in the individual MRA is based on what the member accrued while in Medicaid. As the member earned those dollars while on Medicaid, the State anticipates that there would be a federal match, just as for any other Medicaid expenditure. - For budget neutrality, the PMPM for the MRA includes the value earned based on healthy behaviors plus the administrative costs, less member copays. The premium paid by members are not included in the budget neutrality PMPM. <i>Update: Following this meeting, the State decided to remove from the STCs the ability to allow individuals to use the funds in their MRA accounts after they transition off Medicaid. The State requested a placeholder be included in the STCs for future clarifications that would allow individuals to have access to their remaining premium dollars up to 90 days after they transition off Medicaid.</i>	
2	Member Rewards Account Does the State anticipate including these expenditures in the Budget Neutrality under the current PMPM? Will there be any State dollars included?	Dina	- From a point in time perspective, dollars are earned while the individual was in Medicaid. - In addition, the premiums that fund the MRA will come from the individuals.	

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#	Topic / Question from CMS	From	State Response	Action Item
	<i>CMS anticipates making the demonstration population hypothetical; all expenditures related to the population will also be hypothetical. In our experience, there are challenges when it comes to using Medicaid dollars for individuals who are no longer Medicaid eligible.</i>		- The State will fund its share for points earned through healthy behaviors incentives. <i>Update: Following this meeting, the State decided to remove from the STCs the ability to allow individuals to use the funds in their MRA accounts after they transition off Medicaid.</i>	
3	Member Rewards Account For individuals who are no longer in Pathways, and have 90 days to use the money in the account, what activities or services can they use it for? Is it just to pay premiums or for any specific services?	Heather	- The State envisions that an individual could spend the remaining balance on healthcare-related items and services, similar to expenses that an HSA account would allow. - The State envisions that the core set of services on which someone could spend MRA funds will be the same when someone is in Medicaid as when they are in the 90-day run-out period. - The only difference is that at transition off of Medicaid, an individual will also be able to spend the remaining account balance on premiums, if that individual transitions to commercial insurance. <i>Update: Following this meeting, the State decided to remove from the STCs the ability to allow individuals to use the funds in their MRA accounts after they transition off Medicaid.</i> State Follow-up: - Does it make a difference for CMS if the dollars flow through the CMOs versus being state-administered? - One of the current options the State is looking into is to engage CMOs for the administration of the MRA. The State would appreciate getting more information from CMS, to understand how this approach differs from the perspective of legal authority on the run-out issue. CMS Follow-up: - CMS will follow up with the Managed Care group to provide insights on the State's question. - In the demonstration as it is currently written, CMS notes that the dollars flow through the State.	CMS will follow up with Managed Care on implications of MRA funds flowing through the CMOs, versus being state-administered
4	Member Rewards Account & Approval Timeline Some of CMS' questions can be addressed in the operational model and through the updated PMPM in the Budget Neutrality workbook. If the State needs more time to work out details of the MRA, would the State be willing to move forward with	Dina	- To clarify, does 'approval' mean formal approval of the waiver application? CMS Follow-up: - Correct. CMS is awaiting on some additional information from the State on the MRA and is also in the process of initiating conversations with federal partners.	State will provide a decision to CMS on next steps for the MRA by end of the day

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

#	Topic / Question from CMS	From	State Response	Action Item
	the other demonstration aspects of the package that can be readily approved?		- CMS wants to be sensitive that there is additional information and nuance that will take time for the State to resolve; however, we do not want to delay efforts to move forward with approval. State Follow-up: - To clarify, could the State move forward with the waiver approval, without the MRA component and indicate that the MRA component would be subject to further discussion? - If the MRA component can be incorporated following approval, would this be an amendment to the waiver? CMS Follow-up: - This would not be an amendment. If it comes to that point, general language could be included in the STCs to speak to the State's desire to incorporate an MRA in the demonstration. - In past demonstrations it has been articulated in the approval letter that a component was not approved at the time of approval because operational components were still being worked on. Then a sub-STC proposal would be developed that does not require an amendment. This could be submitted in the 90-day timeline post-approval with the Community Engagement Implementation Plan. - This allows the State more time to submit more details. State Follow-up: - Is CMS' primary concern on the MRA restricted to the post-eligibility period, or are there other concerns that would delay approval? CMS Follow-up: - The potential concerns CMS has at this point are the post-Medicaid expenses to the extent that the individual is no longer Medicaid eligible but would be in receipt of Medicaid dollars. - From our experience with other states, this has been a sticking point with federal partners. Preliminary questions have come up internally. State Follow-up: - Is there is potential to get approval of the majority of the MRA and to provide clarity on run-out piece at a later time? CMS Follow-up: - This is an option as well. If the State is willing to omit the post-eligibility proposal of the MRA, this could a component the State submits post-approval once the component is operationalized.	

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

#	Topic / Question from CMS	From	State Response	Action Item
			<i>State Follow-up:</i> - The State will take this back internally and follow up with CMS regarding the decision.	

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

Title: 1115 Waiver Weekly Call – DCH and CMS**Date:** 7/31/2020**Subject:** STCs Discussion #7 (Data Request and Budget Neutrality)**Attendees:** CMS: Payne, Dina P.; Hawkins, Etta; Ross, Heather; Taylor, Julian

DCH: Fulenwider, Blake; Rhodes, Lynnette; Wilson, Joyce; Krull, Matthew

Deloitte: Burke, Jeff; Conrad, Sadie; Collas, Ariana Areti; Adams, Kiersten; McCarthy, John; Betlach, Tom; Gordon, Darin; Fitzpatrick, Tim

#	Topic / Question from CMS	From	State Response	Action Item
1	Data Request <i>In preparation for briefings done by internal leadership and federal teams, CMS has been requested to provide disenrollment or projected estimates of individuals who may be disenrolled from the program due to their inability for a variety of reasons of meeting the hours and activities threshold.</i> Can the State provide the disenrollment information by year and information on how this has been derived in order to understand the churn rate?	Dina	- The concept of disenrolling someone from Medicaid has great legitimacy in the work waivers that have been approved to date by CMS, but this is less relevant in the context of Georgia Pathways. - In waivers approved to date, states had said they were expanding Medicaid; and subsequently, for a subset of that group, created a community engagement (CE) requirement. - With the Pathways model, the people ineligible for Medicaid in Georgia will continue to be ineligible for Medicaid, unless they meet the threshold of hours and activities at application. No one in Medicaid today is being disenrolled for failure to achieve this threshold; Pathways rather provides a mechanism for those who would otherwise be ineligible to enroll. - For individuals with disabilities, if they are not able to fulfill the qualifying activities, they will be referred to Georgia's vocational rehabilitation agency. If the person is determined eligible for rehabilitation services and participates in those services, they will be deemed eligible for Pathways as a reasonable accommodation. - The disenrollment question assumes that someone has Medicaid already, and through applying a CE requirement, they are disenrolled. In Georgia, the State is not giving beneficiaries Medicaid and then taking it away. CMS follow-up: - For individuals who are otherwise not eligible for Medicaid, who become eligible through the Pathways demonstration, does the State have any estimates how many of those individuals could potentially be terminated or no longer eligible under the demonstration due to an inability to fulfill the activities and hours requirement, or to pay premiums? - CMS anticipates that this number may be relatively low, but this is a standard question for States with CE requirements from our federal partners. State follow-up: - The only way to become eligible for Pathways is to satisfy the hours and activities threshold at application. The State assumes that there may be a	State to provide additional information on modeling estimates for churn/disenrollment

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

#	Topic / Question from CMS	From	State Response	Action Item
			portion of beneficiaries that decide, once enrolled, to no longer fulfill this threshold. However, the State believes the number is very small for a number of reasons. - There are 120 hours for good cause exceptions that a member can use to provide protection against someone's temporary inability to meet the threshold. - If an individual is no longer able to fulfill the threshold due to a longer-term impairment, they may be referred to the State's vocational rehabilitation agency for support. - The State believes that the people who participate in this program will be motivated because they want to be eligible for Medicaid, and because they want to go to school, get a job, or engage in another way. - Once doing this, the State believes that the greater exit will be due to individuals generating enough earnings to income out of Medicaid and gain access to commercial coverage. CMS follow-up: - Can the State provide actual data by each demonstration year of the disenrollment numbers, and a brief summary of how to understand the numbers? State follow-up: - The State does not have a formal estimate as it relates to individuals who might exit Pathways with regards to not paying premiums, or meeting hours. There is not a break-down at this level. - The budget neutrality model does have an underlying churn rate for the Pathways population based upon what the State is seeing in the low-income Medicaid population today. CMS follow-up: - This information is very helpful. Even though CMS understands that Georgia is under a different program to implement the demonstration, CMS is working to provide answers to our federal partners. CMS needs this information from the State, including a narrative on these aspects. - Churn information will be helpful to move forward. Any other additional information, even if it is in narrative form, will be helpful for us. - CMS is advocating to explain that Georgia's demonstration is not like other programs – that the initiative is additional coverage and expanding coverage in this way. - If the State can provide in narrative form and any documentation or thoughts about the State's estimates of individuals disenrolling, or numbers based on other programs, that would be helpful. State follow-up:	

State of Georgia 1115 Waiver / CMS Weekly Call – Question and Answer Brief

#	Topic / Question from CMS	From	State Response	Action Item
			- The State will follow-up with a qualitative description similar to what the State outlined today and the overall churn rate with an explanation of what goes into it. - But the State cannot say a certain number of people that will income out or drop off due to particular reasons. - The State will monitor the reasons why individuals are exiting the program ongoing in order to determine what the reasons are. CMS follow-up: - Although you do not have the level of granularity at this time, please include in the narrative that reasons why individuals exit the program will be monitored.	
2	Budget Neutrality [Reference to Workbook “Georgia 1115 Waiver Submission Model Unlocked 07282020 sent to CMS on 7/28] In the latest budget neutrality document, there is an explanation on the MRA PMPM that it is administrative cost, plus value earned, and minus copay. Can the State provide additional explanation on what this information means? Is “value earned” based on incentive points or other aspects?	Dina	- The administrative cost is the cost of running the program. - The value earned is the healthy behavior values that the member earned for engaging in healthy behaviors. - Copayments are the copays for the provider services. - The MRA PMPM does not include member premiums. It is just those three components. - The State can provide this detail in a write-up.	State to provide information on the components of the MRA PMPM

Additional Discussion Topics/Questions from State and CMS

#	Topic	Raised by:	Notes:	Follow-up:
1	MRA Account	Dina	- CMS acknowledges receipt of the State’s decision on the MRA. - CMS took State’s questions from last week’s discussion (7/24) to Policy SMEs. CMS will be able to revisit the operational aspects of the MRA on a future call.	

Exhibit 11



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

December 23, 2019

VIA E-MAIL AND U.S. MAIL

The Honorable Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20202

Ms. Seema Verma, Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Mr. Calder Lynch, Acting Deputy Administrator & Director
Center for Medicaid and CHIP Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Georgia "Pathways to Coverage" Section 1115 Demonstration Waiver Application

Dear Secretary Azar, Administrator Verma, and Director Lynch:

The State of Georgia is pleased to submit to the U.S. Department of Health and Human Services (DHHS) the enclosed Section 1115 Demonstration waiver application. The State authorized this Demonstration by provisions in the *Patients First Act* (O.C.G.A. 49-4-142.3) signed in to law by Governor Brian P. Kemp on March 27, 2019.

Our application seeks to launch Georgia's "Pathways to Coverage" – an innovative approach that creates a new Medicaid eligibility pathway for hard working Georgians. Too many of our state's working, low-income citizens do not have access to or are unable to afford healthcare coverage. This Demonstration will provide Medicaid coverage or Employee Sponsored Insurance to Georgians ages 19-64 who are below 100% Federal Poverty Level (FPL), not otherwise eligible for Medicaid, and meet qualifying activities threshold. To further support and prepare Georgians on their journey to self-sufficiency and the eventual transition to commercial health insurance coverage, Georgia Pathways is embracing private market policies and principles, such as premiums, copayments, member rewards accounts, and prospective Medicaid eligibility.

The goals for the Demonstration are to improve access, affordability, and quality of healthcare. Georgia's Pathways to Coverage seeks to increase access to affordable healthcare coverage, lower the uninsured rate across Georgia, support members on their journeys to financial independence, and promote members transition from the Medicaid program into private coverage.

Georgia "Pathways to Coverage" 1115 Demonstration Waiver

Application December 23, 2019

Page Two

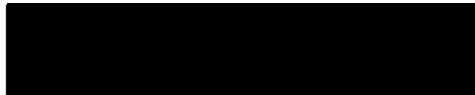
While the Georgia Pathways application is requesting 90/10 funding for a partial expansion to 100% of the FPL, we acknowledge recent guidance given to states by the federal government has addressed this issue. As such, we anticipate, and have budgeted for the State's standard Medicaid match rate. Georgia is requesting approval of its 1115 Demonstration which includes the following:

- Creating a new Medicaid eligibility pathway for working Georgians
- Instituting premiums and copayments for Georgia Pathways members with incomes between 50% and 100% FPL
- Incentivizing healthy behaviors
- Creating a Member Rewards Account
- Implementing a mandatory premium assistance program for employer-sponsored insurance
- Eliminating retroactive Medicaid coverage and hospital presumptive eligibility for Pathways participants

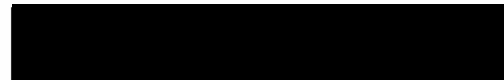
Through the passage of the *Patients First Act*, Georgia has sought to address challenges for hardworking Georgians accessing and affording their health care. Our proposals – both this Section 1115 demonstration application and our Section 1332 application, Georgia Access -- seek to create a market where Georgians can have access to affordable, quality healthcare close to home. Through the Administration's leadership, states have been afforded the opportunity to craft innovative solutions to state specific challenges, and our applications represent a first-step state-led innovative approach.

We appreciate DHHS' commitment to support state innovation, and we look forward to your continued support as we develop innovative approaches to providing Georgians with access to affordable, quality healthcare to further the State's vision of creating "A Healthy Georgia."

Respectfully,



Frank W. Berry
Commissioner
Georgia Department of Community Health



Blake T. Fulenwider
Chief Health Policy Officer
Georgia Department of Community Health

Enclosure

cc: Judith Cash, Acting Director, State Demonstrations Group, CMS Central Office
Shantrina Roberts, Associate Regional Administrator, CMS Atlanta Regional Office
Etta Hawkins, Health Insurance Specialist, Georgia State Lead, CMS Atlanta Regional Office



Georgia Section 1115 Demonstration Waiver Application

December 23, 2019

Department of Community Health

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Section 1: Program Description

Section 1.1: Background

Created in 1999 by the General Assembly, the Georgia Department of Community Health (the Department) is one of the four health agencies serving Georgia, and it is the single state Medicaid agency. The Department's mission is to provide Georgians with access to accessible, affordable, and high-quality healthcare and is dedicated to creating "A Healthy Georgia." Georgia currently enrolls approximately 1,300,000 individuals through its Medicaid managed care program, Georgia Families, which includes non-disabled adults with incomes up to approximately 35% of the federal poverty level (FPL) based on Modified Adjusted Gross Income (MAGI) methodology and children living in households with incomes up to 138% of the FPL. An additional approximately 470,500 aged, blind, and disabled (ABD) low-income individuals are enrolled in the State's fee-for-service program.

During the 2019-2020 Regular Session, the Georgia General Assembly passed Senate Bill 106, the *Patients First Act*. This legislation authorizes the Department to submit a Section 1115 Demonstration waiver to the Centers for Medicare & Medicaid Services (CMS) within the United States Department of Health and Human Services (HHS) which may include an increase in the income threshold up to a maximum of 100% of the FPL. The legislation also allows the governor to submit one or more applications to waive applicable provisions of the federal Patient Protection and Affordable Care Act (PPACA) under Section 1332 with respect to health insurance coverage or health insurance plans. Together, these two waivers represent the State's initiative to empower Georgians to increase their access to affordable healthcare coverage and improve their health and well-being.

Section 1.2: Summary of Proposed Demonstration Program

To meet the intent of the *Patients First Act*, Georgia is requesting approval of an 1115 Demonstration to implement the following new policies that will further the State's vision of creating "A Healthy Georgia":

- Georgia Pathways to Coverage (Georgia Pathways) – Provide a pathway to Medicaid coverage for working Georgians with household incomes up to 95% of the FPL, which includes a 5% of the FPL income disregard (referred to as incomes up to 100% of the FPL), and serves as an incentive for participation in work and other employment-related activities for those not currently engaged
- Consumer Tools – Introduce consumer-engagement elements into the Medicaid program to prepare Georgia Pathways participants to transition into the commercial health insurance market once their income exceeds 100% of the FPL
- Employer Sponsored Insurance (ESI) – Provide premium and cost-sharing assistance to those who become Medicaid-eligible through Georgia Pathways and who have access to ESI through a mandatory Health Insurance Premium Payment (HIPP) program

The State recognizes too many of its working, low-income citizens do not have access to or are unable to afford healthcare coverage. Georgia Pathways is an initiative for these Georgians to gain affordable healthcare coverage. The Georgia Pathways model supports Georgians who are working and/or actively engaged in other employment-related activities by offering these individuals the ability to obtain Medicaid coverage. It also creates an incentive for Georgians to initiate or increase their work effort or engagement in other employment-related activities both to gain access to affordable healthcare coverage and improve their overall health and well-being. Georgia's approach is different than other states because it is not adding a work or community engagement requirement to those who are already eligible for Medicaid. Rather, the State is creating a new eligibility pathway focused on encouraging and incentivizing work and other employment-related activities, for low-income Georgians who are not otherwise eligible for Medicaid coverage.

