Centers for Medicare & Medicaid Services
Office of Information Services
Information Services Design & Development Group
7500 Security Blvd
Baltimore, MD 21244-1850

Section 1115 Demonstration Program

Template

Section 1115 Demonstration
Template for New Demonstrations

Instructions: This template is meant to assist states that are developing an application for a new section 1115 demonstration project; submission of the information provided in this template or the attachments does not guarantee approval of a state's demonstration request. CMS will work with states to identify any additional information necessary to consider demonstration requests. Use of this guide/format is not required; it is a tool that states can use at their option. It was designed to help states ensure the application contains the required elements as provided for under 42 CFR 431.412, as well as promote an efficient review process. It can also be used by states as a template for their application; states can add narrative responses to the information requested in the sections below that are applicable to the state's particular application, and complete the charts and check boxes provided. We will continue to improve this guide based on input from states and expect to have an online section 1115 demonstration application available for use in the future.

Please submit applications electronically to 1115DemoRequests@cms.hhs.gov and mail hard copies to:

Ms. Victoria Wachino
Centers for Medicare & Medicaid Services
Children and Adults Health Programs Group
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244

Section I - Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act). (This summary will also be posted on Medicaid.gov after the application is submitted. If additional space is needed, please supplement your answer with a Word attachment);

2) Include the rationale for the Demonstration (if additional space is needed, please supplement your answer with a Word attachment);

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them (if additional space is needed, please supplement your answer with a Word attachment);

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the

geographic areas/regions of the State where the Demonstration will operate (if additional space is needed, please supplement your answer with a Word attachment);

5) Include the proposed timeframe for the Demonstration(if additional space is needed, please supplement your answer with a Word attachment); and

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems (if additional space is needed, please supplement your answer with a Word attachment).

Section II – Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included). Please refer to Medicaid Eligibility Groups: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid State plan populations, and for an

expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

Example Eligibility Chart

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Transitional Medical Assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)	0 – 100% of the FPL
Families who would qualify for cash assistance if the State had expanded its cash assistance program as allowed under federal law (Parent/Caretaker Relatives)	1902(a)(10)(A)(ii)(III) 42 CFR 435.223 1905(a)	100 – 200% of the FPL
Adults without dependent children not otherwise eligible under the State plan	N/A	0-200% of the FPL

Eligibility Chart
Mandatory State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level

Optional State Plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level

Expansion Populations

Eligibility Group Name	N/A	Income Level

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan (if additional space is needed, please supplement your answer with a Word attachment);

3) Specify any enrollment limits that apply for expansion populations under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment);

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs (if additional space is needed, please supplement your answer with a Word attachment);

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State) (if additional space is needed, please supplement your answer with a Word attachment);

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013) (if additional space is needed, please supplement your answer with a Word attachment); and

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014 (if additional space is needed, please supplement your answer with a Word attachment).

Section III – Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

   ☐ Yes ☐ No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

   ☐ Yes ☐ No (if no, please skip questions 8 - 11)

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Example Benefit Package Chart

Eligibility Group	Benefit Package
Transitional Medical Assistance	Full State Plan
Optional State plan parent/caretaker relatives	Benchmark Equivalent Benefit Package
Expansion Adults	Demonstration-only Benefit Package

Benefit Package Chart

Eligibility Group	Benefit Package

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

   ☐ Federal Employees Health Benefit Package

   ☐ State Employee Coverage

   ☐ Commercial Health Maintenance Organization

   ☐ Secretary Approved

**Please note that, in accordance with section 1937(a)(2)(B) of the Act, the following populations are exempt from benchmark equivalent benefit packages: mandatory pregnant women, blind or disabled individuals, dual eligibles, terminally ill hospice patients, individuals eligible on basis of institutionalization, medically frail and special medical needs individuals, beneficiaries qualifying for long-
term care services, children in foster care or receiving adoption assistance, mandatory section 1931 parents, and women in the breast or cervical cancer program. Also, please note that children must be provided full EPSDT benefits in benchmark coverage.

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

Example Benefit Chart

Benefit	Description of Amount, Duration and Scope	Reference
Inpatient Hospital Services	No limitations – coverage is based on State plan	Mandatory 1905(a)(1)
Podiatrist Services	Limited to 12 visits per year	Optional 1905(a)(6)

Benefit Chart

Benefit	Description of Amount, Duration and Scope	Reference

Benefits Not Provided

Benefit	Description of Amount, Duration and Scope	Reference

Please refer to List of Medicaid and CHIP Benefits: http://www.medicaid.gov/Medicaid- CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Medicaid-and-CHIP-Benefits.pdf, when completing this chart.

6) Indicate whether Long Term Services and Supports will be provided.

☐ Yes (if yes, please check the services that are being offered) ☐ No

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf, and the: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf.

☐ Homemaker
☐ Home Health Aide
☐ Case Management
☐ Personal Care Services
☐ Adult Day Health Services
☐ Habilitation – Residential Habilitation
☐ Habilitation – Supported Employment
☐ Habilitation – Day Habilitation
☐ Habilitation – Pre-Vocational
☐ Habilitation – Other Habilitative
☐ Habilitation – Education (non-IDEA Services)
☐ Respite
☐ Day Treatment (mental health service)
☐ Psychosocial Rehabilitation
☐ Clinic Services
☐ Environmental Modifications (Home Accessibility Adaptations)
☐ Vehicle Modifications
☐ Non-Medical Transportation
☐ Special Medical Equipment (minor assistive devices)
☐ Home Delivered Meals Personal
☐ Assistive Technology
☐ Emergency Response
☐ Nursing Services
☐ Community Transition Services
☐ Adult Foster Care
☐ Day Supports (non-habilitative)
☐ Supported Employment
☐ Supported Living Arrangements
☐ Private Duty Nursing
☐ Assisted Living
☐ Adult Companion Services
☐ Supports for Consumer Direction/Participant Directed Goods and Services
☐ Other (please describe)

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

☐ Yes (if yes, please address the questions below)
☐ No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and

under which authority, and whether the state is modifying its existing program or creating a new program (if additional space is needed, please supplement your answer with a Word attachment);

b) Include the minimum employer contribution amount (if additional space is needed, please supplement your answer with a Word attachment);

c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing (if additional space is needed, please supplement your answer with a Word attachment); and
d) Indicate how the cost-effectiveness test will be met (if additional space is needed, please supplement your answer with a Word attachment).

8) If different from the State plan, provide the premium amounts by eligibility group and income level (if additional space is needed, please supplement your answer with a Word attachment).

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

Example Copayment Chart

Eligibility Group	Benefit	Copayment Amount
Childless Adults	Podiatrist Services	$3 per visit

Copayment Chart

Eligibility Group	Benefit	Copayment Amount

If the state is proposing to impose cost sharing in the nature of deductions, copayments or similar charges beyond what is permitted under the law, the state should also address in its application, in accordance with section 1916(f) of the Act, that its waiver request:

a) will test a unique and previously untested use of copayments;
b) is limited to a period of not more than two years;
c) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients;
d) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and
e) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

Please refer to Information on Cost Sharing http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Information-on-Cost-Sharing-Requirements.pdf requirements for further information on statutory exemptions and limitations applicable to certain populations and services.

10) Indicate if there are any exemptions from the proposed cost sharing (if additional space is needed, please supplement your answer with a Word attachment).

Section IV – Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

   ☐ Yes

   ☐ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms (if additional space is needed, please supplement your answer with a Word attachment);

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ☐ Managed care
  - ☐ Managed Care Organization (MCO),
  - ☐ Prepaid Inpatient Health Plans (PIHP)
  - ☐ Prepaid Ambulatory Health Plans (PAHP)
- ☐ Fee-for-service (including Integrated Care Models)
- ☐ Primary Care Case Management (PCCM)
- ☐ Health Homes
- ☐ Other (please describe)

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

Example Delivery System Chart

Eligibility Group	Delivery System	Authority
Transitional Medical Assistance	Fee-for-service	State plan
Optional State plan parent/caretaker relatives	Managed Care – MCO	Section 1915(b) waiver
Childless Adults	Managed Care – MCO	1115

Delivery System Chart

Eligibility Group	Delivery System	Authority

5) If the Demonstration will utilize a managed care delivery system:

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if additional space is needed, please supplement your answer with a Word attachment)?

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment);

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment);

d) Describe how will the state assure choice of MCOs, access to care and provider network adequacy (if additional space is needed, please supplement your answer with a Word attachment); and

e) Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion (if additional space is needed, please supplement your answer with a Word attachment);

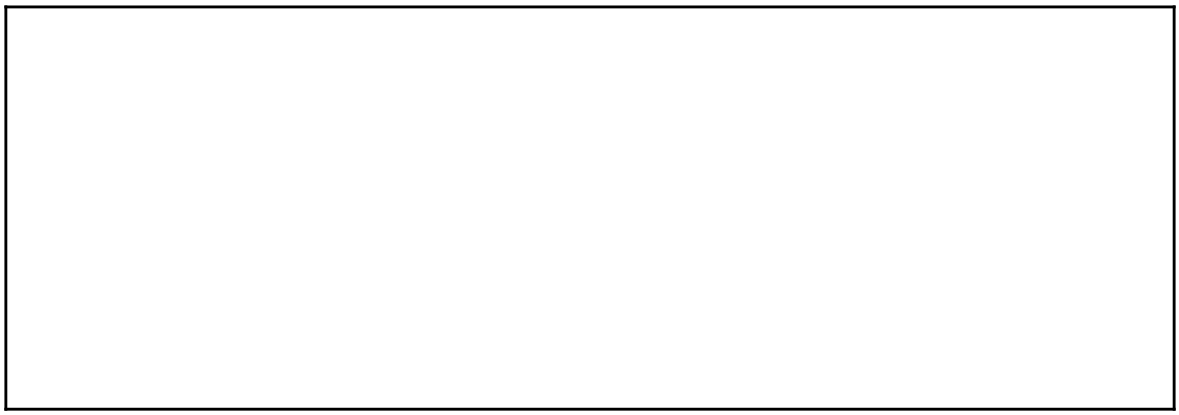
7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).

☐ Yes ☐ No

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology (if additional space is needed, please supplement your answer with a Word attachment);

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438 (if additional space is needed, please supplement your answer with a Word attachment); and

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected (if additional space is needed, please supplement your answer with a Word attachment).



Section V – Implementation of Demonstration

This section should include the anticipated implementation date, as well as the approach that the State will use to implement the Demonstration. Specifically, this section should:

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone (if additional space is needed, please supplement your answer with a Word attachment);

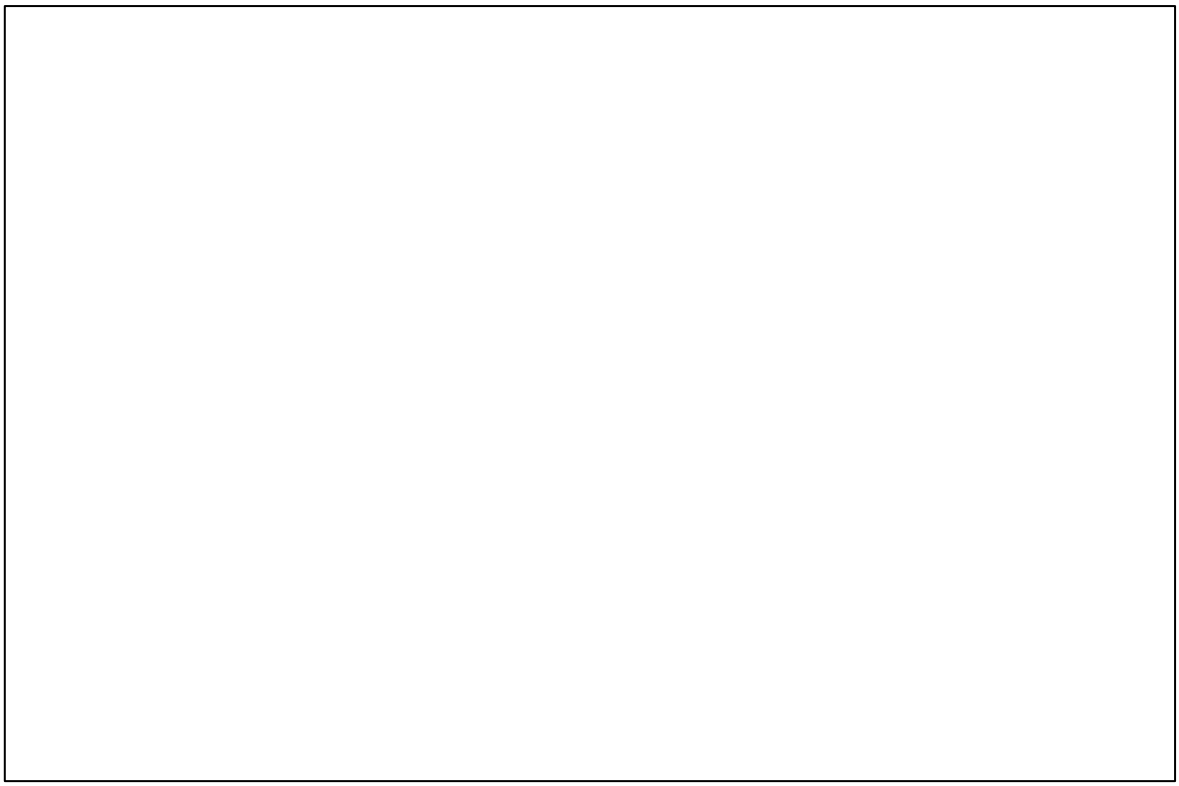
2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration (if additional space is needed, please supplement your answer with a Word attachment); and

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action (if additional space is needed, please supplement your answer with a Word attachment).

Section VI – Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/ 1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.



Section VII – List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In

accordance with 42 CFR 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Provide a list of proposed waivers and expenditure authorities; and

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Please refer to the list of title XIX and XXI waivers and expenditure authorities: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115 /Downloads/List-of-Waivers-and-Expenditure-Authorities.pdf that the state can reference to help complete this section. CMS will work with the State during the review process to determine the appropriate waivers and expenditures needed to ensure proper administration of the Demonstration.

Section VIII – Public Notice

This section should include information on how the state solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408. For specific information regarding the provision of state public notice and comment process, please click on the following link to view the section 1115 Transparency final rule and corresponding

State Health Official Letter: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html

Please include the following elements as provided for in 42 CFR 431.408 when developing this section:

1) Start and end dates of the state's public comment period (if additional space is needed, please supplement your answer with a Word attachment);

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS (if additional space is needed, please supplement your answer with a Word attachment);

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted (if additional space is needed, please supplement your answer with a Word attachment);

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used. If additional space is needed, please supplement your answer with a Word attachment);

5) Comments received by the state during the 30-day public notice period (if additional space is needed, please supplement your answer with a Word attachment);

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application (if additional space is needed, please supplement your answer with a Word attachment); and

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation (if additional space is needed, please supplement your answer with a Word attachment).

If this application is an emergency application in which a public health emergency or a natural disaster has been declared, the State may be exempt from public comment and tribal consultation requirements as outlined in 42 CFR 431.416(g). If this situation is applicable, please explain the basis for the proposed emergency classification and public comment/tribal consultation exemption (if additional space is needed, please supplement your answer with a Word attachment).

Section IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title:
Telephone Number:
Email Address: