DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

March 25, 2025

Jay Ludlam
Deputy Secretary, North Carolina Medicaid
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Dear Deputy Secretary Ludlam:

The Centers for Medicare & Medicaid Services (CMS) is approving North Carolina's request for a new public health emergency (PHE) section 1115 demonstration, titled "North Carolina Hurricane Helene Public Health Emergency Section 1115(a) Demonstration," (Project Number 11-W-00503/4) in accordance with section 1115(a) of the Social Security Act ("the Act"). With this approval, the demonstration will become effective retroactively to September 25, 2024, the first day of the PHE in North Carolina resulting from Hurricane Helene, and continue through March 23, 2025, the final day of the PHE. This demonstration will include federal flexibilities to respond to and address challenges posed by Hurricane Helene.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures authorized under the demonstration.

Extent and Scope of Demonstration

On September 28, 2024, the Secretary of the U.S. Department of Health and Human Services, pursuant to the authority under section 319 of the Public Health Service Act, determined that a PHE exists in the state of North Carolina as a result of the consequences of Hurricane Helene, and has existed since September 25, 2024. This PHE declaration was renewed on December 27, 2024, with a retroactive start date of December 24, 2024, and will conclude on March 23, 2025. On December 9, 2024, North Carolina submitted a request for a section 1115(a) demonstration to address the PHE created by the hurricane. CMS has determined that the state's application is complete, consistent with the exemptions and flexibilities outlined in 42 CFR 431.416(e)(2) and 431.416(g).[1]

[1] Pursuant to 42 CFR 431.416(g), CMS has determined that North Carolina has successfully established that its circumstances constitute an emergency and could not have been reasonably foreseen. Therefore, the existence of unforeseen circumstances resulting from the PHE warrants an exception to the normal state and federal public notice procedures to expedite a decision on a proposed section 1115 demonstration. The state is not required to conduct a

CMS has determined that the North Carolina Hurricane Helene PHE Section 1115(a) Demonstration is necessary to help the state to furnish Healthy Opportunities Pilots (HOP) services to beneficiaries who may be impacted by Hurricane Helene and will also help the state to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the safety and welfare of providers who may be affected by Hurricane Helene.

Specifically, under the demonstration North Carolina will receive authority to provide HOP services to beneficiaries who resided and were approved for HOP services in the affected HOP region on the day the PHE related to Hurricane Helene began (September 25, 2024), but who have since been displaced from the HOP region. This flexibility is needed since the STCs that authorized the HOP program from September 25, 2024, through December 9, 2024, required that a beneficiary reside in a pilot region to be eligible for HOP. This change will ensure that previously eligible HOP beneficiaries will be able to continue to receive the HOP services they are eligible for, regardless of whether they temporarily evacuated the pilot region area due to the hurricane.

The demonstration also provides expenditure authority to provide retainer payments to 1905(a) personal care service providers. The retainer payments are time-limited and cannot exceed one 30-billable-day period. Additionally, the retainer payments may not exceed the approved rate or average expenditure amounts paid during the previous quarter for the service(s) that would have been provided. The STCs include several guardrails associated with the payments to monitor the payments and avoid duplication of billing. The retainer payments seek to serve as a source of relief for providers experiencing decreases in utilization, temporary practice closures, or other circumstances that limit their ability to provide covered services to Medicaid beneficiaries.

Requests Withdrawn by the State

North Carolina originally requested the following expenditure authorities to grant flexibility in the HOP program, which were not implemented by the state:

- Payments for HOP services in the affected region without regard to care plan documentation requirements found in the STCs.
- Payments for HOP services in the affected region without regard to the requirement that the HOP Administrator authorize services found in the STCs and instead permitting the HOP enrollees self-attest to their HOP eligibility.

North Carolina withdrew these from CMS consideration on March 3, 2025.

Requests Not Being Approved at this Time

North Carolina also requested retainer payments for home health and private duty service providers. CMS is not approving this request at this time and considers the request closed since the PHE will end March 23, 2025.

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public notice and input process. CMS is also exercising its discretionary authority to expedite its normal review and approval processes to render timely decisions on the state's application for a section 1115 demonstration. CMS expects the state in good faith and in a prudent manner will offer a post-award public notice process, including tribal consultation as applicable, to the extent circumstances permit. CMS will post the demonstration approval on the Medicaid.gov website.

Budget Neutrality

Consistent with past PHE demonstrations, CMS did not require the state to submit budget neutrality calculations for the North Carolina Hurricane Helene PHE Section 1115(a) Demonstration. In general, CMS has determined that the costs to the federal government are likely to have been otherwise incurred and allowable. North Carolina will still be required to track demonstration expenditures and will be expected to evaluate the connection between those expenditures and the state's response to the PHE, as well as the cost-effectiveness of those expenditures.

Monitoring and Evaluation

Consistent with CMS requirements for monitoring and evaluation of section 1115 demonstrations, the state is required to develop an Evaluation Design and a Final Report, which will consolidate the demonstration's monitoring and evaluation requirements. The draft Evaluation Design will be due to CMS no later than 60 calendar days after approval of the demonstration. The draft Final Report will be due to CMS one year after the expiration of the demonstration approval period. Given the unique circumstances and time-limited nature of the demonstration, CMS expects North Carolina to undertake data collection and/or analyses that are meaningful but not unduly burdensome for the state. Specifically, the state is expected to focus on qualitative methods and descriptive statistics to address evaluation questions that will support understanding the successes, challenges, and lessons learned in implementing the demonstration.

Other Information

CMS's approval of this extension is conditioned on compliance with the enclosed set of STCs defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to CMS receiving written acceptance of this award and the STCs within 30 days of the date of this approval letter.

Your project officer for this demonstration is Ms. Shelby Higgins. She is available to answer any questions concerning your 1115 demonstration and may be reached at Shelby.Higgins@cms.hhs.gov.

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

Sincerely,

Stephanie Carlton
Acting Administrator

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00503/4

TITLE: North Carolina Hurricane Helene Public Health Emergency Section 1115(a) Demonstration

AWARDEE: North Carolina Department of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by North Carolina for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from September 25, 2024 through March 23, 2025 unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

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

1. **Modified Eligibility for the Healthy Opportunities Pilots (HOP).** Expenditures for HOP services, as authorized in the North Carolina Medicaid Reform Demonstration (Project Number 11-W-00313/4), for individuals who resided, and were approved for HOP services, in the affected HOP region on the day the Public Health Emergency (PHE) related to Hurricane Helene began (September 25, 2024) as determined by the Secretary on September 28, 2024, but who have since been displaced from the HOP region. Title XIX requirements not applicable to the expenditure authority for the HOP program under the North Carolina Medicaid Reform Demonstration (Project Number 11-W-00313/4) continue to apply to this modified eligibility expenditure authority.

2. **Retainer Payments.** Expenditures for the state to make retainer payments to 1905(a) personal care service providers to maintain capacity during the emergency. The retainer payments must meet the guardrails outlined in Section 5.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00503/4

TITLE: North Carolina Hurricane Helene Public Health Emergency Section 1115(a) Demonstration

AWARDEE: North Carolina Department of Health and Human Services

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the North Carolina Hurricane Helene Public Health Emergency section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the North Carolina Department of Health and Human Services (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective September 25, 2024 through March 23, 2025, unless otherwise specified.

The STCs have been arranged into the following subject areas:

2. PROGRAM DESCRIPTION AND OBJECTIVES

The demonstration is approved in recognition of the PHE created by Hurricane Helene. The demonstration will help the state to furnish Healthy Opportunities Pilot (HOP) services to beneficiaries who may be impacted by Hurricane Helene and will also help the state to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the safety and welfare of providers who may be affected by Hurricane Helene.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, 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.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP 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 as needed without requiring the state to submit an amendment to the demonstration under STC 3.6. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **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 necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.6 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 earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **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 or CHIP 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 3.6 below, except as provided in STC 3.3.

3.6. **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 the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. 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 set forth in 59 Fed. Reg. 49249 (September 27, 1994) or an explanation of how the state meets the criteria outlined in 42 CFR 431.416(g)(3) for discharge from normal state public notice and input responsibilities to address any of the circumstances described in 42 CFR 431.416(g)(1). In states with Federally-recognized Indian tribes, Indian health programs, and/or Urban Indian health organizations, the state is required to comply with tribal and Indian Health Program/Urban Indian 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, unless the state has established the criteria necessary to obtain an exemption from the normal state public notice process requirements in accordance with 42 CFR 431.416(g)(3). Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current 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 detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and 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.

3.7. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will 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's 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.

3.8. **Federal Financial Participation (FFP).** No federal matching funds 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.

3.9. **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.

3.10. **Common Rule Exemption.** The state must 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 or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS 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 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. **Eligibility Groups Affected by the Demonstration.** Under the demonstration, there is no change to Medicaid eligibility and the standards and methodologies for eligibility

remain set forth under the state plan. However, for DY1 as set forth in STC 9.11, this demonstration temporarily amends the eligibility for the Healthy Opportunities Pilot (HOP) program, as approved in the North Carolina Medicaid Reform Demonstration (Project Number 11-W-00313/4), as follows.

a. Limited to the duration of DY1 as set forth in STC 9.11, beneficiaries who resided, and were approved for HOP services, in the affected HOP region on the day of the Public Health Emergency (PHE) related to Hurricane Helene began (September 25, 2024) as determined by the Secretary on September 28, 2024, but have since been displaced from the HOP region, will continue to be eligible for HOP services.

b. Except as amended in this STC 4.1, the remainder of the requirements for the HOP program, as set forth in the North Carolina Medicaid Reform Demonstration (Project Number 11-W-00313/4), remain in full force and effect.

5. RETAINER PAYMENT REQUIREMENTS

5.1. **Eligibility.** Retainer payments to providers of personal care services as defined under 1905(a) of the Social Security Act to maintain capacity during the PHE when a Medicaid provider is directly impacted by Hurricane Helene.

5.2. **Duration.** Retainer payments are time-limited and cannot exceed one (1) 30-billable-day period.

5.3. **Rates.** Retainer payments may not exceed the approved rate(s) or average expenditure amounts paid during the previous quarter for the service(s) that would have been provided.

5.4. **Monitoring.** The state must have a distinguishable process to monitor payments to avoid duplication of billing, which includes the following listed requirements:

a. Providers are required to sign an attestation prior to claiming retainer payments, in which they must attest to the items listed below:

i. The provider who receives retainer payments will not be eligible for unemployment as to hours covered by the retainer payment.

ii. To retain their availability to the specified Medicaid beneficiary to assist with personal care services as defined in the approved Medicaid state plan, that are consistent with an approved service plan when the impacts of Hurricane Helene that prevented the delivery of services the Medicaid beneficiary have abated.

iii. To report any retainer payments billed, sought, or received in submitting any unemployment insurance claim during the period in which retainer payment is received.

iv. To receive the maximum reimbursement rate or wages per the planned pay period for approved hours/units in an active service plan approved before the retainer agreement was initiated.

v. Retainer payments are for primary staff that provide regularly scheduled services and are unable to deliver services.

vi. Staff members identified as back up staff are not eligible for retainer payments.

vii. To agree to receive a maximum of one retainer agreement for one specified Medicaid beneficiary.

viii. Due to the impacts of Hurricane Helene, the Medicaid beneficiary is not able to receive 1905(a) personal care services in the amount, frequency and duration as listed on the approved plan of care from their current provider.

b. Provider organizations that accept a retainer payment agreement for a specified worker cannot receive duplicative payments and must adhere to the following listed below:

i. The provider agency cannot bill retainer payments on behalf of staff who are laid off.

ii. The provider agency's retainer payment claims must be adjusted to account for any layoffs if staff are laid off.

iii. Provider agency payments must also attest that they have not received funding from other sources that would exceed their revenue for the last full quarter prior to the emergency event or that retainer payments would not result in them exceeding their prior revenue.

5.5. **Recoupment.** If a provider has not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payments amount in excess will be recouped. If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

6. COST SHARING

6.1. **Cost Sharing.** Cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan.

7. DELIVERY SYSTEM

7.1. **Delivery System.** No modifications to the current North Carolina delivery system are imposed through this demonstration. North Carolina Medicaid beneficiaries will continue to receive services through the current delivery system.

8. MONITORING AND EVALUATION REQUIREMENTS

8.1. **Monitoring Calls.** CMS may schedule periodic conference calls with the state. The purpose of these calls will be to discuss any significant, actual or anticipated, developments affecting the demonstration. The state and CMS will jointly develop the agenda for the calls. The monitoring calls for this demonstration may be scheduled in conjunction with other approved section 1115 demonstration monitoring calls.

8.2. **Evaluation Design.** The state must submit an Evaluation Design to CMS within 60 days of the demonstration approval. CMS will provide guidance on an Evaluation Design specifically for the waivers and expenditure authorities approved for the PHE, including any amendments. The state is required to post its Evaluation Design to the state's website within 30 days of CMS approval of the evaluation design, per 42 CFR 431.424(e).

The state is required to test whether and how the approved waivers and expenditure authorities affect the state's response to the PHE. To that end, the state will use research questions that pertain to the approved waivers and expenditure authorities. The evaluation is also expected to conduct a cost assessment by tracking administrative costs and health services expenditures for demonstration beneficiaries and assessing how these outlays affected the state's response to the PHE.

8.3. **Final Report.** The Final Report will consolidate Monitoring and Evaluation reporting requirements for the demonstration. The state must submit this Final Report no later than one year after the end of the demonstration authority. The Final Report will capture data on the demonstration implementation, lessons learned, and best practices for similar situations. Specifically, the state is required to provide qualitative analysis to understand the principal challenges associated with engagement with Medicaid beneficiaries during this PHE, the effectiveness of the demonstration at meeting these challenges, and recommendations for addressing similar public health emergencies. The state is required to track separately all expenditures associated with this demonstration, including but not limited to, administrative costs and program expenditures. CMS will provide additional guidance on the structure and content of the Final Report. Within 30 days of CMS's approval of the Final Report, the state must post the Final Report to its Medicaid website.

Should the approval period of this demonstration exceed one year, for each year of the demonstration that the state is required to complete an annual report required under 42 CFR 431.428(a), the state may submit that information in the Final Report.

9. GENERAL FINANCIAL REQUIREMENTS

9.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

9.2. **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 under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

9.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms, and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

9.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for

expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

9.5. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the

requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

9.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

9.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

9.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

9.9. **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.

9.10. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00503/4). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs that must be reported are identified below in the MEG Detail for Expenditure Reporting table below.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All

administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER.

Table 1: MEG Detail for Expenditure Reporting					
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**
Retainer Payments	Expenditures for retainer payments to personal care providers to maintain capacity during the emergency	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP
HOP Services (PHE)	Expenditures for payments for HOP services for individuals who resided in the affected HOP region on the day of the disaster declaration but have since been displaced and were approved for HOP services to continue receiving those services from organizations in any HOP regions during the PHE	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP

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

Table 2: Demonstration Years		
DY 1	September 25, 2024 – March 23, 2025	6 months

9.12. **Claiming Period.** The state will report all claims for expenditures (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

10. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 3: Schedule of Deliverables for the Demonstration Period

Date	Deliverable
Fifteen days from the date of demonstration approval	State acceptance of demonstration STCs and expenditure authorities
Sixty days from date of the demonstration approval	Evaluation design is submitted to CMS
Thirty days from date of evaluation design approval	Approved evaluation design is posted on state website
One year after expiration of demonstration	Final report with consolidated monitoring and evaluation requirements