SPECIAL TERMS AND CONDITIONS

NUMBER: 11 -W-00326/6

TITLE: Healthy Texas Women

AWARDEE: Texas Health and Human Services Commission

I. PREFACE

The following are the Special Terms and Conditions (STC) for the "Healthy Texas Women" section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable the Texas Health and Human Services Commission (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 Healthy Texas Women demonstration will be statewide and is approved for a five year period, from ~~January 22, 2020 through December 31, 2024~~January 1, 2025 through December 31, 2029.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. Benefits
VI. General Reporting Requirements
VII. General Financial Requirements
VIII. Monitoring Budget Neutrality
IX. Evaluation of the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs:

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Evaluation Report
Attachment C: Annual Monitoring Report Template
Attachment D: Evaluation Design (reserved)

~~Attachment E: Implementation Plan~~

II. PROGRAM DESCRIPTION AND OBJECTIVES

~~The Healthy Texas Women demonstration expands the provision of family planning services, family planning-related services and other preconception women's health services to women ages 18 through 44 with family income at or below 200 percent of the FPL who are not otherwise eligible for Medicaid or CHIP, or enrolled in other creditable health insurance coverage that provides family planning services~~. The demonstration was originally approved on January 22, 2020 for a five year period through December 31, 2024. As originally approved, the demonstration provided federal authority to expand the provision of family planning services, family planning-related services and other preconception women's health services to women ages 18 through 44 with family income at or below 204.2 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid or CHIP, or enrolled in other creditable health insurance coverage that provides family planning services.

HHSC seeks to enhance women's health care services by increasing access to and participation in the HTW program. HTW demonstration services are available statewide to eligible women.

The goals and objectives of the HTW demonstration are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes and high cholesterol; to positively impact maternal health outcomes; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.
- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.
- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective services across a woman's lifecycle .
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III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with 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 modifications to individuals with

disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, 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 the 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, to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
   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 federal 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 instances, the Medicaid state plan 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 medical assistance expenditures, will be available under 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 no later than 120 calendar days 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 explanations must include a summary of any public feedback received and identification of how this feedback was addressed by the state in 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; and
   d. 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 prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries whether currently enrolled or determined to be 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 applicable notice requirements found in 42 CFR, 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. 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 Expenditure Authority. CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. 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 a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

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.** 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 program – 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 AND ENROLLMENT

16. Eligibility Requirements. Family planning, family planning-related, and other preconception women's health services are provided to eligible individuals with income at or below ~~200~~ 204.2 percent of the FPL.

Eligibility in the demonstration is limited to the following individuals who are not currently receiving benefits through or otherwise eligible for Medicaid, CHIP, Medicare Part A or B, and do~~es~~ not have other creditable health insurance coverage: Women ages 18 through 44 who are United States citizens or qualified immigrants, reside in Texas, and who are not currently pregnant. Individuals found income eligible upon application or annual redetermination are not required to report changes for income or household size for 12 months.

~~17.~~ **Eligibility Determination Process.** ~~No later than 18 months from the date of CMS approval of this demonstration, the state will integrate eligibility, application, verification, and redetermination processes into the eligibility system operated by the state for Medicaid state plan coverage in accordance with section 1943 of the Act. No later than ninety (90) calendar days after approval of the demonstration, the state will submit for CMS review and approval, its timeline with milestones for aligning eligibility and application processes with the requirements of section 1943 of the Act (and implementing federal regulations at 42 CFR part 435) as a part of the Implementation Plan. A delay in implementing the processes necessary to align comply with the requirements of 1943 of the Act (and implementing federal regulations at 42 CFR part 435) may subject the state to the penalty described in STC 26.~~

17. The state ~~Until integration~~ integrated its eligibility, application, verification and redetermination processes into the state's Medicaid state plan eligibility system ~~is complete~~ in compliance with applicable federal policies and procedures. T~~t~~he state ~~will~~ conducts a targeted application and eligibility determination process that meets the intent of section 1943 of the Act in accordance with the following processes:

a. Application. ~~The state will make the separate application for~~Women apply for Healthy Texas Women using the Form H1010 -*Texas Works Integrated Application for Assistance* or Form H1205 – *Texas Streamlined Application for Healthcare Coverage*. The applications are~~is~~ available online for download and fax submission, by mail submission, and available at the local county health department for application and submission in person. The state ~~will~~ maintains a prominent location on its Medicaid/Healthy Texas Women website where the state offices are located for in person application, as well as a list of the Healthy Texas Women provider locations where application and receipt of family planning services can be completed onsite and by phone.

b. Reasonable Opportunity Period. The state ~~will~~ provides a process for verification of non-financial information (e.g., citizenship and immigration status) at initial application ~~for each 12-month period of~~ for coverage under the Healthy Texas Women demonstration in alignment with 42 CFR 435.956.

c. Notices. The ~~separate application and~~ beneficiary eligibility determination notices ~~will~~ provide advance notification that eligibility will be for a 12-month period without a requirement to report a change in income or household size.

d. Verifications. The state ~~will continue to~~ uses electronic data sources to which it has system capability to verify factors of eligibility. To the extent the state is not able to verify factors of eligibility electronically, the state ~~will~~ accepts self-attestation, except for income and citizenship/immigration status. To verify income and citizenship/ immigration status, the state may request applicants provide this information as part of the eligibility determination. However, the state may not make a final determination of ineligibility based on lack of documentation of income and citizenship/qualified immigration status provided by the applicant until the state first utilizes an alternative process ~~(pre or post enrollment)~~ to verify this information through the electronic data sources utilized for Medicaid state plan eligibility.

e. Notification to Applicants of Other Coverage Options.

   i. Women applying through the Healthy Texas Women family planning only application are ~~must be~~ provided information about potential eligibility for full-scope Medicaid or CHIP coverage. If individuals indicate they have not applied, but wish to apply for more comprehensive coverage, individuals are ~~must be~~ provided facilitated access to or assistance with applying for full-scope Medicaid or CHIP coverage through the single streamlined application process. Women apply for HTW using the Form H1010 - *Texas Works Integrated Application for Assistance* or Form H1205 – *Texas Streamlined Application for Healthcare Coverage* or can continue to apply using the online YourTexasBenefits.com application. Women are first be determined ineligible for Medicaid and CHIP before being determined eligible for HTW.

   ii. To provide continuity of care, women 18 through 44 years of age whose Medicaid eligibility as a pregnant woman coverage period is ending are ~~will be~~ tested ~~referred~~ for~~to~~ the demonstration if they are not otherwise eligible for full Medicaid benefits and they do not have other creditable health coverage.

   ~~iii. The state will requests attestation on the Healthy Texas Women family planning application from applicants that they have been informed about the availability of full-scope Medicaid or CHIP coverage and are making an informed choice to apply for family planning only coverage.~~

   ~~iv.~~iii. Pregnant women are ~~will be~~ automatically tested ~~referred~~ for coverage under Medicaid or CHIP.

f. Individuals that apply for full-scope Medicaid or CHIP coverage through Texas' streamlined eligibility application ~~system~~ and are determined ineligible for full-scope coverage are ~~must be~~ tested for ~~provided information on the written notice about potential~~ eligibility under the ~~for~~ Healthy Texas Women family planning only coverage and certified, if eligible. Certified individuals are provided with information on how to opt out of the program on their certification notice ~~and how to apply for such coverage.~~

g. Renewals. The state ~~will continue to~~ conducts redeterminations of eligibility once every 12 months.

h. Demonstration Disenrollment. If a beneficiary becomes pregnant while enrolled in the demonstration, she must be determined eligible for Medicaid under the state plan or CHIP. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid state plan or CHIP.

18. ~~Demonstration Disenrollment~~ Managed Care Organization (MCO) Enrollment and Disenrollment Process.

~~If a beneficiary becomes pregnant while enrolled in the demonstration, she must be determined eligible for Medicaid under the state plan or CHIP. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid state plan or CHIP.~~

a. Time to Choose a Plan. All beneficiaries who obtain Medicaid eligibility will have at least 15 days to choose a managed care organization (MCO).

b. Auto-Assignment. If a potential beneficiary does not choose an MCO within the time frames defined in (a), she may be auto-assigned to an MCO. When possible, the auto-assignment algorithm shall take into consideration the beneficiary's history with a primary care provider, and when applicable, the beneficiary's history with an MCO. If this is not possible the state will equitably distribute beneficiaries among qualified MCOs.

c. Re-Enrollment. The State may automatically re-enroll a beneficiary in the same MCO if there is a loss of Medicaid eligibility for six months or less.

d. Disenrollment or Transfer. Individuals should be informed of opportunities no less than annually for disenrollment and ongoing plan choice opportunities, regularly and in a manner consistent with 42 CFR Part 438 and other requirements set forth in the demonstration Special Terms and Conditions.

i. *MCO Transfer at Request of Beneficiary*. Beneficiaries may request transfer to another MCO in the service area through the enrollment broker at any time.

ii. *Disenrollment at Request of Beneficiary*. Recipients that are voluntarily enrolled in a MCO may request disenrollment and return to traditional Medicaid. Mandatory recipients must request disenrollment from managed care in writing to HHSC; however, HHSC considers disenrollment from managed care only in rare situations, when sufficient medical documentation establishes that the MCO cannot provide the needed services, or in any of the circumstances described in 42 CFR 438.56(c). An authorized HHSC representative reviews all disenrollment requests, and processes approved requests for disenrollment from an MCO. HHSC's enrollment broker provides disenrollment education and offers other options as appropriate.

iii. *Disenrollment at Request of MCO*. An MCO has a limited right to request a beneficiary be disenrolled from the MCO without the beneficiary's consent pursuant to 42 CFR 438.56(b).

V. BENEFITS

19. Family Planning Benefits. Beneficiaries eligible under this demonstration ~~-~~receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act, which are reimbursable at the 90 percent Federal matching rate. The specific family planning services provided under this demonstration are as follows:

a. FDA-approved methods of contraception;
b. Contraceptive management, patient education, and counseling;
c. Pelvic examinations with a family planning diagnosis;
d. Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing and treatment services; and
e. Drugs, supplies, or devices related to women's health services described above.

20. Family Planning-Related Benefits. Beneficiaries eligible under this demonstration ~~will~~ also receive family planning-related services and supplies defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies that would be provided under this demonstration include:

a. Drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections.
b. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting.
c. Treatment of major complications arising from a family planning procedure such as:
    i. Treatment of a perforated uterus due to an intrauterine device insertion;
    ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
    iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

21. Preconception Care Services. Individuals eligible under this demonstration ~~will~~ also receive certain women's health services related to better preconception care and birth outcomes. The preconception care services provided under this demonstration are reimbursable at the state's regular FMAP rate and are as follows:

a. Screening and treatment for cholesterol, diabetes, and high blood pressure;
b. Breast and cervical cancer screening and diagnostic services;
c. Screening and treatment for postpartum depression;
d. Immunizations; and
e. Mosquito repellant prescribed by an authorized health professional.

22. **Minimum Essential Coverage (MEC).** The Healthy Texas Women family planning demonstration is limited to the provision of services as described in STCs 19, 20, and 21. Consequently, this demonstration is not recognized as Minimum Essential Coverage (MEC) consistent with the guidance set forth in the State Health Official Letter #14-002, issued by CMS on November 7, 2014.

23. **Primary Care Referrals.** Primary care referrals to other social services and health care providers as medically indicated will be provided; however, the costs of those primary care services are not covered for beneficiaries of this demonstration. The state and MCOs must facilitate access to primary care services for beneficiaries, and must assure CMS that written materials concerning access to primary care services are distributed by the state and MCOs to demonstration beneficiaries. The written materials must explain to beneficiaries how they can access primary care services.

24. **Delivery of Services.** Enrollees will receive family planning demonstration services on a through a fee-for-service (FFS) basismanaged care delivery model. Qualified Healthy Texas Women providers eligible for participation in this demonstration are those that do not perform or promote elective abortions nor affiliate with entities that perform or promote elective abortionsNote: Enrollees who are members of federally recognized tribes will be able to voluntarily enroll in managed care or opt to remainreceive services in fee-for-service (FFS).

a. Qualified Healthy Texas Women providers eligible for participation in this demonstration are those that do not perform or promote elective abortions nor affiliate with entities that perform or promote elective abortions.

The state contracts with managed care organizations on a geographical basis, and for this purpose, the state is divided into service areas. Table 1 provides the definitions of the service areas.

Table 1. Service Areas and Delivery Systems

HTW Service Area	Counties Served
Bexar	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson
Central Texas	Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington
Dallas	Collin, Ellis, Hurt, Kaufman, Navarro, Rockwall, Ellis, Hurt, Kaufman, Navarro, Rockwall
El Paso	El Paso, Hudspeth
Harris	Austin, Brazoria, Harris, Matagorda, Waller, Wharton, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton
Hidalgo	Cameron, Duval, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker
Lubbock	Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry
Northeast	Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison,

HTW Service Area	Counties Served
Texas	Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood
Nueces	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria
Tarrant	Denton, Hood, Johnson, Parker, Tarrant, Wise
Travis	Bastrop, Burnet, Fayette, Hays, Lee, Travis, Williamson, Fayette, Hays, Lee, Travis, Williamson
West Texas	Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Yoakum, Young, Zavala

25. Managed Care Requirements

a. General. The state must comply with the managed care regulations published at 42 CFR Part 438.

b. MCO Participant Advisory Committees. The state shall require each MCO, through its contracts, to create and maintain participant advisory committees through which the MCO can share information and capture enrollee feedback. The MCOs will be required to support and facilitate participant involvement and submit meeting minutes to the State. Copies of meeting minutes will be made available to CMS upon request.

~~**25.Demonstration Access and Operational Information.** To ensure sufficient ongoing beneficiary coverage and access to services, the state will outline specific operational information in the Implementation Plan. The state must submit a draft Implementation Plan to CMS no later than ninety (90) calendar days after approval of the demonstration for CMS review and comment. The state must submit a revised Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The Implementation Plan must cover at least the key policies being tested under this demonstration. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs as Attachment E. 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 information in the Implementation Plan should include but is not limited to ensuring: network adequacy including procedures for provider qualification; access to care; beneficiary communication strategies including outreach and education; maintenance of and beneficiary access to provider directories; and complaints and grievances. The plan should describe the strategy for monitoring health outcomes, including but not limited to a data-driven process for reviewing access to care and addressing: the extent to which beneficiary needs are fully met; the availability of care through enrolled providers; changes in beneficiary service utilization; the characteristics of the beneficiary population; and actual or estimated levels of provider payment available from other payers. With the implementation of the Affordable Care Act's requirement to transition to the use of Modified Adjusted Gross Income (MAGI) for determining Medicaid income eligibility, the state's comparable income limit will be increased to convert existing state income standards to MAGI, effective 18 months from the date of CMS approval of this demonstration.~~

VI. GENERAL REPORTING REQUIREMENTS

26. 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 $1,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 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 submissions 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 demonstration 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.

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

28. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 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.

29. Monitoring Reports. The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 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 provided by CMS, which will be organized by milestone. 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. 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. In addition, the Monitoring Report should document program outreach and education activities conducted and an assessment of the effectiveness of these outreach and education activities;

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the 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.

30. 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 difficulty accessing services). 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.

31. 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 26.

32. 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.

a. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
b. The state and CMS will jointly develop the agenda for the calls.

33. 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.

VII. GENERAL FINANICAL REQUIREMENTS

34. Allowable Expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval periods 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.

35. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports to report total expenditures for services provided under this Medicaid section 1115(a) demonstration following routine CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined cost limits specified in STC 50.

36. Reporting Expenditures Subject to Title XIX Budget Neutrality Agreement. The following describes the reporting of expenditures subject to the budget neutrality limit:

a. Tracking Expenditures. In order to track expenditures under this demonstration, Texas must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of Title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made.
b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded 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 other cost settlements not attributable to this demonstration, the adjustments should be reported on lines 9 or 10C as instructed in the State Medicaid Manual.

c. Use of Waiver Forms. The state must report demonstration expenditures on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report Title XIX expenditures for demonstration services.

37. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must 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.

38. 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 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.

39. 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 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 thirty (30) days after the end of each quarter, the state shall submit Form CMS64 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.

40. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP for family planning, family planning related, and other preconception women's health services at the applicable federal matching rates as described in STCs 19, 20 and 21, subject to the limits and processes described below:

a. For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management, and sterilizations), FFP will be available at the 90 percent federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a diagnosis or indicator that specifically identifies them as a family planning service. Allowable family planning expenditures eligible for

reimbursement at the enhanced family planning match rate of 90 percent, as described in STC 19, should be entered in Column (D) on the CMS-64.9 Waiver Form.

b. Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

c. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if provided by eligible Medicaid providers. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

41. Sources of Non-Federal Share. The state must certify that its match for non-federal share of funds for this 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 the 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 the demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

42.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 related to taxes, including health care provider-related taxes, fees business relationship 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.

43. 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.

44. Medicaid Eligibility 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 calculation, 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 1: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Healthy Texas Women	Hypothetical	X		X	Detailed in STC 16

45. Reporting Expenditures and Member Months. The following describes the reporting of member months for the demonstration:

a. For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the monitoring reports as required under STC 29, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the annual reports, certifying the accuracy of this information.
b. 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 to the total, for a total of four eligible member months. For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the monitoring reports as required under STC 28, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the annual reports, certifying the accuracy of this information. 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 to the total, for a total of four eligible member months.

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

Table 2: Demonstration Years		
Demonstration Year ~~1~~6	~~January 22, 2020 to December 31, 2020~~ January 1, 2025 to December 31, 2025	12 months
Demonstration Year ~~2~~7	~~January 1, 2021 to December 31, 2021~~ January 1, 2026 to December 31, 2026	12 months
Demonstration Year ~~3~~8	~~January 1, 2022 to December 31, 2022~~ January 1, 2027 to December 31, 2027	12 months
Demonstration Year ~~4~~9	~~January 1, 2023 to December 31, 2023~~ January 1, 2028 to December 31, 2028	12 months
Demonstration Year ~~5~~10	~~January 1, 2024 to December 31, 2024~~ January 1, 2029 to December 31, 2029	12 months

47. 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 adjustment to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data provided to establish the budget neutrality expenditure limit are

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

VIII. MONITORING BUDGET NEUTRALITY

48. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding it may receive on approved demonstration service expenditures incurred during the period of demonstration approval. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the approved demonstration period. Actual expenditures subject to budget neutrality expenditure limit shall be reported by the state using the procedures described in STC 36.

49. Risk. Texas shall be at risk for the per capita cost (as determined by the method described in this section), but not for the number of demonstration enrollees. By providing FFP for demonstration enrollees, Texas shall not be at risk for changing economic conditions that impact enrollment levels. 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 has there been no demonstration.

50. Budget Neutrality Annual Expenditure Limits. For each demonstration year, an annual budget limit will be calculated for the demonstration. The Healthy Texas Women annual demonstration cycle is January 1 through December 31. The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share. In response to the Public Health Emergency, CMS will allow for a one-time adjustment to budget neutrality to account for impacts of COVID-19 on enrollment and expenditures.

Table 3: Hypothetical Budget Neutrality Test

TREND	DY ~~1~~6	DY ~~2~~7	DY ~~3~~8	DY ~~4~~9	DY ~~5~~10
4.6%	$27.13	$28.38	$29.69	$31.06	$32.49

a. PMPM Cost. The following table provides the approved demonstration cost trend (based on the state's historical rate of growth) and the PMPM (total computable) ceiling for each demonstration year. Revised CMS budget neutrality policies have been applied to assume an 80 percent rebasing based on actual/estimated state expenditures and 20 from prior approved WOW PMPMs.

b. Composite 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, as reported on the forms listed in STC 36 above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the approval period (see STC 9), the Composite Federal Share will be determined based on actual expenditures for the period

in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.

c. Structure. The demonstration's budget neutrality model is structured as a "pass- through" or "hypothetical" expenditure population. Therefore, the state may not derive savings from the demonstration.

d. Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures reported by the state on the CMS-64 forms. If at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess federal funds will be returned to CMS. If the costs of the demonstration services do not exceed the budget limit, the state may not derive or utilize any such savings.

51. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of this demonstration extension approval period. No later than 90 days after the end of each demonstration year, the state will calculate and report to CMS an annual cumulative expenditure target for the completed year as part of the Annual Monitoring Report described in STC 29. This amount will be compared with the actual cumulative amount the state has claimed for FFP through the completed year. If cumulative spending exceeds the cumulative target by more than the indicated percentage, the state will submit a corrective action plan to CMS for approval. The state will subsequently implement the approved plan.

Year	Cumulative Target Expenditures	Percentage
DY ~~1~~6	~~DY1~~ DY6 budget limit plus:	2.0 percent
~~DY2~~DY7	~~DY1~~ DY6 and ~~DY2~~ DY7 combined budget limit amount plus:	1.5 percent
~~DY3~~DY8	DY6~~1~~ through DY8~~3~~ combined budget limit amount plus:	1.0 percent
~~DY4~~DY9	DY6~~1~~ through DY9~~4~~ combined budget limit amount plus:	0.5 percent
~~DY5~~DY10	DY6~~1~~ through DY10~~5~~ combined budget limit amount plus:	0 percent

52. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from ~~January 22, 2020 to December 31, 2024~~ January 1, 2025 to December 31, 2029. 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.

53. 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 level in the tables below as a guide for determining when corrective action is required.

IX. EVALUATION OF THE DEMONSTRATION

54. 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, 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 26.

55. 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.

56. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with CMS guidance, including but not limited to attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred twenty (120) calendar days after the effective date of these STCs. 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 state may choose to use the expertise of the independent party in the development of the draft Evaluation Design.

57. 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 an attachment 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.

58. 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. Hypotheses should include, but are not limited to, testing the effects of the demonstration on sustainability, and access to women's health, family planning, and preventative care services. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

59. 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.

60. 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.

61. 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.

62. 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. 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 difficulty accessing services). 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.

63. 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, and/or the summative evaluation.

64. 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.

65. 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.