To further support Georgians on their journey to self-sufficiency and the destination of commercial health insurance coverage, Georgia's program is embracing private market policies and principles, such as premiums, copayments, Member Rewards Accounts, and prospective Medicaid eligibility, for a segment of the Georgia Pathways population. Such tools empower members to make cost-conscious healthcare decisions and take responsibility for improving their health. These policies and principles are fundamental components of a commercial health insurance plan. Introducing these elements into the Medicaid program will help better prepare members for their transition into the commercial health insurance market.

Georgia's Demonstration will also implement a mandatory HIPP program, allowing working, low-income Georgians with access to ESI who become eligible through Georgia Pathways to enroll in that coverage in place of Medicaid, if it is cost-effective for the State. Mandatory HIPP engages Georgians in the commercial health insurance market and allows them to realize the benefits of receiving private health insurance coverage with the cost-sharing protections and financial support of Medicaid.

Georgia Pathways to Coverage advances the objectives of the Medicaid program by extending medical assistance to currently ineligible individuals by creating a new Medicaid eligibility pathway for low-income Georgians. Georgia Pathways also helps families and individuals attain independence by integrating commercial health insurance principles and policies into the Medicaid program to assist with a successful transition into the commercial market.

Given that every low-income individual in the expansion population would be eligible either to enroll in Medicaid through the Georgia Pathways approach or purchase health insurance through the Federally Facilitated Exchange (or through the State's new Georgia Access Model, should the corresponding 1332 waiver be approved), the Department is requesting a 90% enhanced match for this 1115 Demonstration Program. As Administrator Verma commented on September 11, 2019, the number of uninsured will continue to increase until the underlying issues in PPACA are addressed. These issues are real in Georgia, where 14.8% of the total population is uninsured.¹ Therefore, the State is proposing comprehensive reforms to both its commercial

¹ U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, available at: <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

health insurance market and Medicaid program to reduce the number of uninsured Georgians and to help support Georgia Pathways participants to effectively transition from Medicaid to a commercial health insurance plan.

Section 1.3: Demonstration Goals and Objectives

Georgia's goals for the Demonstration are to improve **access**, **affordability**, and **quality** of healthcare through strategies that:

- Improve the health of low-income Georgians by increasing their access to affordable healthcare coverage by encouraging work and other employment-related activities
- Reduce the number of uninsured Georgians
- Promote member transition to commercial health insurance
- Empower Georgia Pathways participants to become active participants and consumers of their healthcare
- Support member enrollment in employer-sponsored insurance by providing premium assistance for qualifying employer-sponsored health plans, if doing so is cost-effective for the State
- Increase the number of persons who become employed or engaged in employment-related activities
- Increase wage growth for those who are employed
- Support the long-term, fiscal sustainability of the Medicaid program

Section 1.4: Hypothesis

The foundation of the Georgia Pathways to Coverage program is incentivizing and promoting employment and employment-related activities. Research shows the various positive effects of employment on an individual. Employed individuals are both physically and mentally healthier than those who are unemployed.^{2,3} Work improves various measures of general health and well-being, such as self-esteem, self-rated health, and self-satisfaction.^{4,5} Employed individuals are also more financially stable. The same effects are true for community service, as individuals who volunteer say that they feel better physically, mentally, and emotionally.⁶ Volunteers report that they manage their stress better and feel a stronger connection to their communities. Most importantly, volunteerism can often lead to paid employment. These findings, and the strong connection between employment and engagement in employment-related activities to overall health, serve as the rationale for the Georgia Pathways to Coverage program.

² McKee-Ryan, F.M., et al. Psychological and Physical Well-Being During Unemployment: A Meta-Analytic Study. (2005), *Journal of Applied Psychology* 90(1).

³ Pinto, A.D., et al. Employment Interventions in Health Settings: A Systematic Review and Synthesis. (2018), *Annals of Family Medicine* (16)5.

⁴ Waddell, G. and Burton, A.K. Is Work Good For Your Health And Well-Being? (2006), *EurErg Centre for Health and Social Care Research*, University of Huddersfield, UK

⁵ Robert Wood Johnson Foundation. Work Matters for Health. (2008) Available at <http://www.commissiononhealth.org/PDF/0e8ca13d-6fb8-451d-bac8-7d15343aacff/Issue%20Brief%204%20Dec%2008%20-%20Work%20and%20Health.pdf>

⁶ United Health Group. (2013) Doing good is good for you. 2013 Health and Volunteering Study. Available at <https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2013/UNH-Health-Volunteering-Study.pdf>

In Georgia, 20.7% of individuals between the ages of 19 and 64 are uninsured, which is higher than the national average of 14.8%.⁷ Additionally, 28.5% of Georgia's adult population below 100% of the FPL is uninsured.⁸ Of Georgia's entire uninsured population over the age of 16, 60% of uninsured Georgians are employed at least part-time.⁹ It is the intersection of these two populations – those who are working and uninsured, and those with incomes up to 100% of the FPL – that serve as the target population group for enrollment into Georgia Pathways. This includes individuals who will qualify at the start of the program and those who will become eligible through employment or other employment-related activities over time. Much of this population does not qualify for traditional Medicaid under Georgia's current State Plan, and their incomes below 100% of the FPL make them ineligible to receive subsidies to purchase coverage on the Federally Facilitated Exchange. Thus, these low-income individuals are faced with limited options for healthcare coverage and often remain uninsured; this Demonstration provides a pathway to eligibility for healthcare coverage, specifically Medicaid, for this population.

The State realizes the benefit of providing affordable healthcare coverage to those involved in employment and other employment-related activities both for the individual and the community. Georgia is introducing this program to extend healthcare coverage to working, low-income Georgians and to promote employment and engagement in other employment-related activities across the State. Georgia Pathways seeks to test whether creating a new eligibility pathway will result in more working Georgians having healthcare coverage through the Medicaid program and whether more Georgians will seek employment or engage in other employment-related activities.

To track progress toward program goals, the State will contract with an independent evaluator to test and evaluate the Demonstration throughout the waiver period. Please see **Appendix A** for an outline of potential measures the State may use to evaluate its efforts. The State, working with its independent evaluator, will make future adjustments, subject to CMS approval. Based on CMS guidance, Georgia understands that it will be expected to provide an evaluation plan for CMS comment and approval within 180 days of this 1115 Demonstration waiver application.

Section 1.5: Demonstration Geography and Time Frame

The Demonstration will operate statewide. The State seeks a five-year Demonstration approval period and intends to implement the Demonstration effective July 1, 2021.

Section 1.6: Impact to Medicaid and CHIP

This Demonstration is part of the State's larger initiative to empower Georgians to improve their health by increasing access to affordable healthcare coverage and encouraging employment and

⁷U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, available at: <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

⁸ *Id.*

⁹ *Id.* The Census Bureau defines "employed" as those who either (1) were "at work," that is, those who did any work at all during the reference week as paid employees, worked in their own business or profession, worked on their own farm, or worked 15 hours or more as unpaid workers on a family farm or in a family business; or (2) were "with a job but not at work," that is, those who did not work during the reference week but had jobs or businesses from which they were temporarily absent due to illness, bad weather, industrial dispute, vacation, or other personal reasons. Excluded from the employed are people whose only activity consisted of work around the house or unpaid volunteer work for religious, charitable, and similar organizations; also excluded are all institutionalized people and people on active duty in the United States Armed Forces.

other employment-related activities. The reforms outlined in the following sections only apply to the new Georgia Pathways population. The reforms do not affect or modify any components of Georgia's current Medicaid program.

Section 2: Demonstration Eligibility

Georgia Pathways to Coverage will introduce a new eligibility pathway for working Georgians who would otherwise not be eligible for Medicaid coverage. In order to be eligible for coverage under Georgia Pathways, an individual must meet an hours and activities threshold of 80 hours per month of engagement in a qualifying activity (or combination of activities) such as employment, community service, or education, and have an income up to 100% of the FPL.

Georgia Pathways will align its policies and principles with those of the commercial health insurance market to provide Georgians with an experience similar to that of commercial health insurance. To advance the policies of the commercial health insurance market, Georgia Pathways will include prospective eligibility only and disallows hospital presumptive eligibility for this eligibility group.

Section 2.1: Populations Eligible

The following table identifies populations whose eligibility will be affected by the Demonstration.

Table 2.1: Eligible Populations

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Individuals who meet the Georgia Pathways requirements and are not otherwise eligible for Medicaid	N/A	0% – 100% of the FPL

Section 2.2: Georgia Pathways to Coverage

Section 2.2.1: Eligibility

Population

The population eligible for Georgia Pathways includes parents, caretakers, or guardians with household incomes from 35% to 100% of the FPL who are not currently eligible for Medicaid and adults without dependent children with household incomes up to 100% of the FPL who are not currently eligible for Medicaid, as described in the previous table. Individuals must be between the ages of 19 and 64, must be a resident of Georgia and not incarcerated in a public institution, and must be a citizen of the United States or a documented, qualified alien.

Eligibility Determination

To be determined eligible for Georgia Pathways, an individual must meet the required hours and activities threshold of 80 hours per month and meet the income eligibility requirement of a household income up to 100% of the FPL using the MAGI methodology. If both components are satisfied, the individual is determined eligible to enroll in Medicaid and must enter into a contractual agreement to the terms of the Georgia Pathways program including the associated premium and cost-sharing obligations. Individuals who do not meet the hours and activities threshold, and therefore are not eligible for coverage through Georgia Pathways, will be provided information regarding workforce development resources, such as those offered through the Georgia Department of Labor and those offered by commercial and non-profit entities, where they can gain information about employment or other employment-related activities to help them meet the hours and activities threshold of the waiver.

Eligibility in Georgia Pathways is prospective only. An individual must meet the activity requirements, pay their monthly premium, and select a plan or choose to be auto-assigned before they are enrolled in the Medicaid program. This enrollment will begin at the start of the month following the initial premium payment, if applicable, or the start of the month following enrollment for those who are not required to make a premium payment. Because eligibility in Georgia Pathways is prospective only and has specific activity requirements, there will be no prior quarter determination or hospital presumptive eligibility.

Maintaining Eligibility

To maintain eligibility in Georgia Pathways, a member must continue to meet the hours and activities threshold of 80 hours per month, as well as the income eligibility requirement, and must timely pay required premiums, if applicable. As detailed in *Section 3.2*, individuals who are eligible for ESI must enroll in that insurance, if cost-effective for the State, to maintain Georgia Pathways eligibility. ESI-eligible individuals who decline to enroll in ESI will not be eligible for Georgia Pathways.

Section 2.2.2: Qualifying Activities

Georgia will use a modified version of the Temporary Assistance for Needy Families (TANF) core activities to serve as the basis for allowable activities.¹⁰ Georgia selected using TANF core activities as a basis because TANF is a long-standing program, employs federally accepted standards, and uses a “work-first” approach. Additionally, research studies highlight the positive effects of TANF on states, including a reduction in the number of single parent families living in

¹⁰ 45 CFR § 261.2

poverty,¹¹ an increase in the employment of single mothers,¹² a decline in the receipt of cash assistance,¹³ and an increase in wages.¹⁴

The State will consider the below activities as acceptable for meeting the activities threshold. Georgia Pathways to Coverage requires a minimum of 80 hours per month of a qualifying activity or a combination of qualifying activities.

Table 2.2.2: Activities and Definitions

Activity	Definition
Unsubsidized employment	Full- or part-time employment in the public or private sector that is not subsidized by a public program.
Subsidized private sector employment	Employment in the private sector for which the employer receives a subsidy from public funds to offset some or all of the wages and costs of employing an individual.
Subsidized public sector employment	Employment in the public sector for which the employer receives a subsidy from public funds to offset some or all of the wages and costs of employing an individual.
On-the-job training	Training in the public or private sector that is given to a paid employee while he or she is engaged in productive work, and that provides knowledge and skills essential to the full and adequate performance of the job.
Job Readiness	Activities directly related to the preparation for employment, including life-skills training, resume building, and habilitation or rehabilitation activities. Rehabilitation activities must be determined to be necessary and documented by a qualified medical professional. Members will be allowed to participate in job readiness for no more than a total of six weeks in any 12-month period.
Community Service	Structured programs and embedded activities in which the member performs work for the direct benefit of the community under the auspices of public or nonprofit organizations. Community service programs must be limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural

¹¹ Ben-Shalom, Y. et al., An Assessment of the Effectiveness of Anti-Poverty Programs. (2011) Available at <https://www.nber.org/papers/w17042.pdf>

¹² American Enterprise Institute. TANF has been a success – Let's make it better. (2015) Available at <http://www.aei.org/publication/tanf-has-been-a-success-lets-make-it-better/>

¹³ Cancian, M. and Meyer, DR., Economic success among TANF participants: How we measure it matters. (2014) Available at <https://www.irp.wisc.edu/publications/focus/pdfs/foc232b.pdf>

¹⁴ *Id.*

Activity	Definition
	redevelopment, welfare, recreation, public facilities, public safety, and child care. A state agency shall take into account, to the extent possible, the prior training, experience, and skills of an individual in making appropriate community service assignments.
Vocational Educational Training	Organized educational programs that are directly related to the preparation of individuals for employment in current or emerging occupations. Course hour requirements for vocational educational training shall be determined by the Department of Community Health. Participation in vocational educational training is limited to 12 months in a member's lifetime, unless a member is enrolled in vocational education for a highly sought-after trade through the Technical College System of Georgia High Demand Career Initiative. In this instance, vocational educational training may count as a qualifying activity for the duration of the vocational education program.
Enrollment in an Institution of Higher Education ¹⁵	Enrolled in and earning course credit at a college, university, or other institution of higher learning. A full-time academic workload, as determined by the Department of Community Health, will meet the requirements for 80 hours of qualifying activities in the month. For individuals not enrolled full-time, the Department of Community Health shall determine the associated number of qualifying activity hours based on the course load when compared to full-time. The student's workload may include any combination of courses, work, research, or special studies that the institution considers contributing to the individual's full-time status. As the payor of last resort, students enrolled in an institution of higher education who have access to their parent's health insurance coverage are not eligible for Georgia Pathways coverage.

Medicaid coverage extends to individuals who age out of the foster system. These former foster children are categorically eligible for Medicaid through the age of 26 and should not enroll under Georgia Pathways.

¹⁵ Enrollment in an institution of Higher Education is not a core TANF activity. This definition is modified from that found in the regulations for Institutional Eligibility under the Higher Education Act of 1965, codified at 34 CFR § 668.2.

Section 2.2.3: Reporting and Compliance

Reporting

To remain eligible for Medicaid coverage through Georgia Pathways, a member must report their hours monthly. Reporting of hours will include a member's self-attestation of activity hours, accompanied by supporting documentation such as a pay stub or a transcript. The State will allow submission of supporting documentation through multiple avenues including an online portal or in-person. Members who are self-employed can be verified by using income information and minimum wage data to estimate hours worked. The State will also employ periodic and random audits to verify documentation and compliance with the hours and activities threshold.

Members with evidence of meeting the hours and activities threshold for six consecutive months, based on income data from eligibility determination, will be exempt from the reporting requirement except that members will have an affirmative responsibility to inform the State if their employment status changes. The member will be re-evaluated for eligibility during the annual redetermination. Members who are exempt from the reporting requirement remain obligated to report changes to employment, including increases or decreases in hours. If, at any time, the State is made aware that a member's employment status changed during their current enrollment period, and the member does not report the change in employment status, the member is liable for all incurred capitation rate expenses paid on the member's behalf, as well as any cost-share expenses, if applicable.

Compliance

The member must meet the hours and activities threshold each month. If a member does not meet the hours and activities threshold, they will be suspended from Medicaid and no longer able to receive the Medicaid benefit. The member has three months to meet the hours and activities threshold for Georgia Pathways for the suspension to be lifted. If the member does not meet the requirement after three months of suspension, then the member will be disenrolled from Medicaid. The individual can regain eligibility at any point after being suspended or disenrolled if they meet the hours and activities threshold, income eligibility requirement, and any premium obligations (if applicable) in a single month. The individual would be eligible for re-enrollment on the first of the month following the determination of eligibility, enrollment, and payment of premium, if required, and must maintain the hours and activities threshold to remain enrolled.

If a member pays a premium and they are suspended for the applicable month due to not meeting the hours and activities threshold, the member will receive a credit for the premium paid. This credit will be applied to future premiums once the individual is re-enrolled. If the individual does not regain eligibility, the State will reimburse the individual for the paid premium at the end of the plan year.

The State recognizes there are circumstances that temporarily limit or prevent a member from being able to participate in a qualifying activity or to meet the hours threshold. Therefore, a member, who has previously been satisfying the 80 hour per month activity threshold, will

receive a short-term exception for failure to meet the hours and activities threshold if any of the following events occurred:

- A family emergency or other life changing event
- Birth or death of a family member
- Serious illness or hospitalization of member or a member of their family
- Severe inclement weather including a natural disaster
- Temporary homelessness
- Other good cause reason as defined and approved by the State

Section 2.3: Projected Enrollment

Projected enrollment in Georgia's Pathways to Coverage population is based on the total count of uninsured Georgians under 100% of the FPL and between the ages of 19 and 64 as reported by the U.S. Census Bureau via the American Community Survey five-year estimates.

Table 2.3: Projected Enrollment by Demonstration Year (DY)

Eligibility Group	Projected Enrollment by Eligibility Group				
	DY 1	DY 2	DY 3	DY 4	DY 5
Individuals who meet the Georgia Pathways requirements and are not otherwise eligible for Medicaid	25,028	47,362	48,782	50,490	52,509

Section 2.4: Eligibility Policies

Section 2.4.1: Coverage Effective Date

An individual with an income between 50% of the FPL and up to 100% of the FPL will have a Georgia Pathways coverage effective date on the first of the month after their premium is paid. An individual with an income below 50% of the FPL will have a coverage effective date on the first of the month following their eligibility determination.

Section 2.4.2: Retroactive Coverage

To better align with commercial health insurance coverage, Georgia is requesting a waiver of the requirement to provide three months retroactive coverage to members enrolled through Georgia Pathways. Individuals will become eligible for coverage based on the policies outlined in *Section 2.4.1*.

Section 2.4.3: Presumptive Eligibility

Georgia seeks to waive hospital presumptive eligibility. Eligibility in Georgia Pathways is prospective and has a specific hours and activities threshold requiring verification, which is not practicable for hospitals to evaluate.

Section 3: Demonstration Benefits and Cost-Sharing Requirements

Georgia Pathways to Coverage will provide Georgians with an experience similar to commercial health insurance in order to better prepare them for their transition from Medicaid into a commercial health insurance plan. Building personal responsibility through financial contributions toward their health care will empower Georgia Pathways members to more actively engage in managing their own health and develop important skills needed for a smooth transition into commercial health insurance. These transitions are especially critical to maintain health outcomes that the members may achieve through Georgia Pathways and to avoid potential disruptions in insurance status as a member transitions out of Medicaid.

The State will maintain the State Plan benefits for the Georgia Pathways population, except for non-emergency medical transportation (NEMT). Members enrolled in ESI will have a different benefit package based on the insurance offered by their employer and will receive premium and cost-sharing assistance. Additional benefits such as vision and dental can be purchased through a Member Rewards Account that receives revenue from member contributions and state-funded incentives for healthy behaviors.

The State will also build upon its existing voluntary HIPPP program by paying the ESI premiums and cost-sharing for all Georgia Pathways members with access to health insurance if it is cost-effective for the State. This will strengthen the State's overall insurance market by maintaining individuals in their ESI rather than moving them to a Medicaid Care Management Organization (CMO). In addition, as previously discussed, it will support continuity of coverage for individuals whose incomes rise, and they become ineligible for Medicaid.

Section 3.1: Benefit Package

The benefit package provided under Georgia Pathways will differ slightly from those benefits provided under the Medicaid State Plan. Georgia is seeking to provide a benefit package more consistent with commercial health plan benefits and is requesting a waiver of NEMT for the Georgia Pathways population. The State Plan benefits include Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for enrollees ages 19 and 20.

Table 3.1: Benefit Package by Eligibility Group

Eligibility Group	Benefit Package
Individuals who meet the Georgia Pathways requirements and are not otherwise eligible for Medicaid	Georgia State Plan without NEMT
ESI Eligible Adults	Benefit package provided in the ESI plan Premium and Cost-Sharing Assistance

For members for whom the State is paying the cost of ESI, wraparound benefits (i.e., benefits that are not covered by that ESI plan) are not covered.

Section 3.2: Employer Premium Assistance Program

Georgia currently operates a voluntary HIPP program under its State Plan. Georgia Pathways participants who have access to ESI may be eligible for HIPP if it is determined to be cost-effective for the State. Georgia's current HIPP program does not pay coinsurance or deductibles. An individual is currently eligible to apply for HIPP if the individual or a family member is eligible for Medicaid and the individual is eligible for ESI. Once an individual is determined eligible, Georgia's HIPP program begins reimbursing the monthly premium and associated cost-sharing.

Under Georgia Pathways, members with access to ESI must enroll in HIPP if it is cost-effective for the State. The State will ensure that the employer sponsored plan is cost-effective using a methodology that considers the amount paid under capitation versus what it would pay to cover the cost of premiums and associated cost-sharing.¹⁶ HIPP enrollment, when determined cost-effective, will be a condition of Georgia Pathways eligibility. If a Georgia Pathways member disenrolls from ESI while it still is available and cost-effective, the member is no longer eligible for Medicaid through Georgia Pathways. If during a redetermination or based on other information reported to the State, an employer sponsored plan is no-longer cost-effective, the member will no longer be required to be enrolled in HIPP and can be enrolled in Medicaid through Georgia Pathways, assuming the member is still eligible.

As previously discussed, no wraparound benefits will be provided to Georgia Pathways members enrolled in HIPP.

Section 3.3: Cost-Sharing

Another tool Georgia will use to support members in preparing for commercial health insurance is requiring financial contributions toward the costs of coverage. These funds will then be used to incent members to engage in healthy behaviors and access additional benefits. As detailed below, certain Georgia Pathways members will be assessed enforceable premiums, which will be

¹⁶ Georgia considers cost-effective for purposes of HIPP as a cost-savings to the State of at least \$1.00.

deposited into a Member Rewards Account. From this Account, members will be able to make required copayments as well as use funding to purchase qualified health-related services and goods.

Section 3.3.1: Premiums

A segment of the population eligible for Georgia Pathways will be required to make sliding scale flat rate monthly premium payments tiered based on family income. The payment rates are affordable and calculated to not exceed 2% of household income across each income threshold payment band. Premiums paid will be deposited in the member's (or household's) Member Rewards Account.

Applicable Populations

Members who are required to pay premiums are:

- Adults without dependent children with incomes between 50% and up to 100% of the FPL who are not currently eligible for Medicaid and become eligible and enrolled through Georgia Pathways
- Parents with household incomes between 50% and up to 100% of the FPL who are not currently eligible for Medicaid and become eligible and enrolled through Georgia Pathways

Members who are exempt from premium requirements are:

- Members enrolled through Georgia Pathways who are under the mandatory HIPP program
- Members receiving coverage through Georgia Pathways who are enrolled in, and for two months after graduation from, vocational education programs of highly sought-after trades through the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant programs
- Members enrolled through Georgia Pathways with incomes below 50% of the FPL
- All other populations not enrolled in Georgia Pathways

Premium Amounts

Table 3.3.1 displays the sliding scale monthly premium amounts by income level. Members will pay a monthly premium tiered based on income.

Table 3.3.1: Sliding Scale Premium Contribution Amounts

Percent of the FPL	Monthly Single	Monthly Spouse	Tobacco Surcharge
50% – 84%	\$7.00	\$4.00	\$3.00
85% – 100%	\$11.00	\$7.00	\$5.00

If two spouses in the same household are enrolled in Georgia Pathways, the associated premium for the second enrolled spouse is discounted as detailed in Table 3.3.1.

In addition, the State will apply a premium surcharge for members who use tobacco. This will help evaluate whether providing a financial incentive to engage in activities that are known to improve a member's health will result in improved health outcomes. Only one tobacco surcharge will be applied per household. This surcharge is appealable for a member who disagrees that they are subject to the surcharge.

Georgia will notify individuals about the premium requirements upon eligibility determination, including the premium amounts required by income. Members will be sent monthly invoices for the premium amounts, which will include information about how to report changes in income and the consequences of nonpayment of premiums. If, at any time including at redetermination, the State is made aware that a member's income changed during their current enrollment period, the State will evaluate whether the member's premium contribution amount should be adjusted.

Penalties

As in commercial health insurance, members are required to pay premiums to maintain eligibility for Georgia Pathways. Members who miss a premium will have a three-month period to retain their Georgia Pathways eligibility without being disenrolled, as detailed below.

If a member misses a month's premium, that member enters a one-month grace period in which the member retains eligibility, claims are paid, and the CMO capitation payment for the member is made.

If the member misses a second month's premium, that member is placed in a suspended status in which claims may be pended, but the CMO capitation payment is still made. If the member pays their missed premium within this month, the member's enrollment suspension is lifted at the point of payment, retroactive to the date of suspension, and claims will be paid back to that date.

If the member misses a third month's premium, that member remains in a suspended status during the month. If the member pays their missed premium within this month, the member's enrollment suspension is lifted at the point of payment, retroactive to date of suspension, and claims will be paid back to that date. If the member does not pay the missed premium, the member will be disenrolled at the end of the month.

While the State will make CMO capitation payments during the periods while the member is suspended, if the member is disenrolled at the end of the third month, the State may seek to recoup the capitation payments from the months during which the member was suspended.

Section 3.3.2: Copayments

The same populations subject to premiums will also be required to pay copayments for certain services. These copayments, when combined with other household copayments, will not exceed 3% of the household's income. Copayments and premiums together will not exceed 5% of household income (as evaluated quarterly).

Copayments under Georgia Pathways will not be assessed at the point of service and will not be collected by providers. Instead, copayments will be assessed retrospectively for services already received. The State will use encounter data to determine the applicable copayments for the services the member received over a prior period.

If there are sufficient funds in the member's Member Rewards Account to pay for the required copayment, that amount will be transferred from the Member Rewards Account to the State with the appropriate federal share returned to the federal government as a program offset. If there are not sufficient funds in the member's Member Rewards Account, copayments will still be deducted from the Member Rewards Account, resulting in a negative balance. Any future premium payments or healthy incentive points will be applied to the balance.

Members will be sent monthly invoices for the copayment amounts which will include information about the amount owed, the amount paid out of the member's Member Rewards Account, and how to report changes in income. If, at any time including at redetermination, the State is made aware that a member's income has changed during their current enrollment period, the State will evaluate whether the member is still required to make copayments.

Applicable Populations

Members who will be required to pay a copayment are:

- Adults without dependent children with incomes between 50% and up to 100% of the FPL who are not currently eligible for Medicaid and become eligible and enrolled through Georgia Pathways
- Parents with household incomes between 50% and up to 100% of the FPL who are not currently eligible for Medicaid and become eligible and enrolled through Georgia Pathways

Copayment Amounts

Table 3.3.2 outlines the services for which mandatory copayments will be assessed and the copayment amounts. This mirrors the existing copayment structure under the State Plan, except for the addition of a copayment for non-emergency use of the emergency department.

Table 3.3.2: Copayment for Services

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

Service	Copay
Durable medical equipment (DME)	\$3.00 \$1.00 for rentals and supplies
Pharmacy – Copayment varies based on the cost to the State	\$10.00 or less: \$0.50 \$10.01 to \$25.00: \$1.00 \$25.01 to \$50.00: \$2.00 \$50.01 or more: \$3.00

Section 3.3.3: Member Rewards Account

The Member Rewards Account is a tool to support members in managing their own health and to incent healthy behaviors. Funds in the account will be available to pay copayments as well as to pay for services not covered by Medicaid that will support the member's health goals. Through the Account, the State will provide incentives for members to engage in healthy behaviors and activities that support health outcomes.

Applicable Populations

Groups for whom the State will maintain a Member Rewards Account:

- Adults without dependent children with incomes between 50% and up to 100% of the FPL who are not currently eligible for Medicaid and become eligible and enrolled through Georgia Pathways
- Parents with household incomes between 50% and up to 100% of the FPL who are not currently eligible for Medicaid and become eligible and enrolled through Georgia Pathways

For households with two enrolled spouses, the spouses will share an account that will receive premium revenue from both spouses and pay required copayments for both.

Account Revenue and Uses

Account Revenue

Member premiums will be deposited into the Member Rewards Account.

In addition, the State will set a series of criteria for awarding points, which will translate to dollars upon use. Criteria may include, but not be limited to:

- Being a non-smoker or quitting smoking
- Completing annual well care visits
- Complying with diabetes programs
- Maintaining a body mass index (BMI) between 18.5 and 24.9

*Account Uses*Copayment Costs

If the member has value in their Member Rewards Account, the cost of copayments will be assessed from the Account. If there are not sufficient funds in the account, copayments will still be deducted from the Member Rewards Account, resulting in a negative balance. Any future premium payments or healthy incentive points will be applied to the balance.

Health-Related Expenses

If the balance of the Account exceeds \$200/points, members may use the Member Rewards Account for other medical expenses not covered by Medicaid. Permissible expenses include over the counter drugs, dental services, glasses, contacts, and other state-determined allowable expenses.

Post-Medicaid Expenses

If a member's income exceeds 100% of the FPL and they leave Medicaid and gains commercial health insurance coverage, the remaining member contributions in the Member Rewards Account will be made accessible to the member for future health related expenses.

Penalties

Members will be sent a monthly invoice for their required copayment amounts. If money is available in the Member Rewards Account, those funds will be used to cover the costs of the copayments. If there are not sufficient funds in the account, copayments will still be deducted from the Member Rewards Account, resulting in a negative balance. Any future premium payments or healthy incentive points will be applied to the balance.

Section 4: Delivery System and Payment Rates for Services

Section 4.1: Managed Care Delivery System

The State will use a managed care delivery system to provide services to the Georgia Pathways population. The State currently contracts with four CMOs, which were selected through a competitive procurement process. The State last procured these contracts in 2017 and intends to amend its existing contracts with its CMOs to implement the provisions of this 1115 Demonstration waiver. The State will not use fee-for-service payments for any covered services.

The State will continually monitor geo-access to confirm the CMOs have enough providers to facilitate access for the Georgia Pathways population.

Section 4.2: Health Plan Choice

The State will ensure the Georgia Pathways population has choice of CMOs consistent with Medicaid requirements. Individuals will be able to select one of the CMOs upon application and

will be prospectively enrolled into that plan. The individual will also be able to elect to be auto-assigned into a CMO prospectively using existing algorithms applicable to the current Medicaid program.

Members will have 90 days to switch plans. If a member does not make a different choice within the 90-day period, the member will remain with the selected/assigned CMO until the member's annual choice period.

Section 4.3: Capitated Payments

The capitation rate-setting methodology for Georgia Pathways will be the same methodology used to set rates for the current Medicaid populations and will comply with all federal rate-setting requirements and guidance.

Section 5: Implementation of Demonstration

Georgia intends to begin enrollment in the Georgia Pathways to Coverage eligibility category on July 1, 2021. The cost-sharing, Member Rewards Account, and mandatory HIPP components of the waiver will also begin July 1, 2021. Prior to July 1, 2021 Georgia will complete necessary changes to its existing systems, including the State's eligibility system and Medicaid Management Information System (MMIS), to support the implementation of Georgia Pathways. Georgia is determining whether a separate procurement is needed for a vendor for the Member Rewards Account component.

The State will also make changes to existing business processes or create new business processes to support Georgia Pathways and will complete the staff education and training on those processes with sufficient time for the July 1, 2021 implementation date.

Section 5.1: Notification and Enrollment

Georgia will begin its outreach and communication activities on April 1, 2021. Stakeholder forums and webinars will be conducted across the State beginning April 1, 2021 explaining the Georgia Pathways program and providing information on the eligibility requirements and how individuals can apply for Medicaid through Georgia Pathways. Written descriptions of the Georgia Pathways program requirements will also be disseminated beginning in April 2021 to stakeholder groups across the State. Information about Georgia Pathways will be provided on the Georgia Gateway website (the State's eligibility system).

Individuals seeking to enroll in Georgia Pathways will use existing Medicaid eligibility determination channels and processes.

Section 5.2: Managed Care

Georgia will continue to use its CMOs to provide benefits to the Georgia population. The State conducted its last procurement in 2017 and can amend the existing contracts to include the new Georgia Pathways eligibility group. The State does not need to conduct a procurement action to implement the provisions of this waiver.

Section 6: Demonstration Financing and Budget Neutrality

Please refer to **Appendix B** for the Budget Neutrality With Waiver (WW) and Without Waiver (WOW) exhibits. As discussed below, the State is requesting the Georgia Pathways population be considered “hypothetical”; therefore, a simplified single exhibit is provided.

Overview

The Georgia Pathways Demonstration provides a new pathway to healthcare coverage for low-income Georgians up to 100% of the FPL who are not otherwise eligible for Medicaid coverage. The State is requesting a Demonstration implementation date of July 1, 2021, which aligns with the current managed care program rate period.

The population that will enroll under this Demonstration is not currently Medicaid-eligible; therefore, no actual historical data is available for this population to support Budget Neutrality projections. Therefore, a comparable population was used as a basis for base expenditure per enrollee development. The data used, and adjustments applied to align the costs with the population anticipated to enroll under this Demonstration, are described in the following Expenditure section.

For purposes of this Budget Neutrality calculation, the State is requesting the expenditures under this Demonstration to be considered “hypothetical.” Per the August 22, 2018 State Medicaid Director’s Letter (SMD #18-009):

“In cases where 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 currently makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were approved Medicaid state plan services.”

Enrollment

Table 6.0(a) summarizes enrollment estimates for the Georgia Pathways population. The population figures reflected are the average assumed enrollment for each DY. Enrollment reflects the State’s estimates for both those enrolling in CMOs and individuals enrolling in the mandatory HIPP program.

The base eligible population is the total count of uninsured Georgians up to 100% of the FPL and between the ages of 19 and 64 as reported by the U.S. Census Bureau via the American Community Survey five-year estimates.

Enrollment estimates for DY 1 were phased-in equally over 12 months with the expectation that all initial program phase-in would be captured by the end of DY 1 with an estimated enrolled Georgia Pathways population of 46,206 individuals. After the initial phase-in during DY 1, all

enrollment growth from DY 2 through DY 5 would be attributable to increases in the number of individuals completing qualifying activities. This growth assumption starts at 2.5% in DY 2 and increases by 0.5% increments to 4% by DY 5.

The average number of months per member for our hypothetical population was assumed to be the same as the number of months per member for our comparable Georgia Families population. Review of the Georgia Medicaid data supported the development of a 10 month/member average. Due to initial DY 1 phase-in, the assumed member months per member is set to 12.

Table: 6.0(a): Estimated Enrollment

	DY 1	DY 2	DY 3	DY 4	DY 5
Estimated Enrollment	25,028	47,362	48,782	50,490	52,509
Estimated Member Months	300,342	473,616	487,824	504,898	525,094

Expenditures Per Member Per Month

As previously discussed, no historical expenditure data for the target population to be covered by this Demonstration is available. The 21 to 64-year-old members in the State's Georgia Families managed care program were identified as the best available comparable population to formulate the base cost for the Georgia Pathways population. The Calendar Year (CY) 2017 Medicaid encounter and eligibility data for this comparable population was used to prepare the per member per month (PMPM) expenditure baseline estimates as a proxy for the Georgia Pathways population, as the runout for CY 2017 was more complete than that for CY 2018. Adjustments to the baseline PMPMs were required to account for costs not captured in the base expenditure data. The impact of these adjustments is shown in Table 6.0(b) and described in further detail below.

Table 6.0(b): Estimated Expenditure PMPMs

Demonstration Year	Historical Expenditure PMPM	Population Shift Adjustment	Growth Factor	Acuity Adjustment	Pent-up Demand	Non-Benefit Expenses	Health Insurer Fee (HIF)	Retroactive Coverage	Estimated Expenditure PMPM
DY 1	\$366.45	1.0296	1.2191	.9430	1.0563	1.1228	1.0266	.978	\$516.49
DY 2	\$366.45	1.0296	1.2739	.9430	1.0392	1.1228	1.0266	.978	\$530.97
DY 3	\$366.45	1.0296	1.3312	.9430	1.0000	1.1228	1.0266	.978	\$533.92
DY 4	\$366.45	1.0296	1.3911	.9430	1.0000	1.1228	1.0266	.978	\$557.95
DY 5	\$366.45	1.0296	1.4537	.9430	1.0000	1.1228	1.0266	.978	\$583.05

Population Shift Adjustment

Adjustments to the baseline PMPMs were required to account for differences in member distribution for the Georgia Pathways population relative to the comparable population. The State evaluated the enrollment distribution of the new adult group from other states to reweight the expected enrollment distribution of Georgia's comparable population for factors such as age and gender.

Growth Factor

The comparable population was the best available source of expenditure and enrollment data to develop the expenditure PMPM baseline. However, the historical experience is not a directly appropriate benchmark for the development of the underlying expenditure trends, which are applied to develop the estimated expenditure PMPMs in each demonstration year.

Based on an analysis of the historical data available for the comparable population, programmatic changes and other market forces that are present in the historical timeframe from CYs 2014 through 2016 drove significant volatility in raw annual PMPM trends. Further, trends developed by the State's actuary to set the Georgia Families program's actuarially sound capitation rates for the comparable population are significantly different than those raw observed annual trends, highlighting the disconnect between the data and reasonable trend factors. Finally, as observed in other states where new adult groups have gained Medicaid coverage in recent years, the cost profiles can shift dramatically year over year causing an accurate assessment of underlying medical trends to be challenging and/or unreliable.

Based on Georgia specific analyses, projected trends in the approved CY 2018 Georgia Families Rate Certification, experience observed in other states, and review of the President's trend, the State is applying a 4.5% annual trend rate to develop the growth factors. The growth factor is developed by compounding $1 +$ the annual trend rate from the midpoint of the experience period (July 1, 2017 to the midpoint of the demonstration year (e.g., January 1, 2022 for DY 1)).

Acuity Adjustment

Given evidence that employed persons are generally healthier than unemployed persons of comparable age, it is assumed that the enrolled Georgia Pathways population will be healthier than the comparable population used as the basis for the expenditure PMPMs. Adjustments to account for relative improvement in morbidity were applied to account for the higher incomes of the enrolled population as well as the expectation that the majority of individuals meeting required qualifying activities will be working 80 or more hours per month.

Pent-up Demand

The enrolled Georgia Pathways population will be comprised of low-income individuals who have been uninsured for an uncertain period of time. Based on experience observed in other states, an assumption to account for the increased cost experienced for an individual gaining access to new benefits has been applied. The application of this adjustment is specific to the start of the period in which a new member enrolls in the program and accounts for the initial program

phase-in. Pent-up demand for individuals enrolling after the first demonstration year are expected to be minimal, so no further adjustment was applied.

Non-Benefit Expenses

The actuarially sound capitation rate that will be developed for the Georgia Pathways population will need to include considerations for administrative expenses, risk margin, and premium based taxes. The assumption applied for non-benefit expenses is based on the comparable population non-benefit expense loads in the approved state fiscal year (SFY) 2018 Georgia Families Rate Certification.

Health Insurer Fee

If the moratorium on the health insurer fee (HIF) is not extended, the actuarially sound capitation rate that will be developed for the Georgia Pathways population will need to include an adjustment for this fee. Because the moratorium has not been extended, an adjustment was included. The assumption applied for the HIF is based on the average HIF in CY 2017 and CY 2019.

Retroactive Coverage

The State is requesting to eliminate the three-month retroactive coverage for the Georgia Pathways population. The expected reduction in costs was estimated to reduce expenditure PMPMs by approximately 2.2%.

Premiums and Copays

No adjustment was made for premiums and copays because the funding is either a programmatic offset or the funds may be transferred to the member upon leaving the Georgia Pathways program.

Section 7: List of Proposed Waivers and Expenditure Authorities

Section 7.1: Title XIX Waivers

Below is a list of proposed waivers necessary to implement Georgia's 1115 Demonstration:

- **Reasonable Promptness: Section 1902(a)(3)/Section 1902(a)(8)**
 - To the extent necessary to enable Georgia to begin Medicaid coverage on the first day of the month following an individual's determination of eligibility.
 - To the extent necessary to enable Georgia to begin Medicaid coverage on the first day of the month following an individual's first premium payment.
- **Methods of Administration: Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**
 - To the extent necessary to enable Georgia to waive NEMT services.
- **Provision of Medical Assistance: Section 1902(a)(8)**

- To the extent necessary to enable Georgia to discontinue eligibility for, and not make medical assistance available to, members who fail to comply with the hours and activities threshold under Georgia Pathways.
- **Eligibility: Section 1902(a)(10)(A)**
 - To the extent necessary to enable Georgia to delay coverage until the first day of the month following an individual's determination of eligibility.
 - To the extent necessary to enable Georgia to delay coverage until the first day of the month following an individual's first premium payment.
- **Comparability of Eligibility Requirements: Section 1902(a)(10)(A)(i)(VIII) and 1902(a)(17)**
 - To the extent necessary to enable Georgia to require an hours and activities requirement as a condition to maintain eligibility.
- **Amount, Duration, Scope, and Comparability - Section 1902(a)(10)(B)**
 - To the extent necessary to enable Georgia to allow individuals to receive the benefits provided through an ESI plan, without wrap-around benefits.
- **Cost-Sharing: Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**
 - To the extent necessary to enable Georgia to charge monthly premiums and higher co-pays.
- **Freedom of Choice: Section 1902(a)(23)**
 - To the extent necessary to enable Georgia to restrict the freedom of choice of providers for Demonstration eligibility groups.
- **Retroactive Eligibility: Section 1902(a)(34)**
 - To the extent necessary to enable Georgia to begin eligibility the month following determination of eligibility and payment of any required premium.
- **Prepayment Review: Section 1902(a)(37)(B)**
 - To the extent necessary to enable Georgia to ensure that prepayment review be available for disbursements by members to their providers through the Member Rewards Account.
- **Vision and Dental Coverage: Section 1902(a)(43)**
 - To the extent necessary to enable Georgia not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act for 19- and 20-year-old members.
- **133 Percent Income Level: Section 1902(a)(10)(A)(i)(VIII)**
 - To the extent necessary to enable Georgia to implement a lower income level for the Demonstration group.

Georgia is requesting a waiver of the income level specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, which will permit the State to implement an income level of 95% of the FPL, rather than 133% of the FPL, for the Demonstration group. This will allow the State to receive the full enhanced Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y).

Section 7.2: Costs Not Otherwise Matchable Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of the Demonstration be regarded as matchable expenditures under the State's Medicaid Title XIX State Plan. The expenditure authorities listed below promote the objectives of Title XIX.

1. Demonstration Population I.

- Expenditures to provide health services to non-disabled and non-elderly individuals age 19 through 64 with incomes above the Medicaid standard but at or below 100% of the FPL who are not otherwise eligible for Medicaid.
- Expenditures for premium assistance and associated cost-sharing to subsidize the employee's share of the costs of the insurance premium for employer sponsored health insurance to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 100% of the FPL who are not otherwise eligible for Medicaid as well as their spouses and their children, age 19 through 26, who are enrolled in their parents' ESI plan, who are not otherwise eligible for Medicaid.

Section 8: Public Notice and Comment

Georgia used multiple mechanisms to notify the public about the Demonstration waiver application and provided ample opportunity for the public to provide feedback both via oral testimony and written comment. The Department's public notice and public comment procedures are informed by, and comply with, the requirements specified at 42 CFR § 431.408.

Section 8.1: Public Notice

On November 4, 2019, Governor Brian P. Kemp publicly announced the Georgia Pathways to Coverage 1115 Demonstration waiver application. The Department of Community Health held a Board of Directors meeting on the same day to adopt the public notice and officially open the 30-day public comment period, as part of the State's administrative process. The public comment period began November 4, 2019 and closed on December 3, 2019. The Board meeting was open to the public. Interested parties were notified of the Board meeting via e-mail, and the meeting agenda was posted to the Department's website one week in advance of the meeting. A copy of the presentation given to the Board is included as **Appendix C** of this waiver application.

The Department posted the public notice, including a comprehensive description of the application as well as the locations of the public hearings, on a dedicated webpage on the Department of Community Health's website, <https://medicaid.georgia.gov/patientsfirst>, on November 4, 2019. The notice was shared via social media, including Facebook and Twitter, and it was posted on the Department's main webpage, <https://medicaid.georgia.gov/>. Electronic copies of the waiver application and all presentations related to Georgia Pathways were available

on the Department's dedicated webpage throughout the comment period. The public notice provides instruction for any individual to submit written feedback to the State via an electronic intake portal on the Department's dedicated webpage or by USPS mail. The public notice was also sent to the Division of Family and Children Services' central office for distribution to all 159 individual county offices. A full copy of the public notice and the abbreviated public notice are included as **Appendix D** of this waiver application.

At the onset of waiver development, the Department convened a group of stakeholders to engage during the process when considering changes to the Medicaid program to increase access across the State, lower the cost of healthcare for working Georgians, and improve quality of care. The Department emailed a broad range of interested parties/stakeholders about the public notice and waiver application. The Department assembled the stakeholder group on November 4, 2019 to provide an overview of the Demonstration waiver. This meeting was open to the public. A list of stakeholders notified about this meeting is included as **Appendix E**, and a copy of the stakeholder presentation is included as **Appendix F** of this waiver application.

In addition to the stakeholder meeting, the Demonstration was presented to a public legislative committee hearing, the Joint House and Senate Health and Human Services Committee, on November 5, 2019. This legislative hearing was open to the public and was livestreamed online, and a copy of the hearing is available for viewing at <https://medicaid.georgia.gov/patientsfirst>.

Section 8.2: Public Hearings

While federal regulations only require two public hearings, the State held six formal public hearings in geographically distinct areas of the State during the public comment period. These hearings took place as follows:

- **Savannah, Georgia**
Thursday, November 7, 2019, 9:00 a.m. EST
Hoskins Center for Biomedical Research, Mercer Auditorium
1250 East 66th Street, Savannah, Georgia 31404
- **Macon, Georgia**
Wednesday, November 13, 2019, 9:00 a.m. EST
Mercer University School of Medicine, Auditorium
1550 College Street, Macon, Georgia 31207
- **Bainbridge, Georgia**
Thursday, November 14, 2019, 9:00 a.m. EST
Southern Regional Technical College
The Charles H. Kirbo Regional Center, Dining Room 112
2500 East Shotwell Street, Bainbridge, Georgia 39819
- **Gainesville, Georgia**
Monday, November 18, 2019, 9:00 a.m. EST
Gainesville Civic Center, Chattahoochee Room
830 Green Street, Gainesville, Georgia 30501

- **Rome, Georgia**
Thursday, November 21, 2019, 9:00 a.m. EST
West-Rome Baptist Church, The Well Building
914 Shorter Avenue, Rome, Georgia 30165
- **Kennesaw, Georgia**
Friday, November 22, 2019, 10:00 a.m. EST
North Cobb Regional Library, Multi-purpose Room
3535 Old 41 HWY, Kennesaw, Georgia 30144

Each of the six public hearings followed the same format, beginning with an overview of the Georgia Pathways waiver proposal, followed by the collection of oral public comment. A court reporter transcribed and entered into the public record all verbal comments presented during each of the public hearings. The transcripts from each of the public hearings are available on a dedicated webpage on the Department of Community Health's website, <https://medicaid.georgia.gov/patientsfirst>. A sign language interpreter was available at all the hearings for the individuals present, and individuals requiring special accommodations, including auxiliary communicative aids and services during these meetings could request such accommodations in advance of the meeting. The hearing presentation is included as **Appendix G**. A brief overview of the hearings is provided here. Additional information regarding the totality of comments received and the State's response to those comments is outlined in *Section 8.3*.

Summary of Public Hearings

A total of 126 individuals attended the six hearings the Department hosted across the State. Forty-two individuals gave oral testimony. Speakers spoke on behalf of themselves as Georgia residents and the following organizations: Step Up Savannah, Georgia Legal Services, Georgia Council on Substance Abuse, Georgians for a Healthy Future, Middle Georgia Medical Society, J's Place Recovery, Georgia Primary Care Association, Northeast Georgia Health System, National Multiple Sclerosis Society, Georgia Interfaith Public Policy Center, Mercy Care, Georgia Mountains Health Services, Georgians for a Healthy Future, Planned Parenthood Southeast, Community Catalyst, Georgia Society of Clinical Oncology, Georgia Budget and Policy Institute, Georgia Advocacy Office, NAMI, New Georgia Project, Recovery Bartow, and American Lung Association.

Section 8.3: Public Comments

Following the public comment period, all written and oral comments were cataloged, summarized, and organized. In total, the State received 869 public comments during the public comment period, including 827 written comments, and 42 oral testimonies across the six public hearings. The State reviewed all comments and appreciates the public input received from Georgia residents and interested organizations. The State summarized comments and provided

responses below, including an indication of any modifications that have been made to the waiver application as a result of the public comments.

The following summary combines the testimony offered at the public hearings as well as the comments received by the State through the comment portal and via USPS mail. The Department gave all comments received through the various mechanisms the same consideration. To address public input, comments are summarized by topic and are followed by a response. A complete collection of all public comments submitted is available on a dedicated webpage on the Department of Community Health's website, <https://medicaid.georgia.gov/patientsfirst>.

A number of commenters addressed multiple provisions in the waiver application. Additionally, there were several comments that were either fully in support of or in opposition to the proposed waiver. The majority of comments received were robust and touched on a broad range of topics that generally aligned with the following categories:

- Program Goals
- Eligibility Criteria
- Benefits
- Premiums and Copayments
- Other

Program Goals:

Summary of Comments: Some commenters encouraged the State to fully expand Medicaid up to 138% of the FPL. They referenced a financial benefit accompanying a full expansion; specifically, the enhanced federal match and increased dollars that would come to the State. Some commenters highlighted the increased number of Georgians that would be covered if the State chose to fully expand Medicaid. Others highlighted populations that experience challenges with accessing care, particularly those who are homeless or who live in rural areas and suggested a full expansion to 138% of the FPL as a solution.

State Response: The authorizing legislation, *Patients First Act*, codified at OCGA §49-4-142.3 authorizes the Department of Community Health to file an 1115 waiver for new populations up to 100% of the FPL. The legislation does not permit an expansion to newly eligible populations up to 138% of the FPL, and thus the State does not have the authority to request an increase in coverage beyond 100% of the FPL. Additionally, individuals above 100% of the FPL have the option to purchase insurance off the individual market, and depending on the individual's income, may be eligible for subsidies. The State is seeking 90% enhanced funding match for its waiver.

Eligibility Criteria:

Summary of Comments: Some commenters raised concerns over the work and other employment-related pathway activities, noting the complex nature of economic mobility and access to healthcare. Some suggested the program is designed to limit participation and expressed concerns that too few eligible individuals who would gain coverage under Georgia Pathways and therefore would not significantly impact rural populations and rural hospitals.

Others noted that this program will disproportionately impact certain minority population groups. Some commenters noted the program may pose challenges to seasonal workers, those who are homeless, or those recently released from prison. Others raised concerns about the legality of the Pathways approach.

Some commenters asked the State to consider allowing individuals enrolled in education part-time to be considered eligible for Georgia Pathways as long as they meet the total hours and activities threshold. Specifically, commenters asked the State to consider the eligibility of individuals who attend school part-time and work part-time.

Some commenters asked the State to consider an exemption for caretakers or consider it a qualifying activity, while others asked the State to consider an exemption for individuals with medical conditions that may preclude them from working or maintaining regular hours of employment, such as a chronic condition, serious mental illness, or substance use disorder. Others raised concerns over individuals who, while on Medicaid, may be diagnosed with an illness requiring treatment which may prevent them from meeting the hours and activities threshold and disrupt the continuity of care for individuals who need it while undergoing treatment for an illness. Some expressed concerns regarding continuity of care and continued access to needed medications more generally if members do not maintain coverage. Others requested an exemption for individuals who were undergoing the disability determination process, asserting that such individuals may not be able to work and should still be eligible for Medicaid under Georgia Pathways.

There were other commenters who expressed full support and applauded the State for designing a program that coupled healthcare coverage with work and other employment-related activities.

State Response: The purpose of the waiver is to provide a pathway to coverage for low-income Georgians who meet the qualifying activities threshold and would not otherwise have access to Medicaid and whose income falls below the eligibility threshold for subsidies in the federal marketplace. Importantly, the State is not seeking to limit participation in Georgia Pathways. Rather, Georgia Pathways provides a new avenue for this otherwise ineligible population to enroll in Medicaid. As such, the goal of this waiver is to increase, and not decrease, access to Medicaid in both urban and rural areas. This waiver is designed to improve access, affordability, and quality of healthcare through strategies that help individuals rise out of poverty and attain independence while also providing them with a new pathway to enrollment in Medicaid.

To meet the waiver's goals and to lessen administrative burden, the State chose to follow the current TANF core activity requirements,¹⁷ with some modifications. The State is not seeking to include additional qualifying activities beyond those proposed in the waiver. Although the State is not providing categorical exemptions from the hours and activities threshold for any population, the State recognizes that there may be circumstances that temporarily limit or prevent a member from being able to participate in a qualifying activity or to meet the hours threshold. Therefore, the proposed waiver includes short-term, good cause exceptions for members who have previously qualified under the Georgia Pathways approach for Medicaid coverage and then

¹⁷ 45 CFR § 261.2

experience an unexpected life event such as a serious illness or hospitalization, birth or death in the family, or a family emergency.

The State appreciates the comments received regarding part-time enrollment in institutions of higher education and has modified the higher education qualifying activity to include part-time enrollment, which can be matched with other qualifying activities to satisfy the requirement.

For those with a mental illness or substance use disorder, the State will continue to provide mental health and substance abuse services through existing state-based safety net programs and services. Individuals in need of such services will have continued access to them and will also be eligible to participate in a Pathways activity, either concurrent with or after completion of mental health or substance abuse services, in order to gain enrollment in Medicaid.

The State is not creating an exemption for persons who have applied for a disability determination because at the time of application it is not known if the applicant will, in fact, be determined to be disabled as defined by existing disability determination criteria. If the individual is ultimately determined to be disabled, as defined by existing disability determination criteria, at that time that individual will qualify to be enrolled in the traditional Medicaid program. While the application for disability determination is pending, the applicant would be eligible for Medicaid by meeting the Pathways requirements, including participating in education, training, and/or community service activities.

Benefits:

Summary of Comments: Some commenters raised concerns over waiving NEMT, citing transportation challenges in many rural parts of the State and that it may be a barrier to members seeking necessary care. Other commenters asked the State to reconsider its waiver of retroactive eligibility and hospital presumptive eligibility.

Some commenters asked the State to consider the addition of benefits such as medically tailored meals, more robust post-operative services, or the diabetes prevention program for this population. Others noted that social determinants of health must be addressed before individuals can become employed.

Other commenters raised concerns over the mandatory HIPP program. Specifically, some of these commenters noted that without wraparound services, an employer sponsored plan may not include as robust a benefit package as Medicaid, and this may limit the services available to the member. Other commenters were concerned about the financial burden of the ESI cost-sharing obligations, including copayments and premiums.

State Response: NEMT, retroactive eligibility, and hospital presumptive eligibility are not available to the majority of the Georgia population as part of their health insurance coverage. NEMT is also not a covered benefit for the Children's Health Insurance Program (CHIP) under the State Plan, although CMOs may elect to offer NEMT services as a value-added benefit. As such, the State constructed benefits under this new coverage pathway to be as similar as possible to the benefits the majority of the Georgia population receives under their health insurance coverage, which generally does not include NEMT.

The concept of retroactive eligibility is not consistent with the program design for Georgia Pathways, as member coverage under Georgia Pathways does not begin until the first of the month following eligibility determination and following premium payment, if applicable. Moreover, a hospital presumptive eligibility determination would require the hospital to verify compliance with the hours and activities threshold, which most, if not all, hospitals do not have the capacity to do. Hence, for both policy and operational reasons, the State has requested to waive retroactive and presumptive eligibility in this waiver request.

The benefits offered under Georgia Pathways will be those offered under the current State Plan, except for NEMT services and wraparound benefits for those enrolled in HIPP. The State is not proposing to add any additional benefits to the State Plan. Regarding the social determinants of health, CMOs have the ability to offer additional services to address social determinants of health as value-added benefits.

The mandatory HIPP program provides financial assistance to allow members access to their employer's sponsored plan. The financial assistance provided supports copayments and deductibles, so members should not experience any financial burden beyond what they would pay under Georgia Pathways. Regarding benefit differences, while the State understands that there may be differences in benefit offerings between the State Plan and an employer sponsored plan, it is not the State's intention to extend the Medicaid benefit package to the ESI market. Rather, the State's goal is to assist an individual's transition to ESI. It is also likely that an employer sponsored plan may offer additional access to care due to the fact that many ESI plans offer a broader provider network than does the Medicaid program.

Premiums and Copayments:

Summary of Comments: Some commenters expressed concerns that members with incomes below 100% of the FPL will not be able to afford paying the monthly premium or other cost-sharing obligations. They noted that for members living at or near poverty, a nominal premium payment is unaffordable given the need to pay for other necessities. Other commenters encouraged the State to remove the tobacco surcharge, while some raised the concern that members will lose coverage due to nonpayment of premiums and thus disrupt continuity of care and treatment for members.

Some commenters also raised concerns over the copayment for non-emergency use of the emergency department. They noted this is an issue for all types of insurance across the State, and individuals should not be charged a higher copayment for seeking medical attention when it is needed. Others worried that members may avoid emergency department utilization even in cases when that level of care is appropriate.

State Response: Federal regulations allow cost-sharing of up to 5% of household income for select Medicaid populations and the marketplace. The State is seeking a waiver to extend minimal cost-sharing of up to 5% of income for the Georgia Pathways population with income between 50% and up to 100% of the FPL. This is an important policy lever to engage members and establish personal responsibility similar to what is expected of those insured outside of Medicaid. Other Georgia Medicaid programs also have a cost-sharing requirement, and the

premium structure aligns with affordability across all incomes of Georgia Pathways members. Additionally, PPACA allows for a tobacco surcharge on insurance premiums in commercial health insurance. In an effort to align with the commercial health insurance market, and to provide an incentive to discontinue tobacco use, the State is including a tobacco surcharge for Georgia Pathways members.

Regarding the copayment for non-emergency use of hospital emergency departments, the copayment is not a penalty. The copayment is paid from the Member Rewards Account which is funded through premium payments and engaging in healthy behaviors, which may also include reward contributions for avoiding inappropriate emergency room use. In addition, the copayment does not result in a reduction in hospital reimbursement for the service. Moreover, this copayment is for non-emergency use, not emergent use; emergent use of the emergency department does not have a copayment. The Department would also like to clarify that under federal law, the copayment is not a requirement for service.

Other:

Summary of Comments: Some commenters expressed concerns with the administrative burden for individuals, the State, and other organizations to maintain compliance and provide verification with work and other employment-related activities.

Commenters also advocated for the integration of Grady Health System's Healthy Georgia Solution into the waiver proposal as a comprehensive approach to providing access to care for the uninsured.

Some commenters emphasized the importance that mental health parity be a mandated component of any health reform in Georgia.

Other commenters expressed concern over the existing provider network serving the Medicaid population, with some suggesting that increasing the number of covered Medicaid members will negatively impact wait times for primary care, specialists, and procedures.

Some commenters mentioned this proposal does not address the high rate of uninsured children in Georgia. Others were concerned that Georgia Pathways will threaten their existing Medicaid coverage.

The State also received comments that were not relevant to the Georgia Pathways proposal as well as other comments regarding operational considerations for implementation of the program, including suggestions for healthy behavior activities, mechanisms for reporting qualifying activities, considerations related to capitation recoupment for delinquent premium payments, the mandatory HIPP program's reimbursement methods, the evaluation plan, and supports for qualifying activities.

State Response: The State currently operates the TANF program through the Department of Family and Children Services and requires hours and activities reporting for that program. The State chose to mirror the existing core activities in TANF for Georgia Pathways to reduce the State's administrative burden because the technology and infrastructure to report these activities

currently exists. To reduce the burden on members, the State will provide different mechanisms for reporting qualifying activities, such as using an online portal and reporting in person. Additionally, the State's waiver includes a provision that would exempt members from reporting who have qualified through a pathways approach for six consecutive months until the next annual redetermination period. The State will make every effort to minimize the burden on all those involved while advancing the Georgia Pathways program and increasing coverage to working Georgians.

Georgia appreciates the efforts some have made to develop alternative proposals. The State specifically appreciates the efforts of the Grady Health System in developing and submitting its Healthy Georgia Solution for consideration. However, the Grady Solution only provides the opportunity for coverage in a limited number of sites, whereas Georgia Pathways provides the opportunity for coverage across the entire state, which is the State's preferred approach.

The benefits offered under Georgia Pathways mirror those provided through the existing Medicaid State Plan, except for waiving NEMT and the fact that members enrolled through ESI will not receive wraparound benefits. The Georgia Pathways program offers the same mental health benefits as does the existing Medicaid program. All State Medicaid Agencies are required by federal statute to comply with the Mental Health Parity requirements. To that end, Georgia has developed a reporting and monitoring methodology for self-auditing compliance with the Mental health parity rules. The 1115 Waiver Program falls within the context of general Medicaid coverage and is, therefore, subject to the same compliance requirements.

The new Georgia Pathways population will be enrolled into the State's existing CMOs. Georgia closely monitors the GeoAccess of the existing CMO networks, and if a deficiency is identified, requires the CMO to take corrective action.

For uninsured children, PeachCare for Kids remains available for children age 18 and under in families up to 247% of the FPL. The proposed Georgia Pathways program does not impact the current eligibility criteria for PeachCare for Kids. Similarly, Georgia Pathways does not impact those currently enrolled in Medicaid under Georgia Families or another categorical eligibility group. Rather, Georgia Pathways seeks to increase Medicaid coverage by providing a new avenue for working Georgians who meet the hours and activities threshold who are otherwise ineligible to enroll in Medicaid.

The State appreciates the operational considerations and will take these comments in to account during program design.

8.3.1: Changes to the Waiver

The State appreciates the public's input on the Georgia Pathways 1115 waiver. Based on comments received, both written and those given through oral testimony, and other channels of feedback, the State has proposed the following changes to the waiver:

- **Removal of Transitional Medicaid Assistance:** The State reiterated that Georgia Pathways would not impact the existing Medicaid program or its participants. To reduce confusion, the State is removing all references to the TMA population from the waiver. As is the

State's current policy, members transitioning off low-income Medicaid will receive Medicaid for an additional 6 months, with the potential for 12 months of additional coverage. After the transitional coverage period expires, these individuals will then be eligible for Georgia Pathways, so long as their income is below and up to 100% of the FPL.

- Clarification of Higher Education: The State added language in *Section 2.2.2* to clarify that individuals enrolled in an institution of higher learning who are eligible to remain on a parent's insurance are not eligible for Georgia Pathways. The State also clarified that former foster children are not eligible, as there are alternative Medicaid coverage options for this population. Additionally, the State revised the enrollment commitment for higher education as a qualifying activity in order for part-time enrollment to contribute towards meeting the overall 80 hour per month threshold. The course credits taken as a percentage of full-time enrollment will be converted to hours in meeting the Georgia Pathways requirement (e.g., if a part-time student is enrolled in 6 credit hours and the Department of Community Health deems 12 credit hours to be full-time, then that student would get credit for 40 hours of qualifying activities and would need to meet 40 additional hours through some other qualifying activity).

8.4: Tribal Consultation

The State of Georgia does not have any Federally-recognized Indian tribes within its borders and thus has not established a separate process for consultation with any tribes with respect to this Section 1115 Demonstration waiver application.

Section 9: Demonstration Administration

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Appendix A: Evaluation Plan

Hypothesis	Anticipated Measure	Data Sources	Evaluation Approach
Goal: Improve the health of low-income Georgians by increasing their access to affordable healthcare coverage by encouraging work and other employment-related activities			
Georgia Pathways policies will increase access to primary care	The percentage of members 20 years and older who had an ambulatory or preventive care visit	Claims/ Encounter data	Track and compare primary care utilization rates and trends
Goal: Reduce the number of uninsured Georgians			
Georgia Pathways policies will reduce the number of uninsured in Georgia	Number of adults between the ages of 19 and 64 in Georgia without healthcare coverage	American Communities Survey	Track and compare the uninsured rate in Georgia over the course of the Demonstration
Goal: Promote member transition to commercial health insurance			
Georgia Pathways policies will increase the number of Georgia Pathways participants who transition to commercial health insurance, including employer sponsored insurance and individual health insurance market coverage, after separating from Medicaid	Number of members with reported enrollment in commercial coverage, including ESI and individual health insurance market plans, within one year of disenrollment from Medicaid	Administrative data	Track the number of members who lose eligibility due to gained income Track number of former Georgia Pathways participants successfully transitioning to commercial health insurance coverage
Goal: Empower Georgia Pathways participants to become active participants and consumers of their healthcare			
Georgia Pathways policies will encourage members to use Member Rewards Account for services outside of copays	The percentage of members who use their Member Rewards Account for added services	Administrative data	Track the use of the Member Rewards Account for added services

Hypothesis	Anticipated Measure	Data Sources	Evaluation Approach
Goal: Support member enrollment in employer-sponsored insurance by providing premium assistance for qualifying employer-sponsored health plans, if doing so is cost-effective for the State			
Georgia Pathways policies will increase the number of Georgia residents below and up to 100% of the FPL enrolled in employer sponsored insurance	Number of enrolled members with employer sponsored insurance	Administrative data	Track the number of members with income below and up to 100% of the FPL enrolling in employer sponsored insurance through mandatory HIPP
Goal: Increase the number of persons who become employed or engage in employment-related activities			
Georgia Pathways policies will increase the number of adults below and up to 100% of the FPL who are engaged in at least 80 hours a month of employment or employment-related activities	Percentage of adults engaged in at least 80 hours per month of work or other employment-related activities	Administrative data	Track the number of individuals who become eligible for Pathways
Goal: Increase wage growth for those who are employed			
Georgia Pathways policies will increase wage growth for those made eligible for Medicaid through the Demonstration	Incomes of those enrolled in Georgia Pathways or who transition off of Pathways to commercial coverage	Administrative data	Compare earnings of members at annual redetermination. Track the number of members who graduate from Medicaid coverage into the private health insurance marketplace
Goal: Support the long-term, fiscal sustainability of the Medicaid program			
The General Fund contribution will remain below the national average as measured by the National Association of State Budget Officers (NASBO)	The State share of Medicaid as a percentage of the State budget	Annual NASBO budget survey	Track ranking of Georgia against the national average

Appendix B: Budget Neutrality With and Without Waiver Exhibits

<u>Pathways</u>	DEMONSTRATION YEARS (DY)					TOTAL
Pop Type: Hypothetical	DY 01	DY 02	DY 03	DY 04	DY 05	WOW
Eligible Member Months	300,342	473,616	487,824	504,898	525,094	
PMPM Cost	516.49	530.97	533.92	557.95	583.05	
Total Expenditure	\$ 155,123,640	\$ 251,475,888	\$ 260,458,990	\$ 281,707,839	\$ 306,156,057	\$ 1,254,922,413

<u>Pathways</u>	DEMONSTRATION YEARS (DY)					TOTAL
Pop Type: Hypothetical	DY 01	DY 02	DY 03	DY 04	DY 05	WW
Eligible Member Months	300,342	473,616	487,824	504,898	525,094	
PMPM Cost	\$516.49	\$ 530.97	\$ 533.92	\$ 557.95	\$ 583.05	
Total Expenditure	\$ 155,123,640	\$ 251,475,888	\$ 260,458,990	\$ 281,707,839	\$ 306,156,057	\$ 1,254,922,413

HYPOTHETICALS VARIANCE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Totals may not equal sum of the parts due to rounding.



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Georgia Pathways Section 1115 Draft Waiver



Department of Community Health Board Meeting

November 4, 2019

11:30 AM



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Mission:

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

1115 Waiver Notice Background Information

Patients First Act

Background

- Signed **March 27, 2019**
- Grants the DCH authority to submit a Section 1115 waiver to the Centers for Medicare & Medicaid Services (CMS)

Key Points

- 1115 waiver must be submitted on or before **June 30, 2020**
- Allows increase in Medicaid eligibility to a **max of 100% of the Federal Poverty Level (FPL)**
- Grants **authority to implement** the 1115 waiver



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Purpose of 1115 Waivers

Purpose of the Demonstration Waivers

- Section 1115 of the Social Security Act grants the HHS Secretary authority to approve state waivers to **implement demonstration projects that test different approaches** promoting the objectives of the Medicaid program

Waiver Considerations for CMS Approval

- Waivers must be **budget neutral** for the federal government
- Waivers are typically approved for **five years** and often renewed
- **Revised approval criteria in 2017** grants increased flexibility



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Source: Information from Medicaid.gov [About Section 1115 Demonstrations](#)

Waiver Development Process

1. Completed Environmental Scan

- Conducted review of state and national healthcare trends
- Convened Georgia stakeholders from across the healthcare landscape

2. Developed and Modeled Potential Waiver Options

- Established goals and identified potential waiver options
- Developed actuarial models to assess financial and economic impact
- Consulted with the Centers for Medicare & Medicaid Services (CMS)

3. Drafted Waivers

- Drafted waiver to release for public comment November 4, 2019
- Holding six public hearings across the state
- Accepting public comments online or by mail through December 3, 2019



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Overview of Draft 1115 Waiver Application

Goals of Georgia's 1115 Waiver

Improve access, affordability, and quality of healthcare in Georgia with strategies to:

- **Improve the health of low-income Georgians** by increasing access to affordable healthcare coverage by encouraging work and other employment-related activities
- Reduce the number of **uninsured Georgians**
- Promote member transition to **commercial health insurance**
- **Empower Georgia Pathways participants** to be active participants and consumers of their healthcare
- Support newly eligible member enrollment in **employer-sponsored insurance**
- Increase the number of persons who become **employed**
- **Increase wage growth** for those who are employed
- Ensure the **long-term, fiscal sustainability** of the Medicaid program



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

1115 Waiver Design

Key Features of the Program



Provides **new pathways to Medicaid coverage** for Georgians who are not eligible for Medicaid today



Introduces elements of commercial health insurance, helping members with the eventual transition to that market



Provides premium assistance for eligible individuals with access to employer sponsored health insurance

New pathways begin July 1, 2021



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

New Pathways to Coverage

Georgia residents now have a pathway to Medicaid coverage if they meet the following criteria:

- **Not currently eligible** for Medicaid in Georgia
- Ages **19 to 64**
- Income is **< 100% FPL**
- Working at least **80 hours / month** or engaged in another qualifying activity
- **American citizen** or documented, qualified alien



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



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New Pathways to Coverage

Qualifying Activities

- ✓ Unsubsidized employment
- ✓ Subsidized private sector employment
- ✓ Subsidized public sector employment
- ✓ On-the-job training
- ✓ Job readiness
- ✓ Community Service
- ✓ Vocational educational training
- ✓ Full-time enrollment in an institution of higher education

Elements of Commercial Health Insurance

Members 50 – 100% FPL will have Premiums, Copays, and Rewards Accounts

Premiums

- Monthly premium payments are **based on income**

Copayments

- Copayment amounts **mirror the existing State Plan** (with the addition of a copay for non-emergent visits to the Emergency Department)

Member Rewards Account

- Members **earn points** by engaging in **healthy behaviors**
- Rewards Accounts can be used to purchase items such as **over the counter drugs, dental services, glasses, and contacts**, as well as pay **copayments**



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Employer Sponsored Insurance

Employer Sponsored Insurance (ESI)

- Georgia currently operates a voluntary **Health Insurance Premium Payment (HIPP) program** under the State Plan
- If an eligible individual gaining Medicaid coverage through Georgia Pathways has access to ESI, the **State will assess if it is more cost-effective** to enroll in Medicaid or pay the individual's portion of the ESI premium and other cost-sharing obligations
- If it is more cost-effective, the individual will be required to **enroll in their ESI plan instead of Medicaid**
- **Medicaid will reimburse the individual's portion** of the ESI premium

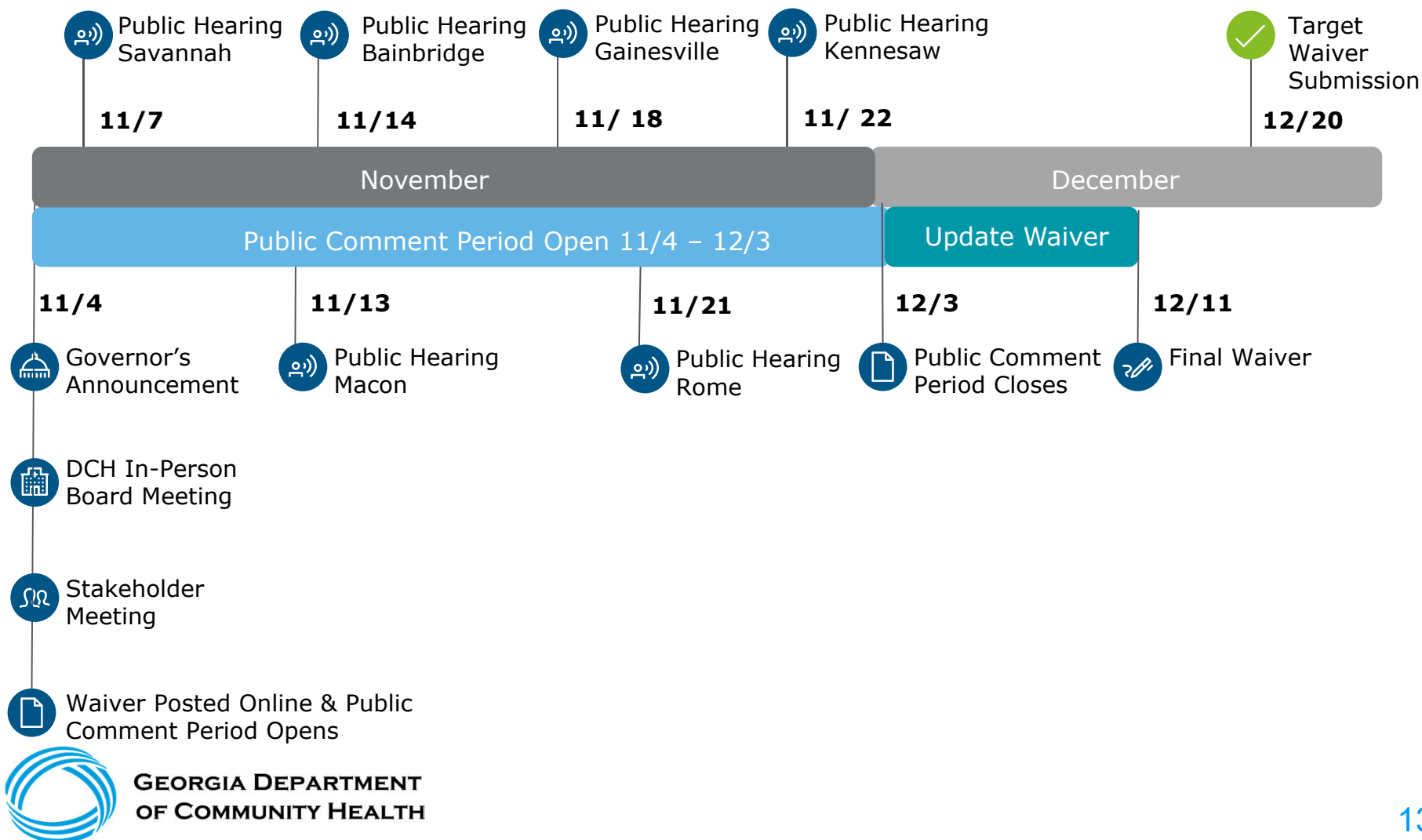


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Public Comment Process



1115 Public Comment Submission

Submit comments through December 3, 2019 **online** at:

<https://medicaid.georgia.gov/patientsfirst>

Mail must be postmarked by December 3, 2019, to:

Lavinia Luca

c/o Board of Community Health

Post Office Box 1966

Atlanta, Georgia 30301-1966



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Questions regarding Georgia Pathways 1115 Demonstration Waiver

Overview of Section 1332 Draft Waiver

Goals of Georgia's 1332 Waiver

Improve access and affordability of individual healthcare coverage in Georgia with strategies to:

- **Reduce premiums**, particularly in high-cost regions
- **Incentivize carriers to offer plans** in more counties across the State
- **Foster innovation** to provide better access to healthcare coverage
- **Expand choice** and **affordability** of options for consumers
- **Attract uninsured individuals** into the market
- **Maintain access** to metal level Qualified Health Plans (QHPs) and Catastrophic Plans
- **Maintain protections** for individuals with pre-existing conditions



1332 Waiver Design

Key Features of the Program



Implement a **reinsurance program** to help stabilize the individual market by **reducing premiums** and attracting and retaining carriers



Transition Georgia's individual market from the Federally Facilitated Exchange **to the Georgia Access Model** to improve access, choice, and affordability for consumers

Reinsurance begins 2021 and Georgia Access in 2022



Reinsurance Overview and Benefits

Elements of the Reinsurance Program

- **Claims-based reinsurance model**, projected parameters for 2022:
 - Attachment Point: \$20,000
 - Cap: \$500,000
 - Tiered Coinsurance Rate: 15%, 45%, 80%
- **Higher coinsurance rates** applied to **high-cost regions** of the state
- Target **10% reduction** in average premiums statewide



Georgia Access Model Overview

Front-End Operations (Private Sector)

- **Consumers shop, compare, and purchase plans** through the private sector (web-brokers or carriers)
- Private sector leverages mechanisms and incentives in the commercial market to provide **education, outreach, and customer service**

Back-End Operations (the State)

- **Certifies plans** eligible for subsidies (QHPs and Eligible Non-QHPs)
- Calculates **eligibility for subsidies**
- **Issues subsidies** to plans on behalf of individuals
- Provides **program oversight** and compliance



Georgia Access Model Benefits

What Stays the Same?

- Access to **current QHP and High-Deductible Plan** options
- **Protections** for individuals with pre-existing conditions
- **Subsidies** to support affordability (mirrors federal structure for 2022)

Benefits of Georgia Access

- **Ability for consumers to view all plans** available to them which are licensed and in good standing with the state via web-broker platforms
- Ability for consumers to **enroll/re-enroll directly with carriers**
- **Expands consumer choice** of affordable options with Eligible non-QHPs
- **Provides flexibility** for the State to adjust the program structure **to best meet the needs of Georgians**





GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Purpose:

Shaping the future of A Healthy Georgia by
improving access and ensuring quality to strengthen
the communities we serve.

Public Notice

Georgia Pathways to Coverage 1115 Demonstration Waiver

The Georgia Department of Community Health (DCH) hereby notifies the public that it intends to submit a Section 1115 Demonstration Waiver to the Centers for Medicare & Medicaid Services (CMS) for Georgia Pathways to Coverage (Georgia Pathways), effective for services provided on or after July 1, 2021.

Pursuant to 42 CFR 431.408, DCH will provide the public the opportunity to review and provide input on the Section 1115 Demonstration Waiver. This notice provides details about the waiver submission and serves to open the 30-day public comment period, which closes on Tuesday, December 3, 2019.

Georgia Pathways Description

Georgia is requesting approval of an 1115 Demonstration Waiver to implement new policies that will further the State's vision of creating "A Healthy Georgia." The State recognizes too many of its working, low-income citizens do not have access to or are unable to afford healthcare coverage. The State is creating a new eligibility pathway focused on encouraging and incentivizing work and other employment-related activities, for low-income Georgians who are not otherwise eligible for Medicaid coverage.

To further support Georgians on their journey to self-sufficiency and the destination of commercial health insurance coverage, Georgia Pathways is embracing private market policies and principles, such as premiums, copayments, member rewards accounts, and prospective Medicaid eligibility, for a segment of the Georgia Pathways population and the Transitional Medical Assistance (TMA) population.

Georgia is using the following policies to implement Georgia Pathways:

- **Georgia Pathways** – Provide a pathway to Medicaid coverage for working Georgians with household incomes up to 95% of the Federal Poverty Level (FPL), which includes a 5% of the FPL income disregard (referred to as incomes up to 100% of the FPL), and serves as an incentive for participation in work and other employment-related activities for those not currently engaged.
- **Consumer Tools** – Introduce consumer-engagement elements into the Medicaid program to prepare Georgia Pathways participants to transition into the commercial health insurance market once their income exceeds 100% of the FPL.
- **Employer Sponsored Insurance (ESI)** – Provide premium assistance to those who become Medicaid-eligible through Georgia Pathways and who have access to ESI through a mandatory Health Insurance Premium Payment (HIPP) program.

Georgia Pathways Goals and Objectives

Georgia's goals for the Demonstration are to improve **access**, **affordability**, and **quality** of healthcare through strategies that:

- Improve the health of low-income Georgians by increasing their access to affordable healthcare coverage by encouraging work and other employment-related activities.
- Reduce the number of uninsured Georgians.
- Promote member transition to commercial health insurance.
- Empower Georgia Pathways participants to become active participants and consumers of their healthcare.
- Support member enrollment in employer-sponsored insurance by providing premium assistance for qualifying employer-sponsored health plans, if doing so is cost-effective for the State.
- Increase the number of persons who become employed or engaged in employment-related activities.
- Increase wage growth for those who are employed.
- Ensure the long-term, fiscal sustainability of the Medicaid program.

Georgia Pathways Proposed Eligibility Requirements, Health Care Delivery System, Benefit Coverage, and Cost Sharing

Proposed Eligibility Requirements

Georgia Pathways to Coverage will introduce a new eligibility pathway for working Georgians who would otherwise not be eligible for Medicaid coverage. In order to be eligible for coverage under Georgia Pathways, an individual must meet an hours and activities threshold of 80 hours per month of engagement in a qualifying activity such as employment, community service, or education, and have an income less than 100% of the FPL.

The State will consider the below activities as acceptable for meeting the activities threshold.

Table 1: Activities and Definitions

Activity	Definition
Unsubsidized employment	Full- or part-time employment in the public or private sector that is not subsidized by a public program.
Subsidized private sector employment	Employment in the private sector for which the employer receives a subsidy from public funds to offset some or all of the wages and costs of employing an individual.
Subsidized public sector employment	Employment in the public sector for which the employer receives a subsidy from public funds to offset some or all of the wages and

	costs of employing an individual.
On-the-job training	Training in the public or private sector that is given to a paid employee while he or she is engaged in productive work, and that provides knowledge and skills essential to the full and adequate performance of the job.
Job Readiness	Activities directly related to the preparation for employment, including life-skills training, resume building, and habilitation or rehabilitation activities. Rehabilitation activities must be determined to be necessary and documented by a qualified medical professional.
Community Service	Structured programs and embedded activities in which the member performs work for the direct benefit of the community under the auspices of public or nonprofit organizations. Community service programs must be limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and child care. A state agency shall take into account, to the extent possible, the prior training, experience, and skills of an individual in making appropriate community service assignments.
Vocational Educational Training	Organized educational programs that are directly related to the preparation of individuals for employment in current or emerging occupations. Course hour requirements for vocational educational training shall be determined by the Department of Community Health.
Enrollment in an Institution of Higher Education	Enrolled in a college, university, or other institution of higher learning with a full-time academic workload. A full-time academic workload shall be determined by the Department of Community Health. The student's workload may include any combination of courses, work, research, or special studies that the institution considers sufficient to classify the student as a full-time student.

The population eligible for Georgia Pathways includes parents, caretakers, or guardians with household incomes from 35% to 100% of the FPL who are not currently eligible for Medicaid and adults without dependent children with household incomes up to 100% of the FPL who are not currently eligible for Medicaid. Individuals must be between ages 19 and 64, must be a resident of Georgia and not incarcerated in a public institution, and must be a citizen of the United States or a documented, qualified alien.

Proposed Healthcare Delivery System

The State will use a managed care delivery system to provide services to the Georgia Pathways population. The State currently contracts with four Medicaid Care Management Organizations

(CMO), which were selected through a competitive procurement process. The State will not use fee-for-service payments for any covered services.

Proposed Benefit Coverage

The benefit package provided under Georgia Pathways will differ slightly from those benefits provided under the Medicaid State Plan. Georgia is seeking to provide a benefit package more consistent with commercial plan benefits and is requesting a waiver of non-emergency transportation (NEMT) for the Pathways population. The State Plan benefits include Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for enrollees ages 19 and 20. Additional benefits such as vision and dental can be purchased through a Member Rewards Account that receives revenue from member contributions and state-funded incentives for healthy behaviors. The State will build upon its existing HIPPP program by paying the ESI premiums for all Georgia Pathways members with access to health insurance if it is cost-effective for the State. This will strengthen the State's overall insurance market by maintaining individuals in their ESI rather than moving them to a CMO.

For members for whom the State is paying the cost of ESI, wraparound benefits (i.e., benefits that are not covered by that ESI) are not covered.

Cost-Sharing

Georgia will support members in preparing for commercial health insurance by requiring financial contributions towards the cost of coverage. These funds will then be used to incentivize members to engage in healthy behaviors and access additional benefits. As detailed below, certain Georgia Pathways and TMA members will be assessed enforceable premiums, which will be deposited into a Member Rewards Account. From this Account, members will be able to make required copayments as well as use funding to purchase qualified health-related services and goods.

Premiums

A segment of the population eligible for Georgia Pathways and TMA will be required to make sliding scale flat rate monthly premium payments tiered based on family income. Premiums paid will be deposited in the member's (or household's) Member Rewards Account.

Applicable Populations

Members who are required to pay premiums are:

- Adults without dependent children with incomes between 50% and 100% of the FPL who are not currently eligible for Medicaid and become eligible and enrolled through Georgia Pathways.
- Parents with household incomes between 50% and 100% of the FPL who are not currently

eligible for Medicaid and become eligible and enrolled through Georgia Pathways.

- Members enrolled in TMA with incomes of 50% of the FPL and above.

Members who are exempt from premium requirements are:

- Members enrolled through Georgia Pathways who are under the mandatory HIPPP program.
- Members receiving coverage through Georgia Pathways or TMA who are enrolled in, and for two months after graduation from, vocational education programs of highly sought-after trades through the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant programs.
- Members enrolled through Georgia Pathways or TMA with incomes below 50% of the FPL.
- All other populations not enrolled in Georgia Pathways or TMA.

Premium Amounts

Table 2: Sliding Scale Monthly Premium Contribution Amounts

Percent of FPL	Monthly Single	Monthly Spouse	Tobacco Surcharge
50% - 84%	\$7.00	\$4.00	\$3.00
85% - 99%	\$11.00	\$7.00	\$5.00
TMA 50% and above	\$11.00	\$7.00	\$5.00

Penalties

As in commercial health insurance, members are required to pay premiums to maintain eligibility for Georgia Pathways. Members who miss a premium will have a three-month period to retain their Georgia Pathways eligibility without being disenrolled.

Copayments

The same populations subject to premiums will also be required to pay copayments for certain services. These copayments, when combined with other household copayments, will not exceed 3% of the household's income. Copayments and premiums together will not exceed 5% of household income.

Copayments under Georgia Pathways will not be assessed at the point of service and will not be collected by providers. Copayments will be assessed retrospectively for services already received..

Copayment Amounts

Services for which mandatory copayments will be assessed mirrors the existing copayment structure under the State Plan, except for the addition of a copayment for non-emergency use of the emergency department.

Table 3: Copayment for Services

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 \$1.00 for rentals and supplies
Pharmacy – Copayment varies based on the cost to the State	\$10.00 or less: \$0.50 \$10.01 to \$25.00: \$1.00 \$25.01 to \$50.00: \$2.00 \$50.01 or more: \$3.00

Member Rewards Account

The State will maintain a Member Rewards Account for the same populations subject to premiums and copayments. Funds in the account will be available to pay copayments as well as to pay for services not covered by Medicaid that will support the member's health goals. Through the Account, the State will provide incentives for members to engage in healthy behaviors and activities that support improvements in health outcomes.

Estimated Annual Enrollment and Aggregate Expenditures

The population that will enroll under this Demonstration is not currently Medicaid-eligible; therefore, no actual historical data is available to support Budget Neutrality projections. The base eligible population is the total count of uninsured Georgians under 100% of the FPL and between the ages of 19 and 64 as reported by the U.S. Census Bureau via the American Community Survey five-year estimates.

Enrollment reflects the State's estimates for both those enrolling in CMOs and individuals enrolling in the mandatory HIPP program.

Table 4: Estimated Annual Enrollment by Demonstration Year

	Year 1	Year 2	Year 3	Year 4	Year 5
Estimated Enrollment	25,028	47,362	48,782	50,490	52,509
Estimated Member Months	300,342	473,616	487,824	504,898	525,094

No historical expenditure data for the target population to be covered by this Demonstration is available. The 21 to 64-year-old members in the State's Georgia Families managed care program were identified as the best available comparable population to formulate the base cost for the Georgia Pathways population.

Table 5: Estimated Annual Federal and State Expenditures

Demonstration Year	Eligible Member Months	PMPM Cost	Total Expenditure
Year 1	300,342	\$426.33	\$128,044,805
Year 2	473,616	\$428.73	\$203,053,388
Year 3	487,824	\$422.55	\$206,130,031
Year 4	504,898	\$433.11	\$218,676,373
Year 5	525,094	\$443.94	\$233,110,230
Total Federal & State Funds			\$989,014,476

Hypotheses and Evaluation Parameters

The key hypotheses for the Georgia Pathways Demonstration are as follows:

- Georgia Pathway policies will increase access to primary care.
- Georgia Pathway policies will reduce the number of uninsured in Georgia.
- Georgia Pathway policies will increase the number of Georgia Pathways participants who transition to commercial health insurance, including employer sponsored insurance and Marketplace plans, after separating from Medicaid.
- Georgia Pathway policies will encourage members to use Member Rewards Account for services outside of copays.
- Georgia Pathway policies will increase the number of Georgia residents under 100% of the FPL enrolled in employer sponsored insurance.
- Georgia Pathways policies will increase the number of adults under 100% of the FPL who

- are engaged in at least 80 hours a month of employment or employment-related activities.
- Georgia Pathways policies will increase wage growth for those made eligible for Medicaid through the Demonstration.
- The General Fund contribution will remain below the national average as measured by the National Association of State Budget (NASBO).

Georgia Pathways will use the following performance measures:

- The percentage of members 20 years and older who had an ambulatory or preventive care visit;
- Number of adults ages 19-64 in Georgia without healthcare coverage;
- Number of members with reported enrollment in commercial coverage, including ESI and Marketplace plans, within 1 year of disenrollment from Medicaid;
- The percentage of members who use their Member Rewards Account for added services;
- Number of enrolled members with employer sponsored insurance;
- Percentage of adults engaged in at least 80 hours per month of work or other employment-related activities;
- Incomes of those enrolled in Pathways or who transition off of Pathways to commercial coverage.

Waiver Authorities

Below is a list of proposed waivers necessary to implement Georgia Pathways:

- **Reasonable Promptness: Section 1902(a)(3)/Section 1902(a)(8)**
 - To the extent necessary to enable Georgia to begin Medicaid coverage on the first day of the month following an individual's determination of eligibility.
 - To the extent necessary to enable Georgia to begin Medicaid coverage on the first day of the month following an individual's first premium payment.
- **Methods of Administration: Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**
 - To the extent necessary to enable Georgia to waive non-emergency medical transportation services.
- **Provision of Medical Assistance: Section 1902(a)(8)**
 - To the extent necessary to enable Georgia to discontinue eligibility for, and not make medical assistance available to, members who fail to comply with the hours and activities threshold under Georgia Pathways.
- **Eligibility: Section 1902(a)(10)(A)**
 - To the extent necessary to enable Georgia to delay coverage until the first day of the month following an individual's determination of eligibility.

- To the extent necessary to enable Georgia to delay coverage until the first day of the month following an individual's first premium payment.
- **Comparability of Eligibility Requirements: Section 1902(a)(10)(A)(i)(VIII) and 1902(a)(17)**
 - To the extent necessary to enable Georgia to require an hours and activities requirement as a condition to maintain eligibility.
- **Amount, Duration, Scope, and Comparability - Section 1902(a)(10)(B)**
 - To the extent necessary to enable Georgia to allow individuals to receive the benefits provided through an ESI plan, without wrap-around benefits.
- **Cost-Sharing: Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**
 - To the extent necessary to enable Georgia to charge monthly premiums and higher co-pays.
- **Freedom of Choice: Section 1902(a)(23)**
 - To the extent necessary to enable Georgia to restrict the freedom of choice of providers for Demonstration eligibility groups.
- **Retroactive Eligibility: Section 1902(a)(34)**
 - To the extent necessary to enable Georgia to begin eligibility the month following determination of eligibility and payment of any required premium.
- **Prepayment Review: Section 1902(a)(37)(B)**
 - To the extent necessary to enable Georgia to ensure that prepayment review be available for disbursements by members to their providers through the Member Rewards Account.
- **Vision and Dental Coverage: Section 1902(a)(43)**
 - To the extent necessary to enable Georgia not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act for 19- and 20-year-old members.
- **133 Percent Income Level: Section 1902(a)(10)(A)(i)(VIII)**
 - To the extent necessary to enable Georgia to implement a lower income level for the Demonstration group.

Georgia is requesting a waiver of the income level specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, which will permit the State to implement an income level of 95% of the FPL, rather than 133% of the FPL, for the Demonstration group. This will allow the State to receive the full enhanced Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y).

Expenditure Authorities

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of the Demonstration be regarded as

matchable expenditures under the State's Medicaid Title XIX State Plan. The expenditure authorities listed below promote the objectives of Title XIX.

1. **Demonstration Population I.**

- Expenditures to provide health services to non-disabled and non-elderly individuals age 19 through 64 with incomes above the Medicaid standard but at or below 100% of the FPL who are not otherwise eligible for Medicaid.
- Expenditures for premium assistance and associated cost-sharing to subsidize the employee's share of the costs of the insurance premium for employer sponsored health insurance to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 100% of the FPL who are not otherwise eligible for Medicaid as well as their spouses and their children, age 19 through 26, who are enrolled in their parents' ESI plan, who are not otherwise eligible for Medicaid.

Locations to Access Copies of Public Notice and Waiver Application

This public notice, the abbreviated public notice, and the demonstration application are also available on the Department's website homepage, at <https://medicaid.georgia.gov/patientsfirst>. This public notice, the abbreviated public notice, and the demonstration waiver application are also available for review at each county Division of Family and Children Services office. A comprehensive statewide list of locations of all Division of Family and Children Services offices can be found at <https://dfcs.georgia.gov/locations>.

Public Hearings and Public Input Procedure

Six opportunities for in-person public comment will be held. DCH will accept oral comments at these meetings. The meetings are as follows:

- **Savannah, Georgia**
Thursday, November 7, 2019, 9:00 a.m. EST
Mercer School of Medicine – Savannah Campus
Hoskins Center for Biomedical Research (*corner of 66th and Ranger Street*)
1250 East 66th Street, Savannah, GA 31404
- **Macon, Georgia**
Wednesday, November 13, 2019, 9:00 a.m. EST
Mercer University School of Medicine – Macon Campus
Mercer Auditorium
1550 College Street, Macon GA 31207

- **Bainbridge, Georgia**
Thursday, November 14, 2019, 9:00 a.m. EST
Southern Regional Technical College
The Charles H. Kirbo Regional Center, Dining Room 112
2500 East Shotwell Street, Bainbridge, Georgia 39819
- **Gainesville, Georgia**
Monday, November 18, 2019, 9:00 a.m. EST
Gainesville Civic Center, Chattahoochee Room
830 Green Street, N.E., Gainesville, Georgia 30501
- **Rome, Georgia**
Thursday, November 21, 2019, 9:00 a.m. EST
West-Rome Baptist Church, The Well Building
914 Shorter Avenue, Rome, Georgia 30165
- **Kennesaw, Georgia**
Friday, November 22, 2019, 10:00 a.m. EST
North Cobb Regional Library, Multi-Purpose Room
3535 Old 41 HWY, Kennesaw, Georgia 30144

Individuals or groups with disabilities, who require special accommodations, including auxiliary communicative aids and services during these meetings should notify Matthew Krull at Matthew.Krull@dch.ga.gov or (404) 651-5016 no later than 24 hours ahead of the scheduled public hearing to ensure any necessary accommodation can be provided.

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Public comments and public testimony will be provided to the Board of Community Health prior to the **December 12, 2019** Board meeting. The Board will vote on any proposed changes at the Board meeting to be held at 10:30 a.m. at the Department of Community Health (2 Peachtree Street, N.W., Atlanta, Georgia 30303) in the 5th Floor Board Room.

NOTICE IS HEREBY GIVEN THIS 4TH DAY OF NOVEMBER 2019
Frank W. Berry, Commissioner

Abbreviated Public Notice

The Georgia Department of Community Health (DCH) hereby notifies the public that it intends to submit a Section 1115 Demonstration Waiver to the Centers for Medicare & Medicaid Services (CMS) for Georgia Pathways to Coverage (Georgia Pathways), effective for services provided on or after July 1, 2021.

Pursuant to 42 CFR 431.408, DCH will provide the public the opportunity to review and provide input on the Section 1115 Demonstration Waiver. This notice provides details about the waiver submission and serves to open the 30-day public comment period, which closes on Tuesday, December 3, 2019.

Georgia Pathways Description

Georgia is requesting approval of an 1115 Demonstration Waiver to implement new policies that will further the State's vision of creating "A Healthy Georgia." The State recognizes too many of its working, low-income citizens do not have access to or are unable to afford healthcare coverage. The State is creating a new eligibility pathway focused on encouraging and incentivizing work and other employment-related activities, for low-income Georgians who are not otherwise eligible for Medicaid coverage.

To further support Georgians on their journey to self-sufficiency and the destination of commercial health insurance coverage, Georgia Pathways is embracing private market policies and principles, such as premiums, copayments, member rewards accounts, and prospective Medicaid eligibility, for a segment of the Georgia Pathways population and the Transitional Medical Assistance (TMA) population.

Georgia is using the following policies to implement Georgia Pathways:

- **Georgia Pathways** – Provide a pathway to Medicaid coverage for working Georgians with household incomes up to 95% of the FPL, which includes a 5% of the FPL income disregard (referred to as incomes up to 100% of the FPL), and serves as an incentive for participation in work and other employment-related activities for those not currently engaged.
- **Consumer Tools** – Introduce consumer-engagement elements into the Medicaid program to prepare Georgia Pathways participants to transition into the commercial health insurance market once their income exceeds 100% of the FPL.
- **Employer Sponsored Insurance (ESI)** – Provide premium assistance to those who become Medicaid-eligible through Georgia Pathways and who have access to ESI through a mandatory Health Insurance Premium Payment (HIPP) program.

Georgia Pathways Goals and Objectives

Georgia's goals for the Demonstration are to improve **access**, **affordability**, and **quality** of healthcare through strategies that:

- Improve the health of low-income Georgians by increasing their access to affordable healthcare coverage by encouraging work and other employment-related activities.
- Reduce the number of uninsured Georgians.
- Promote member transition to commercial health insurance.
- Empower Georgia Pathways participants to become active participants and consumers of their healthcare.
- Support member enrollment in employer-sponsored insurance by providing premium assistance for qualifying employer-sponsored health plans, if doing so is cost-effective for the State.
- Increase the number of persons who become employed or engaged in employment-related activities.
- Increase wage growth for those who are employed.
- Ensure the long-term, fiscal sustainability of the Medicaid program.

Locations to Access Copies of Public Notice and Waiver Application

This public notice, the abbreviated public notice, and the demonstration application are also available on the Department's website homepage, at <https://medicaid.georgia.gov/patientsfirst>. This public notice, the abbreviated public notice, and the demonstration waiver application are also available for review at each county Division of Family and Children Services office. A comprehensive statewide list of locations of all Division of Family and Children Services offices can be found at <https://dfcs.georgia.gov/locations>.

Public Hearings and Public Input Procedure

Six opportunities for in-person public comment will be held. DCH will accept oral comments at these meetings. The meetings are as follows:

- **Savannah, Georgia**
Thursday, November 7, 2019, 9:00 a.m. EST
Mercer School of Medicine – Savannah Campus
Hoskins Center for Biomedical Research (*corner of 66th and Ranger Street*)
1250 East 66th Street, Savannah, GA 31404
- **Macon, Georgia**
Wednesday, November 13, 2019, 9:00 a.m. EST
Mercer University School of Medicine – Macon Campus

Mercer Auditorium
1550 College Street, Macon GA 31207

- **Bainbridge, Georgia**
Thursday, November 14, 2019, 9:00 a.m. EST
Southern Regional Technical College
The Charles H. Kirbo Regional Center, Dining Room 112
2500 East Shotwell Street, Bainbridge, Georgia 39819
- **Gainesville, Georgia**
Monday, November 18, 2019, 9:00 a.m. EST
Gainesville Civic Center, Chattahoochee Room
830 Green Street, N.E., Gainesville, Georgia 30501
- **Rome, Georgia**
Thursday, November 21, 2019, 9:00 a.m. EST
West-Rome Baptist Church, The Well Building
914 Shorter Avenue, Rome, Georgia 30165
- **Kennesaw, Georgia**
Friday, November 22, 2019, 10:00 a.m. EST
North Cobb Regional Library, Multi-Purpose Room
3535 Old 41 HWY, Kennesaw, Georgia 30144

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Frank W. Berry, Commissioner



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

Patients First Act Stakeholder Advisory Council

- Office of Governor Brian P. Kemp, Ryan Loke
- Georgia Department of Community Health, Blake Fulenwider
- Georgia Department of Community Health
- Governor's Office of Planning and Budget
- Georgia Department of Behavioral Health and Developmental Disabilities
- Senator Blake Tillery
- Senator Ben Watson
- Senator Freddie Powell Sims
- Senator Dean Burke
- Representative Jodi Lott
- Representative Sharon Cooper
- Representative Matt Hatchett
- Representative Patty Bentley
- Representative Mack Jackson
- Representative Butch Parrish
- Office of Insurance and Safety Fire Commissioner
- Medical College of Georgia - Augusta University
- Mercer University School of Medicine
- Grady Memorial Hospital
- Children's Healthcare of Atlanta
- Piedmont Hospital
- Wellstar Health System
- Hospital Corporation of America
- Miller County Hospital
- HomeTown Health
- Medical Association of Georgia
- GA Academy of Family Physicians
- American Academy of Pediatrics, Georgia Chapter
- American College of Physicians - Georgia Chapter
- Georgia Pharmacy Association
- Georgia Council on Substance Abuse
- Viewpoint Health
- Georgia Primary Care Association

Healthcare Facility Regulation | Medical Assistance Plans | State Health Benefit Plan | Health Planning

Equal Opportunity Employer



**GEORGIA DEPARTMENT
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- Georgia Association of Community Service Boards
- Georgia Health Care Association
- Georgia Quality Health Plans Association
- Amerigroup Georgia
- CareSource Georgia
- Peach State Health Plan
- WellCare of Georgia
- Anthem Blue Cross Blue Shield of Georgia
- Alliant Health Plans
- Ambetter Health Plans
- Kaiser Health Plans
- Georgians for a Healthy Future
- Voices for Georgia's Children
- Georgia Public Policy Foundation
- Georgia State Health Law Clinic
- United Way



GEORGIA DEPARTMENT
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Georgia Waiver Project



Stakeholder Meeting

November 4, 2019

1:00 PM



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Mission:

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

1115 and 1332 Waiver Background Information

Patients First Act

Background

- Signed **March 27, 2019**
- Grants the Department of Community Health (DCH) authority to submit a Section 1115 waiver to the Centers for Medicare & Medicaid Services (CMS)
- Grants the Governor authority to submit one or more Section 1332 innovation waivers to the Departments of Health and Human Services (HHS) and Treasury

Key Points

- 1115 waiver must be submitted on or before **June 30, 2020**
- Allows increase in Medicaid eligibility to **max of 100% of Federal Poverty Level (FPL)**
- Grants **authority to implement** the 1115 waiver without further legislation
- 1332 waiver(s) must be submitted on or before **December 31, 2021**
- Upon approval of one or more 1332 waivers, **authorizes the state to implement**



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OF COMMUNITY HEALTH

Source: Georgia General Assembly 2019-2020 [SB 106](#)

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Purpose of 1115 Waivers

Purpose of the Demonstration Waivers

- Section 1115 of the Social Security Act grants the HHS Secretary authority to approve state waivers to **implement demonstration projects that test different approaches** promoting the objectives of the Medicaid program

Waiver Considerations for CMS Approval

- Waivers must be **budget neutral** for the federal government
- Waivers are typically approved for **five years** and often renewed
- **Revised approval criteria in 2017** grants increased flexibility



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Source: Information from Medicaid.gov [About Section 1115 Demonstrations](#)

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Revised 1115 Approval Criteria

Revised CMS Waiver Approval Criteria (November 2017)

- **Improve access to high-quality, person-centered services** that produce positive health outcomes for individuals
- **Promote efficiencies** that ensure Medicaid's sustainability over the long-term
- **Support coordinated strategies** to address certain health determinants that promote upward mobility, greater independence, and improved quality of life
- **Strengthen beneficiary engagement** in their personal healthcare plan, including incentive structures that promote responsible decision-making
- **Enhance alignment** between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition
- **Advance innovative delivery system and payment models** to strengthen provider network capacity and drive greater value for Medicaid



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OF COMMUNITY HEALTH

Source: Information from Medicaid.gov [About Section 1115 Demonstrations](#)

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Purpose of 1332 Waivers

Background:

- States may waive parts of the Affordable Care Act (ACA) to pursue innovative strategies to provide access to high-quality, affordable health insurance

Statutory Guardrails:

1. **Comprehensiveness**: Provide coverage at least as comprehensive as provided absent the waiver
2. **Affordability**: Provide cost-sharing protections against excessive out of pocket spending at least as affordable as absent the waiver
3. **Coverage**: Offer healthcare coverage to a comparable number of residents as absent the waiver
4. **Deficit Neutrality**: Must not increase the federal deficit



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OF COMMUNITY HEALTH

Source: Information from CCIIO [Section 1332: State Innovation Waivers](#), Kaiser Family Foundation [Tracking Section 1332 Waivers](#), CMS and Treasury [Guidance October 2018](#)

6

Waiver Development Process

1. Completed Environmental Scan

- Conducted review of state and national healthcare trends
- Convened Georgia stakeholders from across the healthcare landscape

2. Developed and Modeled Potential Waiver Options

- Established goals and identified potential waiver options
- Developed actuarial models to assess financial and economic impact

3. Drafted Waivers

- Drafted waivers and released for public comment November 4, 2019
- Consulted with the Centers for Medicare & Medicaid Services (CMS)
- Holding six public hearings across the state
- Accepting public comments online or by mail through December 3, 2019



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OF COMMUNITY HEALTH

Overview of Draft 1115 Waiver Application

Goals of Georgia's 1115 Waiver

Improve access, affordability, and quality of healthcare in Georgia with strategies to:

- **Improve the health of low-income Georgians** by increasing access to affordable healthcare coverage by encouraging work and other employment-related activities
- Reduce the number of **uninsured Georgians**
- Promote member transition to **commercial health insurance**
- **Empower Georgia Pathways participants** to be active participants and consumers of their healthcare
- Support newly eligible member enrollment in **employer sponsored insurance**
- Increase the number of persons who become **employed**
- **Increase wage growth** for those who are employed
- Ensure the **long-term, fiscal sustainability** of the Medicaid program



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

1115 Waiver Design

Key Features of the Program



Provides **new pathways to Medicaid coverage** for Georgians who are not eligible for Medicaid today



Introduces elements of commercial health insurance, helping members with the eventual transition to that market



Provides premium assistance for eligible individuals with access to employer sponsored health insurance

New pathways begin July 1, 2021



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

New Pathways to Coverage

Georgia residents will now have a pathway to Medicaid coverage if they meet the following criteria:

- **Not currently eligible** for Medicaid in Georgia
- Ages **19 to 64**
- Income is **< 100% FPL**
- Working at least **80 hours / month** or engaged in another qualifying activity
- **American citizen** or documented, qualified alien



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OF COMMUNITY HEALTH



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New Pathways to Coverage

Qualifying Activities

- ✓ Unsubsidized employment
- ✓ Subsidized private sector employment
- ✓ Subsidized public sector employment
- ✓ On-the-job training
- ✓ Job readiness
- ✓ Community Service
- ✓ Vocational educational training
- ✓ Full-time enrollment in an institution of higher education



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



12

Elements of Commercial Health Insurance

Members 50 – 100% FPL will have Premiums, Copays, and Rewards Accounts

Premiums

- Monthly premium payments are **based on income**

Copayments

- Copayment amounts **mirror the existing State Plan** (with the addition of a copay for non-emergent visits to the Emergency Department)

Member Rewards Account

- Members **earn points** by engaging in **healthy behaviors**
- Rewards Accounts can be used to purchase items such as **over the counter drugs, dental services, glasses, and contacts**, as well as pay **copayments**



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



13

Employer Sponsored Insurance

Employer Sponsored Insurance (ESI)

- Georgia currently operates a voluntary **Health Insurance Premium Payment (HIPP) program** under the State Plan
- If an eligible individual gaining Medicaid coverage through Georgia Pathways has access to ESI, the **State will assess if it is more cost-effective** to enroll in Medicaid or pay the individual's portion of the ESI premium and other cost-sharing obligations
- If it is more cost-effective, the individual will be required to **enroll in their ESI plan instead of Medicaid**
- **Medicaid will reimburse the individual's portion** of the ESI premium



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OF COMMUNITY HEALTH



Overview of Section 1332 Draft Waiver

Goals of Georgia's 1332 Waiver

Improve access and affordability of individual healthcare coverage in Georgia with strategies to:

- **Reduce premiums**, particularly in high-cost regions
- **Incentivize carriers to offer plans** in more counties across the State
- **Foster innovation** to provide better access to healthcare coverage
- **Expand choice** and **affordability** of options for consumers
- **Attract uninsured individuals** into the market
- **Maintain access** to metal level Qualified Health Plans (QHPs) and Catastrophic Plans
- **Maintain protections** for individuals with pre-existing conditions



1332 Waiver Design

Key Features of the Program



Implement a **reinsurance program** to help stabilize the individual market by **reducing premiums** and attracting and retaining carriers



Transition Georgia's individual market from the Federally Facilitated Exchange **to the Georgia Access Model** to improve access, choice, and affordability for consumers

Reinsurance begins 2021 and Georgia Access in 2022



Reinsurance Overview and Benefits

Elements of the Reinsurance Program

- **Claims-based reinsurance model**, projected parameters for 2022:
 - Attachment Point: \$20,000
 - Cap: \$500,000
 - Tiered Coinsurance Rate: 15%, 45%, 80%
- **Higher coinsurance rates** applied to **high-cost regions** of the state
- Target **10% reduction** in average premiums statewide



Georgia Access Model Overview

Front-End Operations (Private Sector)

- **Consumers shop, compare, and purchase plans** through the private sector (web-brokers or carriers)
- Private sector leverages mechanisms and incentives in the commercial market to provide **education, outreach, and customer service**

Back-End Operations (the State)

- **Certifies plans** eligible for subsidies (QHPs and Eligible Non-QHPs)
- Calculates **eligibility for subsidies**
- **Issues subsidies** to plans on behalf of individuals
- Provides **program oversight** and compliance



Georgia Access Model Benefits

What Stays the Same?

- Access to **current QHP and High-Deductible Plan** options
- **Protections** for individuals with pre-existing conditions
- **Subsidies** to support affordability (mirrors federal structure for 2022)

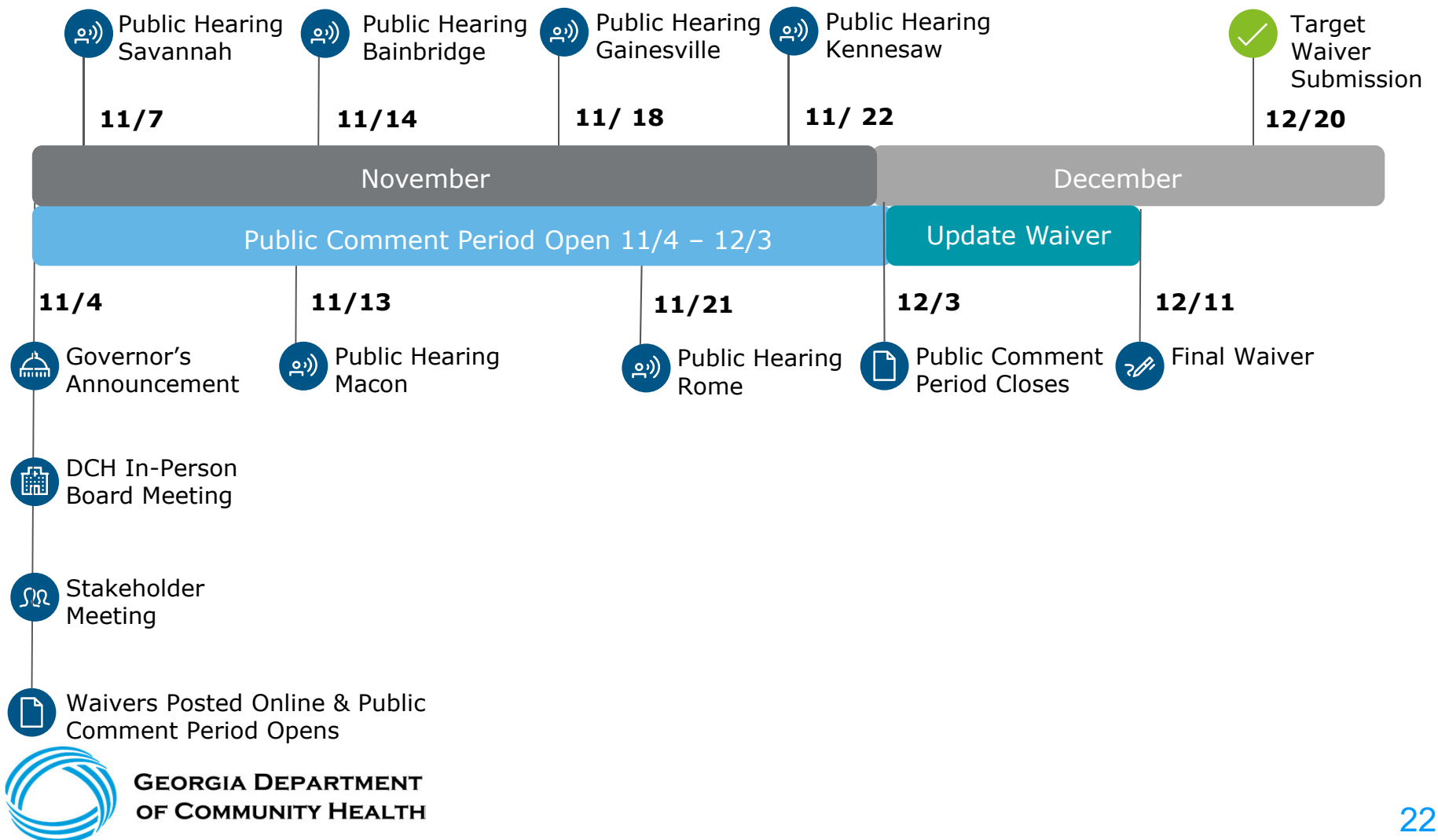
Benefits of Georgia Access

- **Ability for consumers to view all plans** available to them which are licensed and in good standing with the state via web-broker platforms
- Ability for consumers to **enroll/re-enroll directly with carriers**
- **Expands consumer choice** of affordable options with Eligible non-QHPs
- **Provides flexibility** for the State to adjust the program structure **to best meet the needs of Georgians**



Public Comment Period

Public Comment Process



Public Comment Submission

Submit comments through December 3, 2019 **online** at:

<https://medicaid.georgia.gov/patientsfirst>

Submit comments **by mail** to:

For 1115:

Lavinia Luca
c/o Board of Community Health
Post Office Box 1966
Atlanta, Georgia 30301-1966

For 1332:

Ryan Loke
c/o The Office of the Governor
206 Washington Street
Suite 203, State Capitol
Atlanta, Georgia 30334



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Purpose:

Shaping the future of A Healthy Georgia by
improving access and ensuring quality to strengthen
the communities we serve.



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Georgia Section 1115 Draft Waiver



Public Hearing (Location)

(Date)

(Time)



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Mission:

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.

Today's 1115 Waiver Public Hearing

1. Brief overview on the background and waiver design

2. Open to public comments  ***Sign-up sheet***

3. Submit comments online through December 3, 2019 at:

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GEORGIA DEPARTMENT
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GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Draft 1115 Waiver Application

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GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

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GEORGIA DEPARTMENT
OF COMMUNITY HEALTH



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OF COMMUNITY HEALTH



13

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