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New Federal Guidance on Monitoring and Evaluation of Work Requirements and Other Coverage Demonstrations: What Does It Mean for States?

Introduction

In March 2019, the Centers for Medicare & Medicaid Services (CMS) issued detailed guidance for states on the monitoring and evaluation of "eligibility and coverage" Section 1115 Medicaid demonstrations. The new guidance provides standard monitoring metrics and recommended research methods geared specifically toward state Medicaid demonstration waivers that include one or more of the following policies:

- Work or community engagement (CE) as a condition of eligibility
- Beneficiary premiums
- Waivers of retroactive eligibility
- Imposition of non-eligibility periods for failure to meet certain requirements
- Premium assistance

The guidance from CMS marks a substantial increase in the rigor—and associated resource investments—demanded of states for monitoring and evaluating these types of demonstrations. To help state officials and their researcher partners navigate the heightened expectations, this brief provides an overview of the March 2019 guidance, distills key information on its new requirements, and highlights practical considerations for states. While monitoring and evaluation requirements and resources are referenced more broadly, the brief has a particular focus on demonstrations with a work/CE component and is a complement to *Monitoring and Evaluating Work and Community Engagement Requirements in Medicaid: Data Assets, Infrastructure and Considerations for States*, a February 2019 resource guide for states produced by Manatt Health with support from the Robert Wood Johnson Foundation.[1]

The March evaluation guidance builds on existing monitoring and evaluation resources (see **Appendix Exhibit A: Catalog of CMS Guidance on Medicaid Demonstration Monitoring and Evaluation**), and includes three components:

- **An implementation plan template** for work/CE demonstrations
- **A monitoring report template and associated metrics** for eligibility and coverage demonstrations, including but not limited to those with work/CE policies
- **Evaluation design guidance** specific to eligibility and coverage demonstrations, along with a more broadly applicable document on how states can plan the implementation of their demonstrations to enable rigorous evaluations

Support for this work was provided by the Robert Wood Johnson Foundation.

States with demonstrations that contain work/CE or other specified eligibility and coverage provisions will be required to submit implementation plans and monitoring reports that comply with the new guidance. Those with approved work/CE demonstrations are receiving technical assistance from CMS on how to address the new guidance in their implementation plans and future monitoring reports. States will not be required to make specific evaluation design changes in response to the guidance, but CMS expects states to use it as a basis for their discussions with independent evaluators and potentially to support evaluator procurement.

Exhibit 1: Required Components of Medicaid Demonstration Monitoring and Evaluation

Component	Description
Implementation plan	▪ Documents state approach to implementation ▪ Informs monitoring and evaluation activities for the demonstration ▪ Typically due within 90 days of demonstration approval
Monitoring protocol	▪ Describes what state will report on a quarterly basis, developed collaboratively between CMS and the state ▪ Typically due within 150 days of demonstration approval
Monitoring reports	▪ Documents qualitative summaries on metrics trends and implementation updates ▪ Provides standardized monitoring metrics ▪ Due on a quarterly and annual basis
Evaluation design	▪ Documents hypotheses, research questions, outcome measures, and analytic approaches for the state's independent evaluation in accordance with CMS expectations for rigor ▪ Draft typically due within 180 days of demonstration approval; state must provide a revised version within 60 days of receiving CMS comments and process may be iterative
Evaluation reports	▪ Presents relevant data and an interpretation of findings, assesses outcomes, explains methodological limitations, offers recommendations, and discusses implications for future Medicaid policy ▪ Interim report typically due one year prior to expiration of demonstration; summative report draft typically due within 18 months of demonstration end and finalized within 60 days of receiving CMS comments

Notes: Components here reflect requirements for state monitoring and evaluation; see **Appendix Exhibit A** for a catalog of related CMS guidance. Federal evaluations with a cross-state perspective may also be conducted.[2]

Sources: CMS and Mathematica;[3] CMS.[4]

New Rigor Demanded of States for Medicaid Demonstration Monitoring and Evaluation

Over the past few years, CMS has sought to inject more rigor into demonstration monitoring and evaluations,[5] including by:

- developing technical assistance guides for states on appropriate research methods for their evaluations;
- increasing feedback to states on strategies to strengthen their evaluation designs and reports; and
- issuing detailed guidance on substance use disorder (SUD) demonstration monitoring and evaluation, including monitoring protocol and report templates, metrics to be included in the reports, and a technical guide on developing an evaluation design.

Additional information on the monitoring and evaluation components required of all Medicaid demonstrations—regardless of the policies being implemented—is provided in **Exhibit 1**.

Summary of the New Monitoring and Evaluation Guidance

The March 2019 guidance from CMS is extensive, providing a detailed road map for states to navigate their monitoring and evaluation obligations for eligibility and coverage demonstrations. A summary of the templates and associated documents that comprise the guidance is provided below, focusing on the requirements for states with work/CE policies in particular.

***Implementation Plan Template*.** States are expected to complete an implementation plan—which documents policy and operational issues but also informs monitoring and evaluation activities—for all eligibility and coverage policies in their approved demonstrations. However, the implementation plan template provided as part of the March 2019 guidance includes only work/CE policies. CMS expects to release implementation guidance for other types of eligibility and coverage demonstrations later in 2019. In the interim, states may be able to use a similar implementation plan structure for these other policies, but the details must be negotiated with CMS absent specific expectations of the type laid out for work/CE policies.

The template is organized around seven topics, and states are asked to attach any relevant supporting documents:

1. **Specify community engagement policies**—States are required to describe in more detail the work/CE policies outlined in the special terms and conditions (STCs) of the state's demonstration, including indicating how they will define exempt populations, qualifying activities and hours, good-cause exceptions, and compliance actions.
2. **Establish beneficiary supports and modifications**—States are required to describe how they will provide supports to beneficiaries to ensure that they are able to meet work/CE requirements. Specifically, states must address transportation, child care, and language supports at a minimum; strategies for ensuring the availability and accessibility of work/CE activities; and reasonable modifications for people with disabilities.
3. **Establish procedures for enrollment, verification, and reporting**—States are required to describe modifications to enrollment processes as well as verification and reporting of activities and exemptions. Issues include application, enrollment, and renewal procedures; beneficiary and, if applicable, employer or other work/CE entity reporting; and verification of activities and exemptions.

4. **Operationalize strategies for noncompliance**—States are required to describe how they will implement the policies for beneficiaries who do not comply with work/CE requirements, including their strategies for identifying and addressing beneficiaries at risk of noncompliance, stopping managed care payments, reenrolling beneficiaries, and modifying appeals processes.
5. **Develop comprehensive communications strategy**—States must provide detailed information regarding how they will communicate work/CE policies and procedures to internal and external stakeholders. Beneficiary, partner organization, and staff/internal communications must be addressed.
6. **Establish continuous monitoring**—States are required to describe how they will conduct process and quality improvements for the work/CE program. Of note is the fact that states must indicate not only how they will assess potential problems, but also how they may modify their work/CE policies in response or take action to address gaps in beneficiary supports or accommodations. Required information includes a discussion of:
    - any planned analyses beyond what CMS requires and the process for determining whether changes to work/CE policies are needed;
    - actions that may be needed to capture required quarterly and annual metrics (e.g., data sharing agreements);
    - how states will assess and address gaps in reasonable accommodations for people with disabilities and the availability of beneficiary supports more broadly;
    - how states will assess the availability of work/CE activities during a range of times, through a variety of means, and throughout the year; and
    - how states will identify geographic areas with high unemployment and limited economic and/or educational opportunities, as well as how they will adjust work/CE requirements in areas with few opportunities.
7. **Develop, modify, and maintain systems**—Finally, states must describe any system changes needed to implement work/CE policies and meet reporting requirements. Specific areas that may require system development or modification include eligibility and enrollment; beneficiary and employer/other entity reporting; integration with the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and other public programs; and benefit suspension and/or termination.

***Monitoring Report Template* and *Associated Metrics*.** The monitoring report template provides the specific items that states are expected to include in quarterly and annual demonstration monitoring reports to CMS.

Accompanying the template are six modules that lay out the **metrics** to be included in monitoring reports, with a focus on items that can be calculated from the administrative data that states collect in the course of operating their Medicaid programs. Module 1 contains metrics that all states with eligibility and coverage demonstrations must report (see **Appendix Exhibit B: Standard Monitoring Metrics for Any Eligibility and Coverage Demonstration** for details), while Modules 2 through 6 are policy-specific (e.g., see **Appendix Exhibit C: Additional Monitoring Metrics for States with Work/CE Requirements**, which reflects Module 5). Each metric is flagged as either **required** or **recommended**, with a designated **measurement period** (monthly, quarterly, annually). In many cases, metrics must be reported for specified **subpopulations** defined by income, demographic (age, sex, race, ethnicity), exemption, and eligibility groupings. The guidance acknowledges that exempt

populations will vary by state based on the STCs authorizing a demonstration, but does not describe the expected level of reporting detail (e.g., whether some exempt populations can be grouped together for reporting purposes).

Evaluation Design Guidance. The evaluation design guidance for eligibility and coverage demonstrations consists of a broadly applicable technical assistance document supplemented with a series of appendices with evaluation design guidance specific to work/CE, beneficiary premiums, retroactive eligibility, non-eligibility periods, and sustainability. CMS notes that the guidance is intended to support states in developing evaluation designs that will meet its expectations for rigor and comply with evaluation requirements in demonstration STCs. To that end, CMS provides hypotheses, research questions, and evaluation approaches intended to generate strong evaluation designs, along with a general framework for states and their evaluators to use as a starting point for drafting an evaluation design. CMS also issued a separate guidance document that describes how states can plan the implementation of their demonstrations to enable rigorous evaluation, focusing in particular on eligibility and coverage policies.

For work/CE requirements, the guidance indicates that its hypotheses and research questions are consistent with CMS's January 2018 State Medicaid Director Letter on the policy,[6] but that states may add items to reflect unique aspects of their demonstrations.

- **Hypothesis 1:** Medicaid beneficiaries subject to work/CE requirements will have higher employment levels, including work in subsidized, unsubsidized, or self-employed settings, than Medicaid beneficiaries not subject to the requirements.
- **Hypothesis 2:** Work/CE requirements will increase the average income of Medicaid beneficiaries subject to the requirements, inclusive of other benefits, compared to Medicaid beneficiaries not subject to the requirements.
- **Hypothesis 3:** Work/CE requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.
- **Hypothesis 4:** Work/CE requirements will improve the health outcomes of current and former Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.

As noted in the guidance, hypotheses correspond to policy goals, and states must gather a broad array of information to determine whether expected outcomes are being achieved and can be attributed to the demonstration. For example, although successful transitions from Medicaid to commercial health insurance are contemplated as a work/CE hypothesis, overall coverage impacts (including transitions to uninsurance) are not. However, the guidance does include the extent of coverage losses as a primary research question that informs demonstration hypotheses. Medicaid disenrollment due to noncompliance is also noted as an example of a "confounding/contextual" factor to be addressed as part of the evaluation design for a work/CE demonstration.

What the Guidance Means for States

States that are seeking demonstration authority to implement new conditions on Medicaid coverage and eligibility, which number 13 as of this writing,[7] have new and detailed "rules of the road" from CMS that will shape their implementation, monitoring, and evaluation plans throughout the duration of their demonstration projects. CMS has laid out clear expectations while also raising the bar, and states will need to carefully consider and plan for the resource investments required to augment their monitoring data and conduct rigorous evaluations.

With regard to monitoring, many of the practical issues that states with work/CE demonstrations will face, including issues like determining what systems changes are needed to capture required quarterly and annual metrics, are highlighted in and must be addressed through the implementation plan template. Additional monitoring and evaluation considerations for states implementing or contemplating demonstrations with coverage or eligibility features include:

- **Timing.** An implementation plan and monitoring protocol will be due to CMS shortly after demonstration approval, depending in part on the speed with which a state expects its policies to be operational. Implementation plans are typically due within 90 days of demonstration approval, meaning states have to begin moving from policy ideas to policy specificity to operational design quickly—likely even as they are negotiating their demonstration STCs with CMS and determining how they will fulfill any state-specific rulemaking or other administrative requirements that may apply. Although draft evaluation designs are generally due within six months of approval, CMS encourages states to support robust research and early data collection by quickly identifying an evaluation team to consult on implementation planning, placing an imperative on starting evaluation work equally early. In addition to improving the quality of evaluation evidence, CMS notes that integrating implementation and evaluation planning may give states opportunities to systematically refine their demonstration implementation. Early integration also positions states to make use of information gathered during the evaluation process as soon as possible, allowing them to make course corrections in demonstration policies as needed, rather than waiting years for evaluations to fully unfold.
- **Procurements.** Since at least 2014, CMS has specified in demonstration STCs that state evaluations must be conducted by an independent third party.[8] In order to work with an independent evaluator from the earliest stages of demonstration implementation—or even development—states will need to begin a procurement process well in advance. States will also need to determine the extent to which contractors are needed to make the potentially extensive changes necessary to meet monitoring requirements, including the capture of specific metrics for quarterly and annual reports, and to obtain information needed for evaluation purposes. For example, states may need to connect existing state systems (e.g., integrating Medicaid with SNAP, TANF, and other programs) as well as build new ones (e.g., beneficiary portals for work/CE reporting). Procurement documents issued by states highlight some of the challenges involved; for example, Arizona details nearly 20 pages of requirements for a beneficiary portal, spelling out the complex structure needed to capture exemptions, activities, and other relevant information.[9]
- **Analytics.** In addition to capturing information, states must analyze it. In its recent guidance, CMS notes that the metrics it designates as required are critical for monitoring demonstration success and should be readily available to states, and that recommended metrics provide important information but may be more difficult to obtain. However, even when raw data are readily available, states may find it challenging to transform their information into the required format. A forthcoming technical specifications manual with instructions for constructing monitoring metrics (expected in Summer 2019) will be of help to states, but meeting demonstration reporting requirements will necessitate substantial staff and contractor resource investments under any circumstance. In addition, given that the monitoring report metrics required of states for work/CE demonstrations do not reflect all the items that must be described in the state's implementation plan (e.g., an examination of geographic areas with limited opportunities), it is unclear whether and how CMS will require states to provide the results of these additional analyses.
- **Evaluation approach.** Experimental designs that randomly assign individual beneficiaries to groups that are either subject to or not subject to demonstration policies (also called randomized controlled trials, or RCTs) are

the gold standard for program evaluation. As noted in the evaluation guidance from CMS, states must weigh the benefits of RCTs against their drawbacks, including the fact that they can be expensive. In general, states and the federal government each shoulder 50 percent of the costs associated with the procurement of an independent evaluator and any new data collection that may be required. In Kentucky, the state is slated to undertake an approach to its demonstration evaluation that involves random assignment of some beneficiaries to participate in the work/CE requirement while others continue their coverage under existing rules,[10] at a cost of $9.4 million through state fiscal year 2020—a figure that likely will rise given that demonstration evaluations typically unfold over several years.[11]

Demonstration Costs

In its evaluation design guidance for eligibility and coverage demonstrations, CMS includes an appendix with approaches states can take to use cost information in assessing demonstration sustainability (which, as acknowledged, is not a clearly defined concept and will vary depending on the context). While the guidance is provided for purposes of helping states develop their evaluation designs, it also gives states a practical framework for considering the potential cost impacts of their demonstrations, including:

- **Administrative costs** associated with demonstration startup and ongoing operations. Specific items recommended for examination include the cost of (1) contracts or contract amendments to implement demonstration policies, as well as those for monitoring and evaluation; and (2) staff time equivalents required to implement, administer, and communicate with beneficiaries about demonstration policies, such as premium collection, health behavior incentives, and/or community engagement requirements.
- **Health care service costs**, both in the aggregate and per member per month. Depending on a demonstration's effects on enrollment, these measures may move in opposite directions.
- **Uncompensated care costs** accruing to providers, which are more readily available for hospitals but may require new data collection efforts (e.g., state-specific surveys) for other provider types.

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Appendix Exhibit A: Catalog of CMS Guidance on Medicaid Demonstration Monitoring and Evaluation

Component	Type of demonstration and applicable guidance documents/templates
Implementation plan	**Work/CE**: *Medicaid Section 1115 Eligibility and Coverage Demonstration Implementation Plan*[12] **SUD**: *Section 1115 Substance Use Disorder (SUD) Demonstration: Guide for Developing Implementation Plan Protocols*[13]
Monitoring protocol	**SUD**: *Medicaid Section 1115 SUD Demonstration Monitoring Protocol Template*
Monitoring reports	**Eligibility and coverage**: *Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Report*[14] *Monitoring Metrics for Demonstrations with Community Engagement and Other Eligibility and Coverage Policies*[15] **SUD**: *Medicaid Section 1115 SUD Demonstration Monitoring Report*[16] *Monitoring Metrics for Section 1115 Demonstrations with SUD Policies*[17]
Evaluation design	**General:** *Section 1115 Demonstrations: Developing the Evaluation Design*[18] *Planning Section 1115 Demonstration Implementation to Enable Strong Evaluation Designs*[19] *Best Practices in Causal Inference for Evaluations of Section 1115 Eligibility and Coverage Demonstrations*[20] *Selecting the Best Comparison Group and Evaluation Design: A Guidance Document for State Section 1115 Demonstration Evaluations*[21] **Eligibility and coverage**: *Evaluation Design Guidance for Section 1115 Eligibility and Coverage Demonstrations*[22] Appendices on community engagement,[23] beneficiary premiums,[24] retroactive eligibility,[25] non-eligibility periods,[26] and sustainability[27] **SUD**: *Substance Use Disorder (SUD) Section 1115 Demonstration Evaluation Design – Technical Assistance*[28]
Evaluation reports	**General**: *Section 1115 Demonstrations: Preparing the Evaluation Report*[29]

Notes: With the exception of the SUD monitoring protocol template, which CMS has shared with individual states, information shown here is available on the CMS website; CMS may share additional templates and documents with states before they are officially cleared for wider release. Guidance applicable to demonstrations that include delivery system innovations for adults with serious mental illness or children with a serious emotional disturbance (SMI/SED) is under development,[30] with a draft implementation plan template currently available to states.[31]

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Appendix Exhibit B: Standard Monitoring Metrics for Any Eligibility and Coverage Demonstration

Metric	Metric name and description	Required or recommended	Subpopulations				Measurement period
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Enrollment							
AD_1	**Total enrollment in the demonstration.**	Required	X	X	X	X	Monthly
AD_2	**Beneficiaries in suspension status for noncompliance.**	Required	X	X	X	X	Monthly
AD_3	**Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time.**	Required	X	X	X	X	Monthly
AD_4	**Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies.**	Required	X	X	X	X	Monthly
AD_5	**New enrollees.**	Required	X	X	X	X	Monthly
AD_6	**Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance.**	Required	X	X	X	X	Monthly
Mid-year loss of demonstration eligibility							
AD_7	**Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal.**	Required	X	X	X	X	Monthly
AD_8	**Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information.**	Required	X	X	X	X	Monthly
AD_9	**Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary.**	Required	X	X	X	X	Monthly
AD_10	**Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group.**	Required	X	X	X	X	Monthly
AD_11	**Beneficiaries no longer eligible for the demonstration due to transfer to CHIP.**	Recommended	X	X	X	X	Monthly
Cumulative metrics: Enrollment duration at time of disenrollment							
AD_12	**Enrollment duration 0-3 months.**	Recommended	X				Monthly
AD_13	**Enrollment duration 4-6 months.**	Recommended	X				Monthly
AD_14	**Enrollment duration 6-12 months.**	Recommended	X				Monthly
Renewal							
AD_15	**Beneficiaries due for renewal.**	Required	X	X	X	X	Monthly
AD_16	**Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid.**	Required	X	X	X	X	Monthly
AD_17	**Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category.**	Required	X	X	X	X	Monthly

Metric	Metric name and description	Required or recommended	Subpopulations				Measurement period
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
AD_18	**Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP.**	Required	X	X	X	X	Monthly
AD_19	**Beneficiaries who did not complete renewal, disenrolled from Medicaid.**	Required	X	X	X	X	Monthly
AD_20	**Beneficiaries who had pending/ uncompleted renewals and were still enrolled.**	Required	X	X	X	X	Monthly
AD_21	**Beneficiaries who retained eligibility for the demonstration after completing renewal forms.**	Required	X	X	X	X	Monthly
AD_22	**Beneficiaries who renewed ex parte.**	Recommended	X	X	X	X	Monthly
Cost sharing limit							
AD_23	**Beneficiaries who reached 5% limit.** .	Required	X	X	X	X	Monthly
Appeals and grievances							
AD_24	**Appeals, eligibility.**	Recommended					Quarterly
AD_25	**Appeals, denial of benefits.**	Recommended					Quarterly
AD_26	**Grievances, care quality.**	Recommended					Quarterly
AD_27	**Grievances, provider or managed care entities.**	Recommended					Quarterly
AD_28	**Grievances, other.**	Recommended					Quarterly
Access to care							
AD_29	**Primary care provider availability.**	Required					Quarterly
AD_30	**Primary care provider active participation.**	Required					Quarterly
AD_31	**Specialist provider availability.**	Required					Quarterly
AD_32	**Specialist provider active participation.**	Required					Quarterly
AD_33	**Preventive care and office visit utilization.**	Recommended	X	X	X	X	Quarterly
AD_34	**Prescription drug use.**	Recommended	X	X	X	X	Quarterly
AD_35	**Emergency department utilization, total.**	Required	X	X	X	X	Quarterly
AD_36	**Emergency department utilization, non-emergency.**	Recommended (quarterly) Required (annual)	X	X	X	X	Quarterly/ Annual
AD_37	**Inpatient admissions.**	Recommended	X	X	X	X	Quarterly

Metric	Metric name and description	Required or recommended	Subpopulations				Measurement period
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Quality of care and health outcomes							
AD_38A	**Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD).**	Required (AD_38A or AD_38B)	X			X	Annual
AD_38B	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.**	Required (AD_38 or AD_38B)	X			X	Annual
AD_39	**Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (FUA/FUM-AD).**	Required	X			X	Annual
AD_40	**Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD).**	Required	X			X	Annual
AD_41	**PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD).**	Required	X			X	Annual
AD_42	**PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD).**	Required	X			X	Annual
AD_43	**PQI 08: Heart Failure Admission Rate (PQI08-AD).**	Required	X			X	Annual
AD_44	**PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD).**	Required	X			X	Annual
Administrative cost							
AD_45	**Administrative cost of demonstration operation.**	Recommended					Annual

Source: CMS.[32]

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Appendix Exhibit C: Additional Monitoring Metrics for States with Work/CE Requirements

Metric	Metric name and description	Required or recommended	Subpopulations				Measurement period
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Community engagement enrollment counts							
CE_1	**Total beneficiaries subject to the community engagement requirement, not exempt.**	Required		X		X	Monthly
CE_2	**Total beneficiaries who were exempt from community engagement requirements in the month.**	Required		X		X	Monthly
CE_3	**Beneficiaries with approved good cause circumstances.**	Required		X		X	Monthly
CE_4	**Beneficiaries subject to community engagement requirement and in suspension status due to failure to meet requirement.**	Required		X		X	Monthly
CE_5	**Beneficiaries subject to the community engagement requirement and receiving benefits who met the requirement for qualifying activities.**	Required		X		X	Monthly
CE_6	**Beneficiaries subject to the community engagement requirement and receiving benefits but in a grace period or allowable month of noncompliance.**	Required		X		X	Monthly
CE_7	**Beneficiaries who successfully completed make-up hours or other activities to retain active benefit status after failing to meet community engagement requirements in a previous month.**	Required		X		X	Monthly
CE_8	**Beneficiaries in a non-eligibility period who were disenrolled for noncompliance with community engagement requirement and are prevented from re-enrolling for a defined period of time.**	Required		X		X	Monthly
Community engagement requirement qualifying activities							
CE_9	**Beneficiaries who met the community engagement requirement by satisfying requirements of other programs.**	Required		X		X	Monthly
CE_10	**Beneficiaries who met the community engagement requirement through employment for the majority of their required hours.**	Required		X		X	Monthly
CE_11	**Beneficiaries who met the community engagement requirement through job training or job search for the majority of their required hours.**	Required		X		X	Monthly
CE_12	**Beneficiaries who met the community engagement requirement through educational activity for the majority of their required hours.**	Required		X		X	Monthly
CE_13	**Beneficiaries who met the community engagement requirement who were engaged in other qualifying activity for the majority of their required hours.**	Required		X		X	Monthly
CE_14	**Beneficiaries who met the community engagement requirement by combining two or more activities.**	Required		X		X	Monthly

Metric	Metric name and description	Required or recommended	Subpopulations				Measurement period
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Basis of beneficiary exemptions from community engagement requirement							
CE_15	**Beneficiaries exempt from Medicaid community engagement requirements because they were exempt from requirements of SNAP and/or TANF.**	Required		X		X	Monthly
CE_16	**Beneficiaries exempt from Medicaid community engagement requirements on the basis of pregnancy.**	Required		X		X	Monthly
CE_17	**Beneficiaries exempt from community engagement requirements due to former foster youth status.** .	Required		X		X	Monthly
CE_18	**Beneficiaries exempt from Medicaid community engagement requirements due to medical frailty.**	Required		X		X	Monthly
CE_19	**Beneficiaries exempt from Medicaid community engagement requirements on the basis of caretaker status.**	Required		X		X	Monthly
CE_20	**Beneficiaries exempt from Medicaid community engagement requirements due to unemployment insurance compensation.**	Required		X		X	Monthly
CE_21	**Beneficiaries exempt from Medicaid community engagement requirements due to substance abuse treatment status.**	Required		X		X	Monthly
CE_22	**Beneficiaries exempt from Medicaid community engagement requirements due to student status.**	Required		X		X	Monthly
CE_23	**Beneficiaries exempt from community engagement requirements because they were excused by a medical professional.**	Required		X		X	Monthly
CE_24	**Beneficiaries exempt from Medicaid community engagement requirements, other.**	Required		X		X	Monthly
Supports and assistance							
CE_25	**Total beneficiaries receiving supports to participate and placement assistance.**	Required		X		X	Monthly
CE_26	**Beneficiaries provided with transportation assistance.**	Recommended		X		X	Monthly
CE_27	**Beneficiaries provided with childcare assistance.**	Recommended		X		X	Monthly
CE_28	**Beneficiaries provided with language supports.**	Recommended		X		X	Monthly
CE_29	**Beneficiaries assisted with placement in community engagement activities.**	Recommended		X		X	Monthly
CE_30	**Beneficiaries provided with other non-Medicaid assistance.**	Recommended		X		X	Monthly
Reasonable modifications for beneficiaries with disabilities							
CE_31	**Beneficiaries who requested reasonable modifications to community engagement processes or requirements due to disability.**	Recommended		X		X	Monthly
CE_32	**Beneficiaries granted reasonable modifications to community engagement processes or requirements due to disability.**	Recommended		X		X	Monthly

Metric	Metric name and description	Required or recommended	Subpopulations				Measurement period
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
New suspensions and disenrollments during the measurement period							
CE_33	**Beneficiaries newly suspended for failure to complete community engagement requirements.**	Required		X		X	Monthly
CE_34	**Beneficiaries newly disenrolled for noncompliance with community engagement requirement.**	Required		X		X	Monthly
Reinstatement of benefits after suspension							
CE_35	**Total beneficiaries whose benefits were reinstated after being in suspended status for noncompliance.**	Required		X		X	Monthly
CE_36	**Beneficiaries whose benefits were reinstated because their time-limited suspension period ended.**	Recommended		X		X	Monthly
CE_37	**Beneficiaries whose benefits were reinstated because they completed required community engagement activities.**	Recommended		X		X	Monthly
CE_38	**Beneficiaries whose benefits were reinstated because they completed "on-ramp" activities other than qualifying community engagement activities.**	Recommended		X		X	Monthly
CE_39	**Beneficiaries whose benefits were reinstated because they newly meet community engagement exemption criteria or had a good cause circumstance.**	Recommended		X		X	Monthly
CE_40	**Beneficiaries whose benefits were reinstated after successful appeal of suspension for noncompliance.**	Recommended		X		X	Monthly
Re-entry after disenrollment							
CE_41	**Total beneficiaries re-enrolling after disenrollment for noncompliance.**	Required		X		X	Monthly
CE_42	**Beneficiaries re-enrolling after completing required community engagement activities.**	Recommended		X		X	Monthly
CE_43	**Beneficiaries re-enrolling after completing "on-ramp" activities other than qualifying community engagement activities.**	Recommended		X		X	Monthly
CE_44	**Beneficiaries re-enrolling after re-applying, subsequent to being disenrolled for noncompliance with community engagement requirements.**	Recommended		X		X	Monthly
CE_45	**Beneficiaries re-enrolling because they newly met community engagement exemption criteria or had a good cause circumstance.**	Recommended		X		X	Monthly
CE_46	**Beneficiaries re-enrolling after successful appeal of disenrollment for noncompliance.**	Recommended		X		X	Monthly

Source: CMS.[33]

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Endnotes

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