DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

November 14, 2024

Sally Kozak
Deputy Secretary
Pennsylvania Department of Human Services
625 Forster Street, Room 333
Harrisburg, PA 17120

Dear Deputy Secretary Kozak,

The Centers for Medicare & Medicaid Services (CMS) is approving the Commonwealth of Pennsylvania's request for an amendment to the "Medicaid Coverage Former Foster Care Youth from a Different State & Substance Use Disorder (SUD)" section 1115 demonstration (Project Number 11-W-00308/3), in accordance with section 1115(a) of the Social Security Act (the "Act"). Approval of this request will provide expenditure authority to allow the state to provide continuous eligibility to children up to age six, from birth through the end of the month in which their sixth birthday falls and high-risk formerly incarcerated children and adults for 12 months. The state originally submitted this request as part of an application for a new demonstration, titled "Bridges to Success: Keystones of Health for Pennsylvania (Keystones of Health)". However, the state's request for authority to provide continuous eligibility is being approved as an amendment to the "Medicaid Coverage for Former Foster Care Youth from a Different State and (SUD)" section 1115 demonstration to allow the state to implement continuous eligibility while CMS and Pennsylvania continue discussions on the other elements of the state's pending demonstration request. The authority is effective from the date of this approval and will remain in effect through the rest of the demonstration approval period, which is set to expire September 30, 2027.

CMS's approval of this section 1115(a) demonstration amendment is subject to the limitations specified in the attached expenditure authority, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The STCs in Attachment G of this letter should be considered as part of the broader set of STCs that were approved on October 1, 2022 for the Medicaid Coverage Former Foster Care Youth from a Different State & SUD section 1115 demonstration and will be incorporated into the full STCs at the next approval action for this demonstration. All continuous eligibility requirements in statue and regulations, as well as CMS guidance explaining continuous eligibility apply to this demonstration, unless the governing expenditure authorities and STCs state that a particular rule or policy does not apply.

Extent and Scope of Demonstration Amendment

The Commonwealth of Pennsylvania will provide continuous eligibility to these populations for the specified length of time:

- Continuous eligibility for children up to age six through the end of the month of their sixth birthday, regardless of changes in circumstances that would otherwise cause a loss of eligibility.
- 12 months of continuous eligibility for high-risk individuals (including children under age 19) who are released from a state correctional institution. The period of continuous eligibility shall begin at the date of their release and will extend through the end of the 12th month following release, regardless of changes in circumstances that would otherwise cause a loss of eligibility.

Continuous eligibility is intended to support consistent coverage and continuity of care by keeping children and high-risk formerly incarcerated beneficiaries enrolled, regardless of changes in circumstances that would otherwise cause a loss of eligibility or other changes that would affect eligibility, such as a change in income. Expanding continuous eligibility beyond what is allowable in the Medicaid state plan is likely to assist in promoting the objectives of Medicaid by minimizing coverage gaps and helping to maintain continuity of access to program benefits for these populations, thereby improving health outcomes, and reducing churn. In 2018, one in ten Medicaid/CHIP enrollees disenrolled and reenrolled in Medicaid/CHIP in under one year.[1] Continuous eligibility also supports reducing administrative costs resulting from churn; estimates from 2015 show that the administrative cost of one instance of churn (disenrolling and reenrolling) for one individual ranges from $400-$600.[2] Continuous coverage is also likely to be an important driver of reducing the rate of uninsured and underinsured individuals.[3] To facilitate access to and continuity of care, and recognizing that beneficiaries may not be aware of their continued coverage[4], the amendment requires that the state have procedures and processes in place to provide individuals who qualify for a continuous eligibility period that exceeds 12 months an annual reminder of continued eligibility.

Budget Neutrality[5]

CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the

[1] Corallo B, Garfield R, Tolbert J, Rudowitz R. Medicaid enrollment churn and implications for continuous Coverage Policies | KFF. KFF. Published December 15, 2021. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/

[2] Swartz K, Short PF, Graefe DR, Uberoi N. Reducing Medicaid churning: Extending eligibility for twelve months or to end of calendar year is most effective. Health Affairs. 2015;34(7):1180-1187. doi:10.1377/hlthaff.2014.1204

[3] A September 2023 State Health Official letter provides background on the importance of continuous eligibility in preventing interruptions that impede access to health coverage to support better short- and long-term health outcomes, and describes policies related to implementing continuous eligibility under the Consolidated Appropriations Act, 2023 (CAA, 2023) amendments.

[4] McIntyre A, Smith RB, Sommers BD. Survey-Reported Coverage in 2019-2022 and Implications for Unwinding Medicaid Continuous Eligibility. *JAMA Health Forum.* 2024;5(4):e240430. doi:10.1001/jamahealthforum.2024.0430; https://jamanetwork.com/journals/jama-health-forum/fullarticle/2817285.

[5] For more information on CMS's current approach to budget neutrality, see https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. The demonstration amendment is projected to be budget neutral to the federal government. The state will be held to the budget neutrality monitoring and reporting requirements as outlined in the attachment and current STCs. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 demonstration approvals.

CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Under this approval, projected demonstration expenditures associated with the new continuous eligibility population will be treated as hypothetical for the purposes of budget neutrality, and the WOW baselines have been trended forward to determine the maximum expenditure authority for the approval period.

Monitoring and Evaluation Requirements

States are required to conduct systematic monitoring and robust evaluation of section 1115 demonstrations in accordance with the STCs. For the continuous eligibility policy, monitoring reporting must provide metrics data for enrollment and ex parte renewals, and narrative updates on the successes and challenges of collecting and providing applicable information as outlined in the STCs. States must also evaluate the impact of the policy on all relevant populations, appropriately tailored for the specific time span of eligibility. Evaluation hypotheses must focus on, but may not be limited to, enrollment continuity, utilization of age-appropriate preventive care, inpatient admissions and avoidable emergency care, and health disparities.

Consideration of Public Comments

The federal comment period was open from February 15, 2024 through March 16, 2024 for the demonstration request submitted January 26, 2024, during which CMS received 33 comments, 20 of which were relevant to continuous eligibility. These comments were submitted by various local government entities and community and advocacy organizations. The vast majority of commenters were strongly supportive of both the proposal to provide continuous eligibility to

Medicaid children through age six and the proposal to provide 12 months of continuous eligibility to individuals following incarceration. Three commenters encouraged the state to extend the continuous eligibility for Medicaid children to CHIP children as well. Two commenters indicated concern with the overall cost and necessary resources to implement the demonstration.

After carefully reviewing the proposal and the public comments received during the federal comment period, and all other relevant materials provided by the state, CMS has concluded that the approval of this amendment is likely to assist in promoting the objectives of Medicaid.

Other Information

CMS's approval of this demonstration project is conditioned upon compliance with the previously approved expenditure authorities and special terms and conditions, which set forth in detail the nature, character and extent of anticipated federal involvement in the project.

In addition, the approval is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer is Mr. Felix Milburn. He is available to answer any questions concerning this amendment. Felix's contact information is as follows:

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

We appreciate your state's commitment to addressing continuous eligibility, and we look forward to our continued partnership on the "Medicaid Coverage Former Foster Care Youth from a Different State & SUD" demonstration. 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,

[redacted]

Daniel Tsai
Deputy Administrator and Director

Enclosure
cc: Dan Belnap, Monitoring Lead, Medicaid and CHIP Operations Group

Attachment G

CENTERS FOR MEDICARE & MEDICAID SERVICES

Expenditure Authority

NUMBER: **11-W-00308/3**

TITLE: **Pennsylvania Medicaid Coverage Former Foster Care Youth from a Different State & SUD**

AWARDEE: **Pennsylvania Department of Human Services**

Title XIX Expenditure Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the Commonwealth of Pennsylvania for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX plan. The following expenditure authority must only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the Commonwealth of Pennsylvania to implement the section 1115 demonstration amendment. All other requirements of the Medicaid program, including current and future CMS guidance for continuous eligibility, as expressed in law, regulation, and policy statements must apply to these expenditures, unless identified as not applicable below.

Continuous Eligibility. Expenditures for continued state plan benefits for individuals who have been determined eligible as specified in Table 1 of STC 1.2, who are not otherwise excluded under STC 1.3 for the applicable continuous eligibility period, and who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 1.4**.**

SPECIAL TERMS AND CONDITIONS

1. Eligibility and Enrollment

1.1 Continuous Eligibility: Eligible populations, identified in STC 1.2, will receive continuous eligibility through the demonstration. The state is authorized to provide continuous eligibility for the populations for the durations specified in Table 1 below, regardless of the delivery system through which these populations receive Medicaid benefits.

a. For individuals who qualify for continuous eligibility, the continuous eligibility period begins on the effective date of the individual's eligibility under 42 CFR 435.915, the effective date of the most recent redetermination, or the date of their release from a state correctional institution.
b. Because individuals are continuously eligible regardless of changes in circumstances, the state does not need to conduct renewals or redeterminations of eligibility

consistent with 42 CFR 435.916 and 435.919 for individuals who qualify for continuous eligibility until the end of the individual's continuous eligibility period, except in the limited circumstances of a beneficiary meeting one of the exceptions outlined in STC 1.4**.**

c. At the end of the continuous eligibility periods, the Commonwealth of Pennsylvania must conduct a renewal of Medicaid eligibility and consider eligibility on all bases consistent with 42 CFR 435.916(d)(1) prior to terminating coverage. Individuals determined eligible on another basis at the end of the continuous eligibility period will be moved to the appropriate group at that time. Individuals determined eligible on another basis resulting in a reduction of Medicaid eligibility or services or increase in cost sharing or premiums will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E and assessed for potential eligibility for other insurance affordability program in accordance with 42 CFR 435.916(d)(2).

1.2 Populations and Duration: The state is authorized to provide continuous eligibility for the following populations for the associated durations.

a. Children up to age six. Except as provided in STC 1.4**,** individuals age zero through the end of the month of their sixth birthday, who enroll in Medicaid shall qualify for continuous eligibility until the end of the month in which their sixth birthday falls.

b. Formerly Incarcerated. Except as provided in STC 1.4, the state is authorized to provide 12 months of continuous eligibility for individuals aged 19 – 65 who are released from a state correctional institution and meet one or more of the following criteria for high risk:

   i. Have one or more substance use disorders,
   ii. Have serious mental illness,
   iii. Eligible for Medicaid funded 1915(c) home and community-based services administered by the Office of Long-Term Living or Office of Developmental Programs,
   iv. With one or more chronic health conditions,
   v. Are pregnant or in the 12-month postpartum period, or
   vi. With Autism Spectrum Disorder.

   The period of continuous eligibility shall begin at the date of their release and will extend through the end of the 12th month following release.

Table 1: Eligible Populations and Associated Duration for Continuous Eligibility (CE)	
Population	**Duration of CE**
Children up to age 6	Until the end of the month of their 6th birthday
Beneficiaries leaving incarceration (aged 19 - 65) and meet one or more of the following criteria for high risk:	Up to 12 months following their release from a state correctional facility

• Have one or more substance use disorders, • Have serious mental illness, • Eligible for Medicaid funded 1915(c) home and community-based services administered by the Office of Long-Term Living or Office of Developmental Programs, • With one or more chronic health conditions, • Are pregnant or in the 12-month postpartum period, or • With Autism Spectrum Disorder.	

1.3 Eligibility Exclusions: The following adults and children are excluded from receiving continuous eligibility:

a. Have only established Medicaid eligibility as medically needy (as set forth in section 1902(a)(10)(C) of the Act),
b. Have been determined presumptively eligible for Medicaid but have not yet received an eligibility determination based on a regular application, or
c. Upon the adult and child's renewal are determined to only be eligible for Medicaid based on transitional medical assistance (as set forth in section 1925 of the Act).

1.4 Exceptions to Continuous Eligibility: Notwithstanding STC 1.2, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be redetermined or terminated:

a. The beneficiary attains the age limit of the continuous eligibility period or eligibility group (if applicable);
b. The beneficiary is no longer a Commonwealth of Pennsylvania resident;
c. The beneficiary or their representative requests termination of eligibility;
d. The beneficiary dies;
e. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

1.5 Beneficiary-Reported Information and Periodic Data Checks:

a. The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their continuous eligibility as outlined STC 1.4 (such as a change in state residency) and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be

able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

b. For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals.
c. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d)**.** The state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.919 and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j)**.**
d. Because individuals are receiving continuous eligibility beyond their eligibility period, the state does not need to complete the individual's annual renewal or act on changes in circumstances that would otherwise affect eligibility, except as detailed in STC 1.4, until the end of the individual's continuous eligibility period. Additionally, if the state obtains information about changes that may affect eligibility (e.g., change in income), they are not permitted to use the information related to the change to end the continuous eligibility period early and terminate coverage, unless the change relates to one or more of the exceptions detailed in STC 1.4.

1.6 Annual Updates to Beneficiary Contact Information: For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to accept and update beneficiary contact information and must attempt to update beneficiary contact information on an annual basis, which may include examining data sources annually and partnering with managed care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting continuous eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d), the receipt of this third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

1.7 Annual Reminders of Continued Eligibility: The state must have procedures and processes in place to provide individuals who qualify for a continuous eligibility period that exceeds 12 months an annual reminder of continued eligibility. The annual reminder of continued eligibility must:

a. Be written in plain language;

b. Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with 42 CFR 435.905(b); and
c. If provided in electronic format, comply with requirements for electronic notices in 42 CFR 435.918.

The annual reminder of continued eligibility must, at a minimum, include:

d. An explanation of the individual's continued eligibility, including the end date of the continuous eligibility period;
e. The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's continuous eligibility;
f. Basic information on the level of benefits and services available as described at 42 CFR 435.917(b)(1)(iv); and
g. If the beneficiary's eligibility is based on having household income at or below the applicable MAGI standard, the content regarding non-MAGI eligibility described at 42 CFR 435.917(c).

1.8 Cost Sharing within Continuous Eligibility: Individuals receiving continuous eligibility enrolled in this demonstration may be subject to cost sharing responsibilities, such as monthly premiums and co-payments, to the extent allowable under title XIX requirements or as approved under current section 1115 demonstration authority**.** However, beneficiaries may not be disenrolled from this demonstration for failure to pay a premium during the individual's continuous eligibility period approved in the demonstration.

2. Monitoring and Reporting Requirements

2.1 Performance Metrics: For the continuous eligibility policy, monitoring metrics must support tracking enrollment and ex parte renewals. The state must describe successes and challenges related to activities to annually update beneficiary contact information, provide beneficiaries reminders of continued eligibility, verify beneficiary residency, and confirm that the beneficiary is not deceased, for all beneficiaries who qualify for a continuous eligibility period that exceeds 12 months.

3. Evaluation of the Demonstration

3.1 Evaluation Questions and Hypotheses:

a. For the continuous eligibility policy, the state must evaluate the impact of the policy on all relevant populations, appropriately tailored for the specific time span of eligibility. Evaluation hypotheses must focus on, but may not be limited to, enrollment continuity, utilization of age-appropriate preventive care, inpatient admissions and avoidable emergency care, and health disparities.

4. General Financial Requirements

4.1 Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject

to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

Table 2: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
CE – Children TANF/MAGI	**Hypo**	X		X	All expenditures for continued benefits for children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination.
CE – Children SSI/HH and Other Disabled	**Hypo**	X		X	All expenditures for continued benefits for children who have been determined eligible for the continuous eligibility period who would otherwise lose coverage during an eligibility determination.
CE - Formerly incarcerated TANF/MAGI	**Hypo**	X		X	All expenditures for continued benefits for beneficiaries leaving incarceration who meet criteria for high risk during the Continuous Eligibility period and who would otherwise lose coverage during an eligibility determination.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

4.2 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-00308/3). For the CE MEG, 2.6 percent for adults or 0.11 percent for children of expenditures are allocated to the CE MEG. 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 Demonstration Year (DY) according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Member Months. As part of the Quarterly and Annual Monitoring Reports, the state must report the actual number of "eligible member months" and expenditures for all

demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below, with the exception of the Continuous Eligibility (CE) MEGs. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

For the Children CE MEGs, this percentage will be 0.11 percent. For Formerly Incarcerated CE MEGs, this percentage will be 2.6 percent. For example, the actual member months and expenditures for formerly incarcerated individuals in the corresponding MEGs will be reduced by 2.6 percent and the equivalent member months and expenditures will be reported on the CE - Formerly Incarcerated MEG so that the total calculated member months and expenditures between the two MEGs are equal to the actual member months and expenditures for the group.

b. Budget Neutrality Specifications Manual**.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual or calculated expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	CMS-64.9 or 64.10 Line(s) to Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
CE – Children Age 0 to 6 TANF/MAGI	Children who are eligible via CE, equaling 0.11% of total Medicaid expenditures for Children 0-6	Follow 64.9 Base Category of Service Definition	Date of service	MAP	Y 0.11% of total member months for children aged 0-6	11/14/2024	9/30/2027
CE – Children Age 0 to 6 SSI/HH and Other Disabled	Children who are eligible via CE, equaling 0.11% of total Medicaid expenditures	Follow 64.9 Base Category of Service Definition	Date of service	MAP	Y 0.11% of total member months for children aged 0-6	11/14/2024	9/30/2027

	for Children 0-6						
CE Formerly Incarcerated At Risk	Formerly incarcerated individuals who are eligible via CE, equaling 2.6% of total Medicaid expenditure for formerly incarcerated individuals	Follow 64.9 Base Category of Service Definition	Date of service	MAP	Y 2.6% of total member months for formerly incarcerated all adults	11/14/2024	9/30/2027

4.3 Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group: Because not all "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) would be eligible for the entire continuous eligibility period if the state conducted redeterminations, CMS has determined that 97.4 percent of expenditures for individuals defined in 42 CFR 433.204(a)(1) will be matched at the "newly eligible" FMAP rate as defined in 42 CFR 433.10(c)(6) and 2.6 percent will be matched at the state's regular title XIX FMAP rate**.**

4.4 State Reporting for the Continuous Eligibility FMAP Adjustment: 97.4 percent of expenditures for "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the "newly eligible" FMAP rate as defined in 42 CFR 433.10(c)(6), unless otherwise adjusted as described in STC 4.2 above. The state must make adjustments on the applicable CMS-64 waiver forms to claim the remaining 2.6 percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the state's regular title XIX FMAP rate.

4.5 Budget Neutrality Monitoring Tool: The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in Section 5. CMS will provide technical assistance, upon request.[1]

[1] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual or calculated costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

4.6 Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 4.6.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.6. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

    i. Provider rate increases that are anticipated to further strengthen access to care;

    ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

    iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

    iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

    v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

    vi. High cost innovative medical treatments that states are required to cover; or,

    vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

5. Monitoring Budget Neutrality for the Demonstration

5.1 Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual or calculated number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of Federal Financial Participation (FFP) that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

5.2 Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this

demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

5.3 Hypothetical Budget Neutrality Test 2: Continuous Eligibility: The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test **2**. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditure in excess of the limit from Hypothetical Budget Neutrality Test **2** are counted as WW expenditures under the Main Budget Neutrality Test.

Table 4: Hypothetical Budget Neutrality Test 2

MEG	PC or AGG	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY06 10/1/22-9/30/23	DY07 10/1/23-9/30/24	DY08 10/1/24-9/30/25	DY09 10/1/25-9/30/26	DY10 10/1/26-9/30/27
CE – Children Age 0 to 6 TANF/MAGI	PC	Both	$473.92	4.8%	$0	$0	$496.67	$520.51	$545.49
CE – Children Age 0 to 6 SSI/HH and Other Disabled	PC	Both	$794.65	4.8%	$0	$0	$832.80	$872.77	$914.66
CE - Formerly incarcerated At Risk	PC	Both	$717.11	5%	$0	$0	$752.97	$790.62	$830.15

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver