DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

December 26, 2024

Sally Kozak
Deputy Secretary
Office of Medical Assistance Programs
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 a five-year section 1115 demonstration (Project Number 11-W-00484/3), in accordance with section 1115(a) of the Social Security Act ("the Act"). This approval is effective as of December 26, 2024, through December 31, 2029, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

CMS has determined that Pennsylvania's Keystones of Health demonstration is likely to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality medical assistance and improving health outcomes for beneficiaries.

Approval of this demonstration provides expenditure authority for limited coverage for certain services furnished to certain incarcerated individuals for up to 90 days immediately prior to the individual's expected date of release. Approval of this demonstration also provides expenditure authority for new initiatives related to promoting services addressing health-related social needs (HRSN). With this demonstration, Pennsylvania is introducing new initiatives and investments to assist the state in improving health coverage, access, and consistent provision of high-quality services for Medicaid beneficiaries, while additionally making important gains in advancing health equity among its beneficiary populations.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STC), 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 waived or not applicable to expenditures under the demonstration.

Extent and Scope of the Demonstration

Approval of Pennsylvania's Keystones of Health demonstration includes the following initiatives: (1) Reentry and (2) HRSN. The overall goals of this demonstration include:

1. Expanding support services to populations who face barriers to health care due to their social circumstances;
2. Improving coordination and integration of physical, behavioral, and social services for beneficiaries who have complex health and social needs;
3. Enhancing quality and efficiency of care delivery by addressing the root causes of poor health outcomes; and
4. Promoting health equity and reduce health disparities by targeting services and supports to beneficiaries who experience higher rates of morbidity and mortality due to their social risk factors.

1) Pre-Release Services under the Reentry Demonstration Initiative

Expenditure authority is being provided to Pennsylvania to provide limited coverage for a targeted set of services furnished to certain incarcerated individuals for 90 days immediately prior to the individual's expected date of release. The state's proposed approach closely aligns with CMS' "Reentry Demonstration Opportunity" as described in the State Medicaid Director Letter (SMDL) released on April 17, 2023.

Eligible Individuals

Pennsylvania will cover a set of pre-release benefits for certain individuals who are inmates residing in prisons and jails (herein after referred to as "correctional facilities"). To qualify for services covered under this demonstration approval, individuals residing in a correctional facility have been determined eligible for Medicaid pursuant to an application filed before or during incarceration, be age 19 or older, have an expected release date within 90 days, and meet one or more of the following health-related criteria:

1. Have one or more substance use disorders (SUD);
2. Have serious mental illness (SMI);
3. Be eligible for Medicaid funded 1915(c) home and community-based services (HCBS) administered by the Office of Long Term Living or Office of Developmental Programs upon release;
4. Have one or more chronic health conditions;
5. Be pregnant or in the 12-month postpartum period;
6. Have Autism Spectrum Disorder (ASD).

Medicaid Eligibility and Enrollment

CMS is requiring, as a condition of approval of this demonstration, that Pennsylvania make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the correctional facilities listed above and outlined in the STCs.

For a Medicaid covered individual entering a correctional facility, Pennsylvania will not terminate Medicaid coverage, but will suspend the individual's coverage. For individuals not enrolled in Medicaid upon entering a correctional facility, Pennsylvania will ensure the

individual receives assistance with completing and submitting a Medicaid application sufficiently prior to their anticipated release date such that the individual can receive the full duration of pre-release services, unless the individual voluntarily refuses such assistance or chooses to decline enrollment.

Scope of Pre-Release Benefit Package

The pre-release benefit package is designed to improve care transitions of such eligible individuals back to the community, including by promoting continuity of coverage, service receipt, and quality of care, as well as the proactive identification of both physical and behavioral health needs and HRSNs. It is designed to address these overarching demonstration goals, while aiming to ensure that participating correctional facilities can feasibly provide all pre-release benefits to qualifying incarcerated individuals.

CMS is authorizing Pennsylvania to provide coverage for the following services to be detailed in an attachment to the demonstration's Special Terms and Conditions (STCs):

- Case management to assess and address physical and behavioral health needs and health-related social needs;
- Medication assisted treatment (MAT) for all types of substance use disorders (SUDs) as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;
- A 30-day supply of all prescription medications provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;

CMS recognizes that many individuals exiting correctional facilities may not have received sufficient health care to address all of their physical or behavioral health care needs while incarcerated. This demonstration initiative will provide individuals leaving correctional facilities the opportunity to receive short-term Medicaid pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, while providing the state the opportunity to test whether these pre-release services improve uptake and continuity of MAT and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, and overdose-related death. In addition, Pennsylvania has state specific goals for the reentry demonstration initiative including improving continuity of care for beneficiaries who are transitioning out of incarceration. Therefore, CMS is approving a demonstration benefit package in Pennsylvania that is designed to improve identification of physical and behavioral health needs and HRSNs to facilitate connections to providers with the capacity to meet those needs in the community during the period immediately before an individual's expected release from a correctional facility. Once an individual is released, the coverage for which the individual is otherwise eligible must be provided consistent with all requirements applicable to such coverage.

Eligible Juveniles and This Reentry Demonstration Initiative

Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) amends the Social Security Act (the Act) and describes a mandatory population (eligible juveniles and targeted low-income children) and set of pre-release and post-release services, while section 5122 of the CAA, 2023 amends the Act and gives a state the option to receive federal financial participation for the full range of coverable services for eligible juveniles and targeted low-income children while pending disposition of charges. Every state is required to submit Medicaid and Children's Health Insurance Program (CHIP) State Plan Amendments (SPAs) attesting to meeting the requirements in Section 5121 beginning January 1, 2025.[1]

To the extent there is overlap between the services required to be covered under section 1902(a)(84)(D) of the Act and coverage under this demonstration, we understand that it would be administratively burdensome for states to identify whether each individual service is furnished to a beneficiary under the state plan or demonstration authority. Accordingly, to eliminate unnecessary administrative burden and ease implementation of statutorily required coverage and this demonstration, we are approving a waiver of the otherwise mandatory state plan coverage requirements to permit the state instead to cover at least the same services for the same beneficiaries under this demonstration. This approach will ease implementation, administration, and claiming, and provide a more coherent approach to monitoring, and evaluation of the state's reentry coverage under the demonstration. The state will provide coverage under the reentry demonstration to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act, at a level equal to or greater than otherwise would be covered under the state plan. Compliance and state plan submission requirements under section 5121 of the CAA, 2023 will remain unchanged. Coverage of the population and benefits identified in section 1902(a)(84)(D) of the Act, as applicable, will automatically revert to state plan coverage in the event that this demonstration ends or eliminates coverage of beneficiaries and/or services specified in those provisions.

Implementation and Reinvestment Plans

As described in the demonstration STCs, Pennsylvania will be required to submit to CMS a Reentry Initiative Implementation Plan (Implementation Plan) and Reinvestment Plan documenting how the state will operationalize coverage and provision of pre-release services and how existing funding for correctional facility health services will continue to support access to necessary care and achievement of positive health outcomes for the justice-involved population.

The Implementation Plan must be submitted to CMS consistent with the STCs and must describe the milestones and associated actions being addressed under this demonstration and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities and describe the state's strategic approach for making significant improvements on the milestones and actions, as well as associated timelines for meeting them, for both program policy implementation and investments in transitional

[1] SHO# 24-004, RE: Provision of Medicaid and CHIP Services to Incarcerated Youth. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf

nonservice elements, as applicable. The Implementation Plan will also outline any potential operational challenges that the state anticipates and the state's intended approach to resolving these and other challenges the state may encounter in implementing the reentry demonstration initiative. The operational plan requirement in section 1902(a)(84)(D) of the Act is satisfied by the state's Implementation Plan. The state is still required to provide coverage and otherwise meet state plan requirements with respect to any population or service specified in section 1902(a)(84)(D) of the Act that is not covered under this demonstration.

The reentry demonstration initiative is not intended to shift current correctional facility health care costs to the Medicaid program. Section 5032(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (P.L. 155-271) makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of title XIX, which includes the inmate payment exclusion, in recognition that the correctional authority bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve correctional authorities in Pennsylvania of their Constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a tribal, state, or local correctional authority to the Medicaid program.

Pennsylvania agrees to reinvest the total amount of new federal matching funds for the reentry demonstration initiative received under this demonstration into activities or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for physical and behavioral health needs that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement, Pennsylvania will develop and submit a Reinvestment Plan to CMS outlining how the federal matching funds under the demonstration will be reinvested. The Reinvestment Plan should align with the goals of the state's reentry demonstration initiative. It should detail the state's plans to increase access to or improve the quality of health care services for those who have recently been released, and those who may be at higher risk of future criminal justice system involvement, particularly due to untreated behavioral health conditions. The Reinvestment Plan should describe the activities or initiatives selected by Pennsylvania for investment and a timeline for implementation. Any investment in carceral health care must add to and/or improve the quality of health care services and resources for individuals who are incarcerated and those who are soon to be released from carceral settings, and not supplant existing state or local spending on such services and resources. The reinvestment plan may include the services provided to eligible juveniles under section 1902(nn)(2) of the Act, who are covered under this demonstration.

2) HRSN Services

CMS is authorizing the state to offer coverage of certain services that address HRSN for qualifying beneficiaries, as evidence indicates that these benefits are critical drivers of an

individual's access to health services that keep them well.[2,3] Under this demonstration, the state will receive authority to cover the following HRSN housing interventions: case management for housing, housing navigation and tenancy support, one-time transition and moving costs other than rent, utility assistance, first month's rent as a transitional service, and short-term rental assistance. The state will also receive authority to cover the following HRSN nutrition interventions: home-delivered meals and medically-tailored meals. Coverage of targeted HRSN services and supports is likely to assist in promoting the objectives of Medicaid because it is expected to help beneficiaries stay connected to coverage and access to needed health care. The housing and nutritional support services authorized under the demonstration are expected to stabilize the housing and nutritional situations of eligible beneficiaries and thus increase the likelihood that they will keep receiving and benefitting from the Medicaid- and demonstration-covered services to which they are entitled.

Coverage of targeted, clinically appropriate HRSN services will also provide a regular source of care to meet individuals' comprehensive health needs. This is likely to improve health outcomes directly, as well as improve the use of other clinical services. By providing the short-term services needed to stabilize housing, this demonstration will test whether the individual's health outcomes will improve in addition to their utilization of appropriate care.

Moreover, the Medicaid statute, including both sections 1905 and 1915 of the Act, already includes mechanisms that reflect the critical role of upstream services (i.e., those that help avert more intensive medical interventions) in meeting the medical assistance needs of certain Medicaid-eligible populations (e.g., individuals with disabilities).

Medical assistance made available under a state plan option authorized under section 1915(i) of the Act provides that same package of home and community-based services (HCBS) to individuals meeting needs-based criteria that are less stringent than criteria required for institutional placement. These services are also intended to avert a need for nursing facility care.

Available evidence[4] suggests there may be populations in addition to those eligible under section 1915(c) or 1915(i) criteria that would benefit clinically from the section 1915(c) or 1915(i) services described above, as well as additional upstream HRSN services. Additional research is needed to better understand the effects of providing these types of services to a broader group of people. To that end, this demonstration will test whether expanding eligibility for these services to additional populations or providing additional services can improve the health outcomes of

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[2] As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federalpolicy-guidance/downloads/sho21001.pdf, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While "social determinants of health" is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute to poor health. See also https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/full/

[3] Bachrach, D., Pfister, H., Wallis, K., Lipson, M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund; 2014; https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf.

[4] September 23, 2021. ASPE Contractor Project Report: Building the Evidence Base for Social Determinants of Health Interventions. https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions

certain Medicaid beneficiaries. The demonstration will also test whether extending eligibility for a broader range of Medicaid beneficiaries or providing additional services will help to maintain coverage by preventing health-related incidents that could lead to enrollment churn.[5]

Moreover, access to these services for individuals with poorer health outcomes may help to reduce health disparities. Expanding who can receive these services is expected to help a broader range of Medicaid beneficiaries not only receive, and benefit from, the medical assistance to which they are entitled, but also, these services are expected to further reduce health disparities often rooted in socioeconomic factors.[6] Thus, broadening the availability of certain HRSN services is expected to promote coverage and access to care, improve health outcomes, reduce disparities, and create long-term, cost-effective alternatives or supplements to traditional medical services.

All HRSN nutrition interventions with provision of food (i.e., full board; that is, three meals a day or any other complete nutritional regimen) are limited to a duration of 6 months, renewable while the beneficiary continues to meet qualifying criteria.

As specified further in the STCs, HRSN services authorized in this demonstration must be clinically appropriate for the beneficiary. Beneficiaries qualified to receive HRSN services are those eligible for and enrolled in Medicaid with a documented medical need for the services. Attachment G, which CMS is approving concurrently with this demonstration approval, reflects a comprehensive list of the populations, clinical criteria, and social risk factors that the state will incorporate into the post-approval protocol that will define beneficiary qualifications for HRSN services.

CMS also expects the state to maintain existing state funding and efforts for HRSN services, without this demonstration authority supplanting existing efforts, and to have in place partnerships with other state and local entities to coordinate possible pathways to permanency for services to be provided without demonstration authorities.

HRSN Infrastructure

CMS is authorizing expenditure authority for the state to claim federal financial participation for certain infrastructure expenditures to support the development and implementation of HRSN services, as specified further in the STCs.

Provider Rate Increase Condition

CMS is committed to improving access to quality care for all Medicaid beneficiaries and is engaged in an "all of Medicaid" approach to improve coverage, access to, and quality of care, as well as to improve health outcomes for all beneficiaries consistent with Medicaid's statutory

[5] April 12, 2021. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf
[6] April 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

objectives. Further, we expect that such policies will also have the effect of mitigating health disparities. Research shows that increasing Medicaid payments to providers improves beneficiaries' access to health care services and the quality of care received.

As a condition of approval and ongoing provision of federal financial participation (FFP) in HRSN expenditures over this demonstration period of performance, DY 1 through DY 5, the state will in accordance with the STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and/or require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates. That rate increase must be at least two percentage points in the ratio of Medicaid to Medicare provider rates for one of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services for any delivery system operated by the state is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for any delivery system operated by the state, the state must increase provider payment rates in accordance with the STCs.

Budget Neutrality

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 demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration.[7] The demonstration is projected to be budget neutral to the federal government, meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. 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 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" (WOW) costs). The state will be held to the budget neutrality monitoring and reporting requirements as outlined in the STCs.

Hypothetical Budget Neutrality Treatment

Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as "hypothetical" for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as

[7] https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's "with waiver" (WW) hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS. The "Supplemental HRSN Aggregate Ceiling," or SHAC, for HRSN expenditures is different, as discussed below.

For each of these Medicaid Eligibility Groups (MEGs), discussed below in this section, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each of these MEGs in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Reentry Budget Neutrality

The Medicaid expenditures for pre-release services furnished to incarcerated beneficiaries under the reentry demonstration initiative include coverage of services that states can and do cover through Medicaid state plan or other title XIX authority, for beneficiaries who are not subject to the inmate payment exclusion. CMS considers these expenditures to be "hypothetical" because the pre-release services would be coverable under the Medicaid state plan or other title XIX authority if furnished to a beneficiary outside a carceral setting, similar to how CMS treats expenditures for services furnished to certain beneficiaries who are short-term residents in an institution for mental diseases primarily to receive treatment for SUD, or SMI or serious emotional disturbance (SED), under the SUD and SMI/SED section 1115 demonstration opportunities. Any population identified in section 1902(a)(84)(D) of the Act and covered instead under this demonstration will be included in the reentry MEG.

HRSN Budget Neutrality

CMS is treating HRSN expenditures authorized under this approval as "hypothetical" for the purposes of the budget neutrality calculation. Some of these expenditures could be covered under other title XIX authority, and treating those expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. Other HRSN expenditures could not otherwise be covered under title XIX authority, such as expenditures on section 1915 services for beneficiaries who are not otherwise eligible for them under section 1915, but there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical is also consistent with how CMS has historically treated similar expenditures. Additionally, treating demonstration HRSN expenditures as hypothetical will give the state the flexibility to test these worthy innovations,

especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs, based on robust academic-level research, but predicting these downstream effects on overall Medicaid program costs is extremely difficult. To ensure that treating HRSN expenditures as hypothetical does not have a significant negative fiscal impact on Medicaid, CMS is applying a budget neutrality ceiling to HRSN services expenditures and an additional sub-ceiling to HRSN infrastructure expenditures, and is referring to these expenditures collectively as the "Supplemental HRSN Aggregate Ceiling (SHAC)" expenditures in the STCs. The SHAC differs from the usual limit CMS places on hypothetical expenditures (the "supplemental test" discussed above) in several respects. The expenditures subject to the SHAC are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects. The upper limit on the SHAC is based on a range of estimates of the likely cost of these expenditures over a 5-year period, and is set at a mid-point in that range, but in no case can it exceed 3 percent of the state's total computable Medicaid spending. The sub-ceiling for infrastructure costs cannot exceed 15 percent of total HRSN expenditure authority. And, if the state exceeds these limits, it will not be permitted to offset the additional costs with savings from the rest of the demonstration. However, unspent HRSN infrastructure authority can be applied to HRSN services in the same demonstration year.

Midcourse Correction

CMS has also updated its approach to mid-course corrections to budget neutrality calculations 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.

Monitoring and Evaluation

Consistent with CMS's requirements for section 1115 demonstrations, and as provided in the demonstration's STCs, the state is required to conduct systematic monitoring and robust evaluation of the demonstration, per applicable CMS guidance and technical assistance. The state must develop a Monitoring Protocol to incorporate how it will monitor the demonstration components, including relevant metrics data as well as narrative details describing progress with implementing the demonstration. In addition, the state is required to conduct an independent Mid-Point Assessment of the reentry demonstration initiative, as provided in the STCs, to support identifying risks and vulnerabilities and subsequent mitigation strategies.

The state is required to conduct an evaluation of the demonstration to support a comprehensive assessment of whether the demonstration components are effective in producing the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid program. Evaluation of the demonstration must align with the requirements detailed in the STCs, including examining impacts on coverage, access to and quality of care, utilization of services, health outcomes, and carceral and community coordination in service provision, among others. Eligible juveniles eligible under section 1902(nn)(2) of the Act are included under this reentry demonstration initiative and must be included in applicable monitoring and evaluation activities. The state's monitoring and evaluation efforts must facilitate understanding the extent to which the demonstration might support reducing existing health disparities.

Consideration of Public Comments

The federal comment period was open from February 15, 2024, through March 16, 2024, and CMS received 34 comments. Comments came from a variety of individuals, research and advocacy groups, elected officials or government agencies, and medical providers or insurers.

Thirty-one comments were supportive of Pennsylvania's request to provide reentry services and health-related social needs services to address social determinants of health. Several commentors advised that the state expand eligibility and services for the demonstration, with recommendations including extending reentry services to juveniles, expanding community health worker services, and investing in data collection and comprehensive data sharing initiatives. Two comments opposed Pennsylvania's demonstration application, expressing concern about the financial and budgetary implications of the demonstration.

After careful consideration of the public comments submitted during the federal public comment period and the information received from the state public comment period, CMS has concluded that the demonstration is likely to assist in promoting the objectives of Medicaid.

Other Information

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

The project officer for this demonstration is Rabia Khan. She is available to answer any questions concerning this section 1115(a) demonstration. Ms. Khan'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: Rabia.Khan1@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,

Chiquita Brooks-LaSure

Enclosure

cc: Margaret Kosherkenzo, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00484/3

TITLE: Keystones of Health

AWARDEE: Pennsylvania Department of Human Services

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 from December 26, 2024, through December 31, 2029, unless otherwise specified, be regarded as expenditures under the commonwealth's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the Commonwealth of Pennsylvania to operate the above-identified section 1115 demonstration.

1. **Expenditures for Pre-Release Services**. Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 90-days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.

2. **Expenditures for Pre-Release Administrative Costs**. Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 5.12, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903 of the Act, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.

3. **Expenditures for Health-Related Social Needs (HRSN) Services.** Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 6.6. This expenditure authority is contingent upon compliance with Section 6, as well as all other applicable STCs.

4. **Expenditures for Health-Related Social Needs Services Infrastructure.** Expenditures for allowable HRSN administrative and infrastructure costs not otherwise covered under section 1903 of the Act, as described in Section 6 of the STCs.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release and HRSN Services:

Statewideness **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

To enable the state to provide HRSN services only in certain geographic areas of the state, as specified in the HRSN Implementation Plan (STC 6.19).

Comparability; Amount, Duration and Scope; Provision of Medical Assistance **Section 1902(a)(10)(B) and Section 1902(a(17)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

To the extent necessary to allow the state to offer HRSN services and to vary the amount, duration, and scope of HRSN services covered for a subset of beneficiaries, depending on beneficiary needs as determined by the application of qualifying criteria, as specified in Section 6.6 of the STCs.

Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: 11-W-00484/3

TITLE: Keystones of Health

AWARDEE: Pennsylvania Department of Human Services

Under the authority of the section 1115(a)(1) of the Social Security Act (the "Act"), the following waivers are granted to enable the Commonwealth of Pennsylvania (referred to herein as the "state") to operate the Keystones of Health demonstration. These waivers are effective beginning December 26, 2024, and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Keystones of Health, including the granting of the waivers described below, is likely to assist in promoting the objectives of the title XIX of the Act.

Except as provided below with respect to expenditure authority, all requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning December 26, 2024, through December 31, 2029.

1. **Coverage of Certain Screening, Diagnostic, Release and Targeted Case Management Services for Eligible Juveniles in the 90-days Prior to Release Section 1902(a)(84)(D)**

   To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 90 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONITIONS

NUMBER: 11-W-00484/3

TITLE: Keystones of Health

AWARDEE: Pennsylvania Department of Human Services

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Keystones of Health" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Commonwealth of Pennsylvania (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid (CMS) has granted a waiver of certain requirements under section 1902(a) of the Social Security Act (Act) and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waiver and expenditure authorities, and describe in detail the nature, character, an 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 from December 26, 2024, through December 31, 2029, unless otherwise specified.

The STCs have been arranged into the following subject areas:

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

Attachment A:	Developing the Evaluation
Attachment B:	Preparing the Interim and Summative Evaluation Reports
Attachment C:	Reserved for Reentry Demonstration Initiative Implementation Plan
Attachment D:	Reserved for Reentry Demonstration Initiative Reinvestment Plan
Attachment E:	Reserved for HRSN Implementation Plan
Attachment F:	Reserved for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services Protocol
Attachment G:	HRSN Services Matrix
Attachment H:	Reentry Demonstration Initiative Services
Attachment I:	Reentry Demonstration Initiative Health-Related Criteria
Attachment J:	Reserved for HRSN-Related Provider Payment Increase Attestation Table
Attachment K:	Reserved for Monitoring Protocol
Attachment L:	Reserved for Evaluation Design

2. PROGRAM DESCRIPTION AND OBJECTIVES

In 2024, the state submitted the Keystones of Health section 1115 demonstration application. The application proposed demonstration programs to improve health outcomes for beneficiaries reentering society from correctional facilities, beneficiaries facing food insecurity and diet-sensitive conditions, and beneficiaries without stable housing.

During the demonstration period, the state seeks to achieve the following goals:

1.	Expand support services to populations who face barriers to health care due to their social circumstances.
2.	Improve coordination and integration of physical, behavioral, and social services for beneficiaries who have complex health and social needs.
3.	Enhance quality and efficiency of care delivery by addressing the root causes of poor health outcomes.
4.	Promote health equity and reduce health disparities by targeting services and supports to beneficiaries who experience higher rates of morbidity and mortality due to their social risk factors.

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 if applicable 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 3.7. 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 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the 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. **State Plan Amendments**. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS

as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid 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 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to 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 of STC 3.12. 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.

3.8. **Extension of the Demonstration**. States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out**. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **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. 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.

3.11. **Adequacy of Infrastructure**. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties**. The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. **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.

3.14. **Administrative Authority**. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. **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, all eligibility will be defined under the state plan and the demonstration affects all eligibility groups under the state plan through the provision of additional services.

In addition, individuals eligible for Medicaid in the state through section 1915(c) waiver programs will be eligible for services under the demonstration when they meet certain clinical and social criteria to qualify for the services as further specified in STC 5.3. The state will require and ensure that these eligible individuals will, to the extent applicable, first receive housing, food, and nutrition services and supports under that section 1915(c) waiver program and then only access Keystones of Health services when unable to access similar services under the section 1915(c) waiver program in which they are enrolled.

Keystones of Health eligibility will be determined through existing state plan processes and eligibility.

5. REENTRY DEMONSTRATION INITIATIVE PROGRAM

5.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to certain individuals who are inmates residing in prisons and jails (hereinafter "correctional facilities"). To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid as determined pursuant to an application filed before or during incarceration and must have an expected release date no later than 90 days as further specified in the STCs below.

5.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with

community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The reentry demonstration initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other Substance Use Disorder (SUD) and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and health-related social needs;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medication for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release;

i. Ensure a seamless transition and continuity of care for justice-involved beneficiaries; and

j. Enhance the reintegration of justice-involved beneficiaries into the community while optimizing their access to essential healthcare services.

5.3. **Qualifying Criteria for Pre-Release Services**. To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 5.1; and

b. Have been determined eligible for Medicaid;

c. Have an expected release date within 90 days;

d. Be age 19 or older;

e. Meet one or more of the health-related criteria, described below and further defined in Attachment I;

i. Have one or more substance use disorders;

ii. Have a 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 upon release;

iv. Have one or more chronic health conditions;

v. Are pregnant or in the 12-month postpartum period;

vi. Have Autism Spectrum Disorder (ASD).

5.4. **Scope of Pre-Release Services**. The pre-release services authorized under the reentry demonstration initiative include the following services, which are described in Attachment H, Reentry Demonstration Initiative Services.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and health-related social needs;

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;

b. The state must also provide a 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy.

c. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these

STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the Commonwealth of Pennsylvania Medicaid State Plan, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT treatment services for qualifying Medicaid beneficiaries under age 21) are not available to qualifying individuals through the reentry demonstration initiative.

5.5. **Participating Correctional Facilities.** The pre-release services will be provided at prisons and jails, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to the Commonwealth of Pennsylvania's Department of Human Services approval of a facility's readiness, according to the implementation timeline described in STC 5.9. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the reentry demonstration initiative.

5.6. **Participating Providers.**

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under the Commonwealth of Pennsylvania scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as a Medicaid provider.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

5.7. **Suspension of Coverage**. Upon entry of a Medicaid individual into a correctional facility, the Commonwealth of Pennsylvania's Department of Human Services must not terminate and generally shall suspend their Medicaid coverage.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

5.8. **Interaction with Mandatory State Plan Benefits for Eligible Juveniles**. To the extent the Commonwealth of Pennsylvania's reentry demonstration includes coverage otherwise required to be provided under section 1902(a)(84)(D) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality expenditure limit, the state will claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

5.9. **Reentry Demonstration Initiative Implementation Timeline.** Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). The Department of Human Services will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid application and enrollment processes for individuals who are not enrolled in Medicaid prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 5.3;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;

d. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, and social service departments;

e. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 90-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

f. Operational approaches related to implementing certain Medicaid requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific

to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

g. A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

h. Reporting of data requested by the Department of Human Services to support program monitoring, evaluation, and oversight; and

i. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

5.10. **Reentry Demonstration Initiative Implementation Plan**. The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in the State Medicaid Director Letter (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

a. The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. The finalized Implementation Plan will be incorporated into the STCs as Attachment C titled "Reentry Demonstration Initiative Implementation Plan."

b. CMS will provide the state with a template to support the development of the Implementation Plan.

5.11. **Reentry Demonstration Initiative Reinvestment Plan.** To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment D) and subject to CMS approval. The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the reentry demonstration initiative, defined as services not previously provided or paid by the correctional facility with custody of qualifying individuals prior to the facility's implementation of the reentry

demonstration initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative, with respect to the relevant increase in expenditures, as described in Attachment XX the Reentry Demonstration Initiative Reinvestment Plan) is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

iii. Improved access to or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment D) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the

types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment D titled "Reentry Demonstration Initiative Reinvestment Plan."

5.12. Reentry Demonstration Initiative Planning and Implementation

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid pre-release applications. In addition, reentry demonstration initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the reentry demonstration initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among the Pennsylvania Department of Human Services and Qualified Applicants listed in STC 5.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

    i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the reentry demonstration initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 5.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 5.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

    ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 5.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems.** Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures.** Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 90 days immediately prior to the expected date of release for individuals qualifying for reentry demonstration initiative services.

vi. **Additional Activities to Promote Collaboration**. Expenditures for additional activities that will advance collaboration among the Commonwealth of Pennsylvania's Qualified Applicants in STC 5.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. **Planning.** Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid application; (3) submitting the Medicaid application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 1. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more

demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 1. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 1	DY 2	DY 3	DY 4	DY 5
Total Computable Expenditures	$44,768,868	$44,768,868	$44,768,868	$14,922,956	$0

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

d. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the state Medicaid Agency, correctional facilities, other state agencies supporting carceral health, Probation Offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the state Medicaid agency.

6. HEALTH-RELATED SOCIAL NEEDS DEMONSTRATION INITIATIVE

6.1. **Health-Related Social Needs (HRSN) Services.** The state may claim FFP for expenditures for certain qualifying HRSN services identified in STC 6.2 and Attachment G, subject to the restrictions described below. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and health-related social risk criteria across services and with other relevant, non-Medicaid social support agencies, to the extent possible and appropriate. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through other local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans, as applicable, of their responsibilities to make payment for other covered services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on a beneficiary's receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 6.10 (Service Delivery) and Attachment G.

6.2. **Allowable HRSN services.** The state may cover the following HRSN services:

a. Case management services for access to housing (e.g., outreach and education; linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees).

b. Housing interventions, including:

i. Housing supports without room and board, including:

1. Pre-tenancy navigation services (e.g., finding and securing housing).
2. One-time transition and moving costs other than rent, to assist with identifying, coordinating, securing, or funding one-time necessary services and modifications to help a person establish a basic household (e.g., security deposit, application and inspection fees, utilities activation fees and payment in arrears as necessary to re-establish utility service (capped at a total of six months of total arrear and prospective payments), movers, relocation expenses, pest eradication, pantry stocking (up to 30 days of food), cooking supplies, and the purchase of household goods and furniture). Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services. This does not include clothing.
3. Tenancy and sustaining services (e.g. eviction prevention, tenant rights education).

ii. Utility assistance, capped at six months per demonstration period for total prospective/retrospective payments (utility assistance provided as a one-time transition service under STC 6.2.b.i.2 is included in this limit), including activation expenses and back payments to secure utilities, limited to individuals receiving housing supports with or without room and board as described in this STC. Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services.

iii. Room and board-only supports (also referred to as "rent-only" supports or interventions), limited to a clinically appropriate amount of time, including:

1. First month's rent as a transitional service.
2. Short-term rental assistance with room alone or with room and board together, without clinical services included in the rental assistance payment.

c. Nutrition interventions (standalone, outside of joint room and board interventions):

i. Nutrition interventions <u>with</u> provision of food, including:

1. Home delivered meals or pantry stocking (also referred to as grocery provisions), appropriate for the beneficiary's health condition or status as a child or pregnant person.
2. Medically tailored meals to individuals with nutrition-sensitive conditions (e.g., pregnant individuals, individuals with diabetes), as specified in STC 6.6.

6.3. **HRSN Intervention Duration and Frequency.**

a. Housing interventions with room and board.

i. Housing interventions that are classified as room and board-only support, as described in STC 6.2.b.iii, may be covered for a qualifying beneficiary up to a combined 6 months per household per demonstration period.

ii. For this 6-month cap, coverage will be permitted in one or more spans or episodes, as long as the total duration remains under the cap for the demonstration period.

b. Nutrition interventions with provision of food.

i. HRSN nutrition interventions with provision of food (full board, i.e., 3 meals/day or any other complete nutritional regimen) are limited to a duration of 6 months, renewable while the beneficiary continues to meet qualifying criteria.

ii. HRSN nutrition interventions with provision of food are not available to the extent that that benefit, together with any other service payments that include payment for food made on behalf of the beneficiary, would exceed full board for the beneficiary, as the HRSN nutrition benefit or payment would be duplicative. For example, medically tailored meal delivery is not available for an individual who is receiving short-term rental assistance for a stay in a facility that provides 3 meals per day included in the payment to the facility, and pantry stocking or nutrition prescriptions are not available for an individual who is receiving a full board regimen of medically tailored meals.

c. The state will define other HRSN service duration limitations in Attachment F, subject to CMS approval as indicated in STC 6.7.

6.4. **Excluded Services.** Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction (bricks and mortar) except as needed for approved medically necessary home modifications specified in STC 6.2;

b. Capital investments;

c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months, except as specified in STC 6.2 and 6.3;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Services furnished to beneficiaries for which payment is not available under the inmate payment exclusion in the matter following the last numbered paragraph of section 1905(a) of the Act except case management of HRSN services provided as part of an approved reentry demonstration initiative;

f. Services provided to individuals who are not lawfully present in the United States;

g. Expenditures that supplant services and/or activities funded by other local, state and/or federal governmental entities;

h. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

i. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.

    i. For all HRSN housing interventions with room and board, the following setting exclusions apply: Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space.

6.5. HRSN Infrastructure

a. The state may claim FFP for expenditures for infrastructure investments to support the development and implementation of HRSN services, subject to STC 6.3. This FFP will be available for the following activities

    i. Technology – e.g., electronic referral systems, shared data platforms, electronic heath record (EHR) modifications or integrations, screening tool and/or case management systems, licensing, databases/data warehouses, data analytics and reporting, data protections and privacy, and accounting and billing systems.

    ii. Development of business or operational practices – e.g., developing policies, procedures and workflows, training and technical assistance, and administrative activities to support or expand HRSN operations.

    iii. Workforce development – e.g., recruiting and hiring, salary and fringe benefits for staff, necessary certifications, cultural competency training, trauma-informed training, developing and training staff on new policies and procedures, and training materials.

    iv. Outreach, education, and interested parties convening – e.g., design and production of outreach and education materials, translation, obtaining community input, and interested parties convening and community engagement activities.

b. The state may claim FFP for HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 2. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years, not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 2 Annual Limits of Allowable Total Computable Expenditures for HRSN Infrastructure

	DY1	DY2	DY3	DY4	DY5	Total
Total Computable Expenditures	$18,200,000	$31,850,000	$31,850,000	$9,100,000	$0	$91,000,000

c. Infrastructure expenditures will receive the FFP match for applicable administrative costs for the expenditure.

d. This infrastructure funding is separate and distinct from payments for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 6.5 are not included in HRSN service payments (including capitation payments, as applicable) and that there is no duplication of payments to entities providing or administering HRSN service benefits.

e. The state may not claim any FFP in HRSN infrastructure expenditures until Attachment F (HRSN Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services Protocol) is approved, as described in STC 6.9. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of when the demonstration expenditure authority for HRSN infrastructure was approved.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

6.6. **Covered Populations.** Expenditures for HRSN services may be made for the populations of focus specified in Attachment F, consistent with this STC. To qualify to receive coverage for HRSN services, individuals must be Medicaid (or Medicaid demonstration)-eligible and have a documented medical/clinical need for the services and the services must be determined medically/clinically appropriate, as described STC 6.1, to address the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail, including the clinical and other health related-social needs criteria, is outlined in Attachment F. Attachment G, the HRSN Service Matrix, describes the full list of clinical and social risk factors the state anticipates incorporating into Attachment F over the course of the demonstration at the time of the demonstration approval of the expenditure authority for HRSN services. While Attachment G reflects the full list of clinical and social risk factors the state is authorized to implement, the state is not required to implement all of the clinical and social risk factors outlined in Attachment G. Additionally, the state can later include additional clinical and social risk factors in compliance with STC 6.7 and 6.8.

6.7. Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for HRSN Services. The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of the HRSN expenditure authority. The protocol must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for

defining a medically appropriate population of focus for each service, the process by which those criteria will be applied including care plan requirements and/or other documented processes, and provider qualification criteria for each service. Any changes to the initial scope of clinical and social risk factors reflected in Attachment G must be effectuated through the process indicated in STC 6.8. The state must resubmit a revised protocol if required by CMS feedback on the initial submission. The state may not claim FFP for HRSN services until CMS approves the initial protocol. Once the initial protocol is approved, the state can claim FFP in expenditures for HRSN services retrospectively to the date of approval of the expenditure authority for HRSN services. The approved protocol will be appended to the STCs as Attachment F.

If the state adds new HRSN services beyond those specified in STC 6.2 through a demonstration amendment, the state must also submit revisions to the Protocol to CMS no later than 90 days after the approval of the amendment to the demonstration. The Protocol revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population of focus for each new service, the process by which those criteria will be applied including service plan requirements and/or other documented processes, and provider qualification criteria for each new service. This revised protocol must comply with applicable STCs.

Specifically, the protocol must include the following information:

a. A list of the covered HRSN services (not to exceed those allowed under STC 6.2), with associated service descriptions and service-specific provider qualification requirements.

b. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary qualifications, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

c. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may determine the service to be medically appropriate.

    i. Plan to identify medical appropriateness based on clinical and social risk factors.

    ii. Plan to publicly maintain these clinical and social risk criteria to ensure transparency for beneficiaries and other interested parties.

d. A description of the process for developing care plans based on assessment of need.

    i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

    ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma informed, as appropriate.

e. A plan to avoid duplication/displacement of existing food assistance/nutrition services, including how the state will prioritize and wrap around Supplemental Nutrition Assistance Program (SNAP) and/or Women Infants and Children (WIC) enrollment, appropriately adjust HRSN demonstration initiative benefits for individuals also receiving SNAP and/or WIC services, and ensure eligible beneficiaries are enrolled to receive SNAP and/or WIC services.

f. An affirmation that the state agrees to meet the enhanced monitoring and evaluation requirements stipulated in STCs 10.5.b and 11.6, which require the state to monitor and evaluate how the renewals of recurring nutrition services under STC 6.3.b affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services. As required in STCs 10.5.b and 11.6, the Monitoring Protocol and Evaluation Design are subject to CMS approval.

6.8. Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services:

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in Attachments F and G. Certain changes to the state's service offerings and qualifying criteria, within what CMS has approved in Attachment G, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change in Attachment F by the following process:

    i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.

    ii. The state must provide public notice.

    iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in STC 6.8.a. above, if the state seeks to implement additional clinical and/or social risk factors than what are included in approved Attachment G, the state must follow the process below to update the protocol:

    i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and/or social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in Table 8.

    ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this STC 6.8.b.

iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this STC 6.8.b. This restriction is not applicable to the process and scope of changes outlined in STC 6.8.a.

6.9. **HRSN Infrastructure Protocol.** The state must submit, for CMS approval, an HRSN Infrastructure Protocol to CMS no later than 90 days after approval of the expenditure authority for HRSN infrastructure expenditures. The protocol must include the state's proposed uses of HRSN infrastructure funds. The state must resubmit the revised protocol as may be required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP for HRSN infrastructure expenditures until CMS approves the protocol. Once the protocol is approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the date of approval of the expenditure authority for HRSN infrastructure. The approved protocol will be appended to the STCs as Attachment F. If the state adds new HRSN services through a demonstration amendment, the state must submit revisions to the Protocol to CMS no later than 90 days after approval, if required based on changes to expenditures for HRSN infrastructure to support the newly added HRSN services. The revisions must include a list of proposed uses of HRSN infrastructure funds, if different than previously submitted. Specifically, the protocol(s) must include the following information: Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

6.10. **Service Delivery.** HRSN services will be delivered through the fee-for-service (FFS) delivery system.

a. HRSN services will be paid on a FFS basis when those HRSN services are provided to beneficiaries through the Medicaid FFS.

b. In accordance with STC 6.1, CMS expects the state to have appropriate claims data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate documentation for claims payment. Therefore, CMS requires that, for HRSN services delivered in a FFS delivery system, the state must clearly document the name and definition of each HRSN service as well as the coding used on claims data. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology codes that identify each HRSN service. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 6.15. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the delivery of HRSN services through FFS.

6.11. **Phased in Implementation of HRSN Services.** As further discussed in the state's Implementation Plan as required in STC 6.19, the state will phase in HRSN service(s) beginning in DY 2, and will phase in regionally based on state-determined readiness criteria.

6.12. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statutes and regulation.

6.13. **Person Centered Plan.** The state shall ensure there is a person-centered service plan for each beneficiary receiving HRSN services that is person-centered, identifies the beneficiary's needs and individualized strategies and interventions for meeting those needs, and developed in consultation with the beneficiary and the beneficiary's chosen support network, as appropriate. The service plan must be reviewed and revised as appropriate at least every 12 months, when the beneficiary's circumstances or needs change significantly, or at the beneficiary's request.

6.14. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in HRSN service planning and delivery, including by ensuring that appropriate separation of service planning and service provision functions is incorporated into the state's conflict of interest policies.

6.15. **HRSN Rate Methodologies.** For FFS payment methodologies and/or rates, the state must comply with the payment rate-setting requirements in 42 CFR Part 447, as though a state plan amendment were required, to establish any payment rate and/or methodology for HRSN services as approved under demonstration expenditure authority 3. The state must conduct state-level public notice under 42 CFR 447.205 prior to the implementation of the applicable FFS payment rates or methodologies for HRSN and maintain documentation of these FFP payment rates or methodologies on its website described in 42 CFR 447.203. The state may receive FFP for HRSN service expenditures authorized under this demonstration upon implementation of the FFS payment rates and/or methodologies for which it has conducted prior public notice and may begin claiming for this FFP (for dates of service no earlier than the effective date of approval for the relevant expenditure authority) no earlier than the date of submission of the payment rates and/or methodology to CMS for approval. However, any FFS payments to providers or claims for FFP prior to CMS approval of the payment rate or methodology must be reconciled to the ultimately approved FFS payment rate and/or methodology within one year of CMS's approval. All requirements for timely filing of claims for FFP continue to apply.

For managed care payments and rates (including capitation rates, non-risk payments, and state directed payments), the state must comply with all federal requirements, including those in 42 CFR Part 438 and these STCs. As applicable, the state must also notify CMS at least 60 days prior to intended implementation if it intends to direct its managed care plans on how to pay for HRSN services (i.e., state directed payments).

All rates/payment methodologies for HRSN services, for both FFS and managed care delivery systems, must be submitted to CMS for review and approval, including but not limited to fee-for-service payments as well as managed care capitation rates, any state directed payments that require prior written approval, and non-risk payments, as outlined in the STCs. For all payment methodologies and/or rates, for both FFS and managed care delivery systems, in addition to submitting the payment rates and/or methodology, the state must also submit all supporting documentation requested by CMS, including but not limited to how the rates and/or methodology were developed, state responses to any public comments on the rates and/or methodology (when applicable), and information about Medicaid non-federal share financing.

6.16. **Maintenance of Effort (MOE**). The state must maintain a baseline level of state funding for ongoing social services related to housing and housing transition supports and nutrition supports for the duration of the demonstration, not including one-time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN Implementation Plan required by STC 6.19 that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 10.5, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

6.17. Partnerships with State and Local Entities. To ensure that expenditures for HRSN services under this demonstration do not supplant any other available funding sources available to the beneficiary through other local, state, or federal programs, the state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authorities) to assist beneficiaries in obtaining non-Medicaid funded housing supports, if available, upon the conclusion of temporary demonstration payment for such supports, in alignment with beneficiary needs identified in the beneficiary's care plan, as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and/or nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 10.5, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

6.18. **Provider Payment Rate Increase.** As a condition of approval of the HRSN services expenditure authority, the state must comply with the provider rate increase requirements in Section 7 of these STCs.

6.19. HRSN Implementation Plan

a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The state must submit the MOE information required by STC 6.16 no later than 90 calendar days after approval of demonstration expenditure authority for HRSN services. All other Implementation Plan requirements outlined in this STC must be submitted no later than 9 months after the approval of demonstration expenditure authority for HRSN services. The Implementation Plan shall be submitted to CMS but does not require CMS approval. CMS will ensure it is complete and contains sufficient detail for purposes of on-going monitoring. The state may update the implementation plan as initiatives are changed or added, with notification to CMS. The Implementation Plan will be appended as Attachment E.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services (Attachment F); however, as applicable, the information provided in the two deliverables must be aligned and consistent.

c. The Implementation Plan must include information on, but not limited to, the following:

    i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services interested parties to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;

    ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

    iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, qualification and consent to receive HRSN services, screening, referrals, and service provision;

    iv. A plan for tracking and improving the share of demonstration beneficiaries in the state who are eligible and enrolled in SNAP, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and/or federal, state, and local housing and/or other nutrition assistance programs, relative to the number of total eligible demonstration beneficiaries in the state (including those who are eligible but unenrolled);

    v. An implementation timeline and considerations for demonstration evaluation that may be impacted by the timeline (e.g., in the case of a phased rollout of HRSN services), to facilitate robust evaluation designs;

    vi. Information as required per STC 6.16 (MOE); and

    vii. Information as required per STC 6.17 (Partnerships with State and Local Entities).

7. PROVIDER RATE REQUIREMENTS

7.1. The provider payment rate increase requirements described hereafter are a condition for the HRSN expenditure authorities, as referenced in expenditure authorities 3 and 4.

7.2. As a condition of approval and ongoing provision of FFP for the HRSN expenditures over this demonstration period of performance, DY 1 through DY 5, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for one of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent. If the state's average Medicaid rates already equal or exceed 80 percent of Medicare in any of these three categories for either FFS or managed care, then the state is not subject to a provider rate increase requirement in that service category and delivery system, but the state must at least sustain rates for such categories at existing levels for the remainder of the demonstration period.

7.3. The state may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

7.4. The state will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

7.5. No later than 90 days of the demonstration effective date, and if the state makes FFS payments, the state must establish and report to CMS the state's average Medicaid to Medicare FFS provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

i. For primary care and obstetric care services in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); AND

ii. For behavioral health services (the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)); OR

b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 7.4.

ii. Medicaid and Medicare data must be from the same year and not older than 2019.

iii. The state's methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

7.6. To establish the state's ratio for each service category identified in STC 7.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 7.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the State pay providers based on state plan fee-for-service payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 7.5(b) using Medicaid managed care provider payment rate and utilization data.

7.7. In determining the ratios required under STC 7.5 and 7.6, the state may not incorporate FFS supplemental payments that the state made or plans through December 31, 2029, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d).

7.8. If the state is required to increase provider payment rates for managed care plans per STC 7.2. and 7.6, the state must:

a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two-percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

7.9. For the entirety of DY 3 through DY 5, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 1, and such rate will be in effect on the first day of DY 3. A required payment rate increase shall apply to all services in a service category as defined under STC 7.4.

7.10. If the state uses a managed care delivery system for any of the service categories defined in STC 7.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 3 through DY 5, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 1 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment increase shall apply to all services in a service category as defined under STC 7.4.

7.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY 3 (or, as applicable, the first day of the first rating period that starts in DY 3), the state will provide an alternative effective date and rationale for CMS review and approval.

7.12. Pennsylvania will provide the information to document the payment rate ratio required under STC 7.5 and 7.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

7.13. For demonstration years following the first year of provider payment rate increases, if any, Pennsylvania will provide an annual attestation within the State's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.

7.14. No later than 90 days following the demonstration effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STCs 7.5 and 7.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment J.

Table 3. Pennsylvania HRSN-Related Provider Payment Increase Assessment – Attestation Table.

The reported data and attestations pertain to HRSN related provider payment increase requirements for the demonstration period of performance DY 1 through DY 5.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 7.5(a) or STC 7.5(b)]	[insert approach, either ratio derived under STC 7.6(a) or STC 7.6(b), insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Obstetric Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 7.5(a) or STC 7.5(b)]	[insert approach, either ratio derived under STC 7.6(a) or STC 7.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and

		Medicare to derive the ratio]
Behavioral Health Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 7.5(a) or STC 7.5(b)]	[insert approach, either ratio derived under STC 7.6(a) or STC 7.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]

In accordance with STCs 7.1 through 7.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in the service category in each delivery system, as applicable to the state's Medicaid or demonstration service delivery model, if for that delivery system the ratio is both the lowest ratio among the three and below 80 percent. Such provider payment increases for each service will be effective beginning on January 1, 2027, and will not be lower than the highest rate for that service code in DY 1 plus a two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least December 30, 2029.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 7.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b. below]

☐a. The effective date of the rate increases is the first day of DY 3 January 1, 2027 and will be at least sustained, if not higher, through DY 5 December 30, 2029.

☐b. Pennsylvania has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of DY 3 January 1, 2027. Pennsylvania will effectuate the rate increases no later than the CMS approved date of January 1, 2027, and will sustain these rates, if not made higher, through DY 5 December 30, 2029.

Pennsylvania *[insert does or does not]* make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the HRSN STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*].

Pennsylvania *[insert does or does not]* include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 7.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than [*insert date*].

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 7.8, I attest that necessary arrangements will be made to assure that 100 percent of the two-percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.

	Pennsylvania further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 7.
	I, *[insert name of SMD or CFO (or equivalent position)] [insert title],* attest that the above information is complete and accurate. [*Provide signature]*_____ *[Provide date]* *[Provide printed name of signatory]*

8. Cost Sharing

8.1. The demonstration will not include cost-sharing for any demonstration services. The demonstration will make no changes to other Health Insurance Premium Payment Program (HIPP) benefits and cost sharing.

9. Delivery System

9.1. The services provided under Keystones of Health will be in addition to the services provided through the Medicaid state plan. All demonstration beneficiaries will continue to receive services through the same delivery system arrangements as currently authorized in the state. Services approved through this demonstration will be delivered through the FFS delivery system.

10. Monitoring and Reporting Requirements

10.1. **Deferral for failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)")) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30-days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection 10.1.b. below; or 2) 30-days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements.

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for any extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process will be provided. CMS may agree to a corrective action plan submitted by the state as an

interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection(b) above, and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditures System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

As the purpose of the Section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any for an extension, amendment, or for a new demonstration.

10.2. **Submission of Post-Approval Deliverables**. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

10.3. **Compliance with Federal Systems Updates**. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new system.

b. Ensure all section 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

10.4. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment K. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the demonstration. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 10.5), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS, as applicable. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography) and demonstration component.

For the HRSN services and the reentry initiative authorized through this demonstration, the Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g., the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e., social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones, as provided in the HRSN Infrastructure Protocol and Implementation Plan.

The state will also be expected to set up its HRSN service delivery system to allow screening of beneficiaries for identified needs, and to develop an appropriate closed-loop referral system or other feedback loop to ensure beneficiaries receive service referrals and provisions, and provide any applicable update on this process via the Monitoring Reports, in alignment with information provided in the Monitoring Protocol.

In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

For the qualitative elements (e.g., operational updates as described in STC 10.5(a) below), CMS will provide the state with guidance on narrative and descriptive information, which will supplement the quantitative metrics on key aspects of the demonstration policies. The

quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

10.5. **Monitoring Reports**. The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/ Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates:** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operation and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by individuals; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics.** Per applicable CMS guidance and technical assistance, the performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration's program and policy implementation and infrastructure investments, and transitional non-service expenditures, as applicable and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on beneficiaries' outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, and grievances and appeals.

Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives populations. Such reporting must also be stratified by key demographic

subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

i. For HRSN components, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations, and the contracted providers of applicable services (e.g., managed care plans and their contracted HRSN providers). In alignment with STC 6.16, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing agencies, leverage their expertise and existing housing resources instead of duplicating services. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

ii. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 5.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

iii. As applicable, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics; these metrics are specifically relevant for the state's HRSN initiatives.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis

c. **Budget Neutrality and Financial reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the general financial requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the form CMS-64. Administrative costs for this demonstration should be reported separately on the form CMS-64.

d. **Evaluation Activities and Interim Findings.** Per CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

10.6. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment by the end of the third year of the demonstration approval, and the state must provide a copy of the report to CMS no later than 60 calendar days after the end of the third year of the demonstration approval.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that

the independent assessor consult with key stakeholders including, but not limited to: providers participating in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

10.7. **Corrective Action Plan Related to Demonstration Monitoring**. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial, sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

10.8. **Close-Out Report**. Within 120-calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 11.7 and 11.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out Report.

d. The state must take into consideration CMS's comments for incorporation in the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30-calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 10.1.

10.9. **Monitoring Call**. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operating, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

10.10. **Post Award Forum**. Pursuant to 42 CFR 431.420(c), within 6-months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30-calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its Annual Monitoring Report.

11. EVALUATION OF THE DEMONSTRATION

11.1. Cooperation with Federal Evaluators and Learning Collaborative: As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and

providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring, and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in Section 10.1.

11.2. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

11.3. **Evaluation Budget**. A budget for the evaluation shall be provided with the Draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design, if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

11.4. **Draft Evaluation Design**. The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval date of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The draft Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs, and any applicable evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STC 17.10 and 17.11.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment components. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the Monitoring Reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

11.5. **Evaluation Design Approval and Updates**. The state must submit a revised draft evaluation design within 60-days after receipt of CMS's comments. Upon CMS approval of the draft evaluation design the document will be included as an attachment to these STCS. Per 42 CFR 431.424(c), the state will publish the approved evaluation design to the state's website within 30-days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the evaluation design in Monitoring Reports.

11.6. **Evaluation Questions and Hypotheses**. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing must include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by NQF.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the

various demonstration policy components, including but not limited to beneficiary experiences with access to and quality of care and the HRSN and reentry demonstration components. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Hypotheses must cover all policies and goals of the demonstration and should be crafted not only to evaluate whether overall demonstration goals were achieved but also the extent to which each component contributed to outcomes. Where demonstration components offer tailored service to specific populations, evaluation hypotheses must include an assessment of whether these programs improved quality of care outcomes and access to health care for the targeted population while also promoting the desired administrative and fiscal efficiencies.

Evaluation hypotheses for the HRSN demonstration components must focus on areas such as assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on prevalence and severity of beneficiaries' HRSNs and the provision of beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care; utilization of and costs associated with potentially avoidable, high-acuity health care; utilization of hospital and institutional care; and beneficiary physical and mental health outcomes.

In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

Hypotheses must be designed to help understand the impact of housing supports and case management activities on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level. As applicable, the state must also include research questions and hypotheses focused on how renewals of recurring nutrition

services affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services.

The evaluation must also assess the effectiveness of the implementation and capacity building infrastructure funding authorized through the demonstration to support the development and implementation of the HRSN initiatives. The evaluation must also assess whether and how local investments in housing supports change over time in concert with new Medicaid funding toward those services. In addition, considering how the demonstration's HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including: utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

As part of its evaluation efforts, the state must conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. The state must analyze the budgetary effects of the HRSN and reentry initiatives. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost

analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

11.7. **Interim Evaluation Reports.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Evaluation Report should be posted to the state's website with the application for public comment.

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted. If the state is not requesting an extension for the demonstration, the draft Interim Evaluation Report is due one year prior to the end of the demonstration.

d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

f. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

11.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

11.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

11.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation reports, and/or the Summative Evaluation Report. Presentations may be conducted remotely.

11.11. **Public Access**. The state shall post the final documents (e.g., Implementation Plans, Monitoring Protocols, Monitoring Reports, Mid-Point Assessments, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

11.12. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of other reports and related publications (including, for example, journal articles), by the state, contractor, or any other third party (an entity which is not the state or contractor) over which the state Medicaid agency has control. Prior to release of these reports, articles and other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

12. GENERAL FINANCIAL REQUIREMENTS

12.1. **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.

12.2. **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.

12.3. **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.

12.4. **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.

12.5. **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.

12.6. **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.

12.7. **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 deliverable is subject to the deferral as described in STC 10.1. 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.

12.8. **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, subject to the budget neutrality expenditure limits described in the STCs in section 13:

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.

12.9. **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.

12.10. 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.

Table 4: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
HRSN Services	SHAC		X	X	All expenditures for certain HRSN initiatives.
HRSN Infrastructure	SHAC		X	X	All infrastructure expenditures for certain HRSN initiatives.
Reentry	Hypo 1	X		X	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.
Reentry Non-Services	Hypo 1		X	X	Expenditures for allowable planning and non-services for the reentry demonstration initiative.

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

12.11. **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-00484/3). 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 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.

12.12. **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.

12.13. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

12.14. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

12.15. **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. Unless indicated otherwise on the MEG Charts and in the STCs in Section 12, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

12.16. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in Section 10.5, the state must report the actual number of "eligible member months" 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. 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.

12.17. **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 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 5: MEG Detail for Expenditure and Member Month 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**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
HRSN Services	Report all expenditures for approved HRSN initiatives		Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service/Date of payment	MAP/ ADM	N	12/26/24	12/31/29
HRSN Infrastructure	Report all infrastructure expenditures for approved HRSN initiatives		Follow standard CMS 64.10 Category of Service Definitions	Date of service/Date of payment	ADM	N	12/26/24	12/31/29
Reentry	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.	None	Follow CMS-64.9 Based Category of Service Definition	Date of service	MAP	Y	12/26/24	12/31/29
Reentry Non-Services	Expenditures for allowable planning and non-services for the reentry demonstration initiative.	None	Follow CMS-64.10 Base Category of Service Definition	Date of payment	ADM	N	12/26/24	12/31/29

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

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

Table 6: Demonstration Years		
Demonstration Year 1	December 26, 2024 to December 31, 2025	12 months
Demonstration Year 2	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 3	January 1, 2027 to December 31, 2027	12 months
Demonstration Year 4	January 1, 2028 to December 31, 2028	12 months
Demonstration Year 5	January 1, 2029 to December 31, 2029	12 months

12.19. **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 12. CMS will provide technical assistance, upon request.[1]

12.20. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made 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.

12.21. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will

[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 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.

reflect the phase out of impermissible provider payments by law or regulation, where applicable.

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

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

12.22. **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.

12.23. **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 12.25. 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 3.7. 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.

12.24. **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:

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

b. 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;

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

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

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

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

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

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

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

b. 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.

13. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

13.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of one or more Hypothetical Budget Neutrality Tests and a Supplemental HRSN Aggregate Ceiling (SHAC) Test, if applicable, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

13.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 4, Master MEG Chart and Table 5, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk

for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

13.3. **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 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 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.

13.4. **Main Budget Neutrality Test.** This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests, including supplemental HRSN aggregate ceiling (SHAC) hypothetical expenditures. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

13.5. **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.

13.6. **Hypothetical Budget Neutrality Test 1: Reentry** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. 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 expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 7: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
Reentry Services	PC	Both	5.7%	$0	$1,168.52	$1,235.13	$1,305.53	$1,379.95
Reentry Non-Services	Agg	Both		$44,768,868	$44,768,868	$44,768,868	$14,922,956	$0

13.7. **Supplemental HRSN Aggregate Ceiling (SHAC) Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 6), CMS considers these expenditures to be "supplemental HRSN aggregate ceiling (SHAC)" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, SHAC expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for SHAC expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent SHAC Budget Neutrality Test, which subjects SHAC expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the SHAC Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the SHAC for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's SHAC spending exceeds the SHAC Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the SHAC.

13.8. **SHAC Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the SHAC Budget Neutrality Test. 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 SHAC 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 expenditures in excess of the limit from the SHAC Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 8: SHAC Budget Neutrality Test

MEG	Agg	WOW Only, WW Only, or Both	DY 1	DY 2	DY 3	DY 4	DY 5
HRSN Services	Agg	Both	$0	$92,620,000	$155,700,000	$149,180,000	$119,420,000
HRSN Infrastructure	Agg	Both	$18,200,000	$31,850,000	$31,850,000	$9,100,000	$0

13.9. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

13.10. **Exceeding Budget Neutrality**. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from December 26, 2024, to December 31, 2029. If at the end of the demonstration approval period the SHAC Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

13.11. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure

limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 9: Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

14. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Due	Deliverable	STC
Administrative		
30 calendar days after demonstration approval	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
Post-Approval Protocols		
120 calendar days after approval date	Reentry Demonstration Initiative Implementation Plan	STC 5.10
6 months after approval date	Reentry Demonstration Initiative Reinvestment Plan	STC 5.11
90 calendar days after approval date	Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for HRSN Services	STC 6.7
90 calendar days after approval date	Maintenance of Effort (MOE) Plan for Baseline Social Services Expenditure	STC 6.16
9 months after approval date	HRSN Implementation Plan	STC 6.19
Monitoring and Evaluation Deliverables		
150 calendar days after approval date	Monitoring Protocol(s)	STC 10.4

180 calendar days after approval date	Evaluation Design	STCs 11.4 and 11.5
One year prior to the expiration of the demonstration	Interim Evaluation Report	STC 11.7
Within 18 months after approval period ends	Summative Evaluation Report	STC 11.8
60 days after the end of the third year of demonstration	Reentry Demonstration Initiative Mid-Point Assessment	STC 10.6
60 calendar days after the end of each quarter except 4th quarter	Quarterly Monitoring Reports	STC 10.5
90 calendar days after end of demonstration year	Annual Monitoring Reports	STC 10.5
Other Deliverables		
90 calendar days after end of each demonstration year	Annual Budget Neutrality Reports	STC 10.5.c
30 calendar days after the end of each quarter	Quarterly Budget Neutrality Reports	STC 10.5.c
If applicable, 120 calendar days after the end of the demonstration	Close-Out Report	STC 10.8

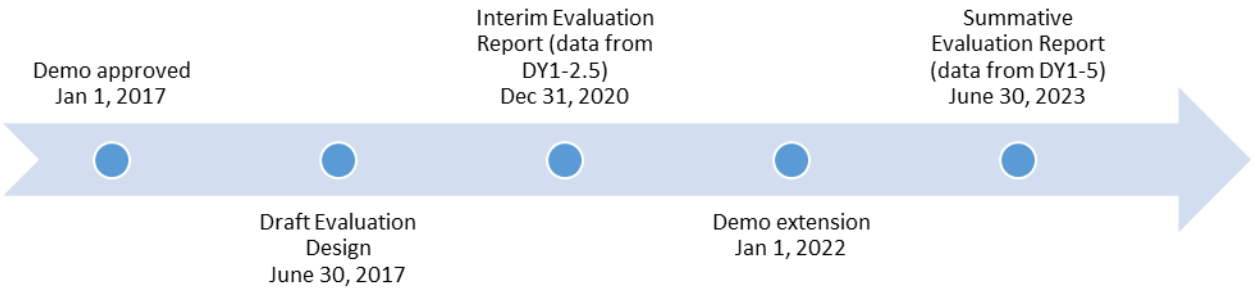
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, the potential magnitude of the issues, and why the state selected this course of action to address the issues (e.g., a narrative on why the state submitted a section 1115 demonstration application).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

3. A description of the population groups impacted by the demonstration.

4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, or expansion of, the demonstration.

5. For extensions, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.

2. Address how the hypotheses and research questions promote the objectives of Titles XIX and XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.

4. Include a Logic Model or Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the goal, the primary drivers that contribute directly to achieving the goal, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

5. Include implementation evaluation questions to inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Implementation evaluation research questions can focus on barriers, facilitators, beneficiary and provider experience with the demonstration, the extent to which demonstration components were implemented as planned, and the extent to which implementation of demonstration components varied by setting.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate. The evaluation approach should also consider principles of equitable evaluations, and involve partners such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in developing an evaluation approach. The state's Request for Proposal for an independent evaluator, for example, could encourage research teams to partner with impacted groups.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre–test or

post–test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Focus and Comparison Populations* – Describe the characteristics of the focus and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.). Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid–Eligible Adults, metrics drawn from the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:

   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t–tests, chi–square, odds ratio, ANOVA, regression).

b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
c. Include a discussion of how propensity score matching and difference–in–differences designs may be used to adjust for differences in comparison populations over time, if applicable.
d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	–Measure 1 –Measure 2 –Measure 3	–Sample e.g. All attributed Medicaid beneficiaries –Beneficiaries with diabetes diagnosis	–Medicaid fee–for–service and encounter claims records	–Interrupted time series
Research question 1b	–Measure 1 –Measure 2 –Measure 3 –Measure 4	–Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	–Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	–Measure 1 –Measure 2	–Sample, e.g., PPS administrators	–Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long–

standing, it may be difficult for the state to include baseline data because any pre–test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non–complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;
    c. No state issues with CMS–64 reporting or budget neutrality; and
    d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation–related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

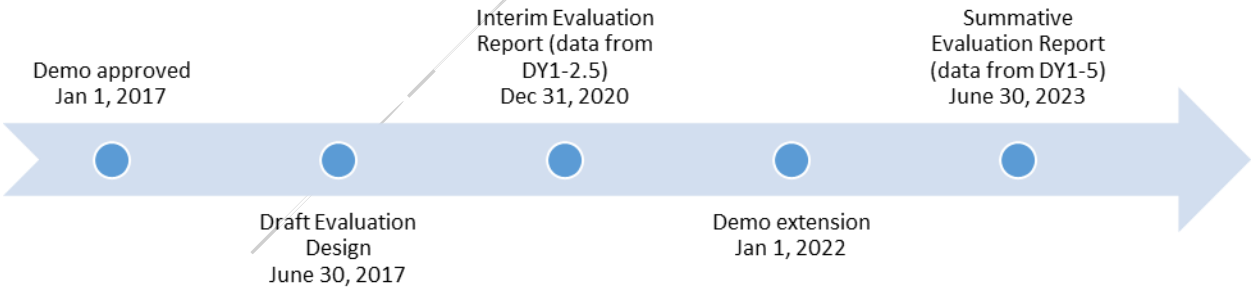
ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already–approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
    1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, how the state became aware of the issues, the potential magnitude of the issues, and why the state selected this course of action to address the issues.
    2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
    3. A description of the population groups impacted by the demonstration.
    4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, or expansion of, the demonstration.
    5. For extensions, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. **Evaluation Questions and Hypotheses** – In this section, the state should:
    1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
    2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
    3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
    4. The inclusion of a Logic Model or Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. **Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

    An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is

appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post–only data, with or without comparison groups, etc.

2. *Focus and Comparison Populations* – Describe the focus and comparison populations, describing inclusion and exclusion criteria.

3. *Evaluation Period* – Describe the time periods for which data will be collected.

4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t–tests, chi–square, odds ratio, ANOVA, regression, etc.).

7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. **Methodological Limitations** – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. If the state did not fully achieve its intended goals, why not?
3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. **Interpretations, Policy Implications and Interactions with Other State Initiatives** – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long–range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels. Interpreting the implications of evaluation findings should include involving partners, such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in which the demonstration was implemented.

I. **Lessons Learned and Recommendations** – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:
    1. What lessons were learned as a result of the demonstration?
    2. What would you recommend to other states which may be interested in implementing a similar approach?

ATTACHMENT C
Reserved for Reentry Demonstration Initiative Implementation Plan

ATTACHMENT D
Reserved for Reentry Demonstration Initiative Reinvestment Plan

ATTACHMENT E
Reserved for HRSN Implementation Plan

ATTACHMENT F
Reserved for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Service Protocol

ATTACHMENT G
HRSN Services Matrix

Pennsylvania 1115 HRSN Services Matrix

Service Category	Service	SMI	SUD	Pregnant or Postpartum	Acute Cancer with Active Chemo-Therapy	High-Risk Pregnancy	Diet-sensitive chronic health condition	High-Risk Chronic health condition	Autism Spectrum Disorder
Housing/Home Environment interventions without room and board	Case management for housing	X	X	X	X	X		X	X
	Housing navigation and tenancy support*	X	X	X	X	X		X	X
	One-time transition and moving costs *other than* rent	X	X	X	X	X		X	X
	Utility assistance	X	X	X	X	X		X	X
Housing interventions with Room and Board (Rent Only Interventions)	First month's rent, as a transitional service	X	X	X	X	X		X	X
	Short-term rental assistance	X	X	X	X	X		X	X
Nutrition interventions with food	Home Delivered meals			X					
	Medically Tailored Meals				X	X	X		

*Includes Housing transition and navigation services, Pre-tenancy navigation services, and Tenancy sustaining services

	Service	Population	Social Risk Factor	Clinical Criteria for the pop
Housing/Home Environment interventions without room and board	Case management for housing	1) SMI 2) SUD 3) Pregnant or Postpartum 4) Acute Cancer with active chemotherapy 5) High-Risk Chronic Health Condition, or 6) Autism Spectrum Disorder	Homeless or At Risk of Homelessness	1) Meets the criteria for the Adult Priority Group for adults with serious mental illness (SMI) set forth in bulletin OMHSAS-19-03, "Serious Mental Illness: Adult Priority Group," issued August 6, 2019 or most current version. 2) Substance use disorders (as defined by the Pennsylvania adopted version of the ASAM Criteria) in addition to a diagnosis identified on the Department approved SUD ICD 10 codes list. 3) Pregnant or up to 12 months after the end of pregnancy. 4) Acute Cancer with active chemotherapy (incarcerated population only) 5) Chronic Health condition with treatment plan (incarcerated population only): • End-stage renal disease with active dialysis • Chronic pulmonary disease requiring oxygen • Type 1 diabetes • Type 2 diabetes requiring at least one injectable insulin/day. 6) Diagnosis of Autism Spectrum Disorder (incarcerated population only)
	Housing navigation and tenancy support*	1) SMI 2) SUD 3) Pregnant or Postpartum 4) Acute Cancer with active chemotherapy 5) High-Risk Chronic Health Condition, or 6) Autism Spectrum Disorder	Homeless or At Risk of Homelessness	1) Meets the criteria for the Adult Priority Group for adults with serious mental illness (SMI) set forth in bulletin OMHSAS-19-03, "Serious Mental Illness: Adult Priority Group," issued August 6, 2019 or most current version. 2) Substance use disorders (as defined by the Pennsylvania adopted version of the ASAM Criteria) in addition to a diagnosis identified on the Department approved SUD ICD 10 codes list. 3) Pregnant or up to 12 months after the end of pregnancy. 4) Acute Cancer with active chemotherapy (incarcerated population only) 5) Chronic Health condition with treatment plan (incarcerated population only): • End-stage renal disease with active dialysis • Chronic pulmonary disease requiring oxygen • Type 1 diabetes • Type 2 diabetes requiring at least one injectable insulin/day. 6) Diagnosis of Autism Spectrum Disorder (incarcerated population only)
	One-time transition and moving costs other than rent	1) SMI 2) SUD 3) Pregnant or Postpartum 4) Acute Cancer with active chemotherapy 5) High-Risk Chronic Health Condition, or 6) Autism Spectrum Disorder	Homeless or At Risk of Homelessness	1) Meets the criteria for the Adult Priority Group for adults with serious mental illness (SMI) set forth in bulletin OMHSAS-19-03, "Serious Mental Illness: Adult Priority Group," issued August 6, 2019 or most current version. 2) Substance use disorders (as defined by the Pennsylvania adopted version of the ASAM Criteria) in addition to a diagnosis identified on the Department approved SUD ICD 10 codes list. 3) Pregnant or up to 12 months after the end of pregnancy. 4) Acute Cancer with active chemotherapy (incarcerated population only) 5) Chronic Health condition with treatment plan (incarcerated population only): • End-stage renal disease with active dialysis • Chronic pulmonary disease requiring oxygen • Type 1 diabetes • Type 2 diabetes requiring at least one injectable insulin/day. 6) Diagnosis of Autism Spectrum Disorder (incarcerated population only)

	Utility assistance	1) SMI 2) SUD 3) Pregnant or Postpartum 4) Acute Cancer with active chemotherapy 5) High-Risk Chronic Health Condition, or 6) Autism Spectrum Disorder	Homeless or At Risk of Homelessness	1) Meets the criteria for the Adult Priority Group for adults with serious mental illness (SMI) set forth in bulletin OMHSAS-19-03, "Serious Mental Illness: Adult Priority Group," issued August 6, 2019 or most current version. 2) Substance use disorders (as defined by the Pennsylvania adopted version of the ASAM Criteria) in addition to a diagnosis identified on the Department approved SUD ICD 10 codes list. 3) Pregnant or up to 12 months after the end of pregnancy. 4) Acute Cancer with active chemotherapy (incarcerated population only) 5) Chronic Health condition with treatment plan (incarcerated population only): • End-stage renal disease with active dialysis • Chronic pulmonary disease requiring oxygen • Type 1 diabetes • Type 2 diabetes requiring at least one injectable insulin/day. 6) Diagnosis of Autism Spectrum Disorder (incarcerated population only)

Pennsylvania 1115 HRSN Services Matrix: Housing

	Service	Population	Social Risk Factor	Clinical Criteria for the pop
Room and Board (Rent Only Interventions)	First month's rent, as a transitional service	1) SMI 2) SUD 3) Pregnant or Postpartum 4) Acute Cancer with active chemotherapy 5) High-Risk Chronic Health Condition, or 6) Autism Spectrum Disorder	Homeless or At Risk of Homelessness	1) Meets the criteria for the Adult Priority Group for adults with serious mental illness (SMI) set forth in bulletin OMHSAS-19-03, "Serious Mental Illness: Adult Priority Group," issued August 6, 2019 or most current version. 2) Substance use disorders (as defined by the Pennsylvania adopted version of the ASAM Criteria) in addition to a diagnosis identified on the Department approved SUD ICD 10 codes list. 3) Pregnant or up to 12 months after the end of pregnancy. 4) Acute Cancer with active chemotherapy (incarcerated population only) 5) Chronic Health condition with treatment plan (incarcerated population only): • End-stage renal disease with active dialysis • Chronic pulmonary disease requiring oxygen • Type 1 diabetes • Type 2 diabetes requiring at least one injectable insulin/day. 6) Diagnosis of Autism Spectrum Disorder (incarcerated population only)
	Short-term rental assistance	1) SMI 2) SUD 3) Pregnant or Postpartum 4) Acute Cancer with active chemotherapy 5) High-Risk Chronic Health Condition, or 6) Autism Spectrum Disorder	Homeless or At Risk of Homelessness	1) Meets the criteria for the Adult Priority Group for adults with serious mental illness (SMI) set forth in bulletin OMHSAS-19-03, "Serious Mental Illness: Adult Priority Group," issued August 6, 2019 or most current version. 2) Substance use disorders (as defined by the Pennsylvania adopted version of the ASAM Criteria) in addition to a diagnosis identified on the Department approved SUD ICD 10 codes list. 3) Pregnant or up to 12 months after the end of pregnancy. 4) Acute Cancer with active chemotherapy (incarcerated population only) 5) Chronic Health condition with treatment plan (incarcerated population only): • End-stage renal disease with active dialysis • Chronic pulmonary disease requiring oxygen • Type 1 diabetes • Type 2 diabetes requiring at least one injectable insulin/day. 6) Diagnosis of Autism Spectrum Disorder (incarcerated population only)

	Service	Population	Social Risk Factor	Clinical Criteria for the pop
Nutrition interventions with food	Home Delivered Meals	1) Pregnant or Postpartum	Meet USDA Definition of Low or Very Low Food Security	1) Pregnant or up to 8 weeks after the end of pregnancy.
	Medically Tailored Meals	1) Acute Cancer with Active Chemotherapy, 2) High-Risk Pregnancy, or 3) Diet-sensitive chronic health condition	Meet USDA Definition of Low or Very Low Food Security	1) Acute Cancer with active chemotherapy 2) Gestational Diabetes 3) At least one inpatient visit with primary, secondary or tertiary diagnosis of: •Congestive Heart Failure; or •End Stage Renal Disease; or •Poorly Controlled Diabetes.

Pennsylvania 1115 HRSN Services Matrix: Clinical Criteria Detail

Clinical Risk Factor	Clinical Criteria Detail
Serious Mental Illness	Meets the criteria for the Adult Priority Group for adults with serious mental illness (SMI) set forth in bulletin OMHSAS-19-03, "Serious Mental Illness: Adult Priority Group," issued August 6, 2019 or most current version.
Substance Use Disorder	Substance use disorders (as defined by The Pennsylvania adopted version of the ASAM Criteria) in addition to a diagnosis identified on the Department approved SUD ICD 10 codes list.
Pregnant or Postpartum	Pregnant or up to 12 months after the end of pregnancy.
Acute Cancer with active chemotherapy	Acute Cancer with active chemotherapy
High-Risk Pregnancy	Gestational Diabetes
Diet-sensitive chronic health condition	At least one hospitalization with diagnosis of: •Congestive Heart Failure; or •End Stage Renal Disease; or •Poorly Controlled Diabetes.
High-Risk Chronic health condition	Chronic Health condition with treatment plan: • End-stage renal disease with active dialysis • Chronic pulmonary disease requiring oxygen • Type 1 diabetes • Type 2 diabetes requiring at least one injectable insulin/day.
Autism Spectrum Disorder	Diagnosis of Autism Spectrum Disorder

Pennsylvania 1115 HRSN Services Matrix: Social Risk Factor Detail

Social Risk Factor	Social Criteria Detail
Low or Very Low Food Security	USDA Defined Low or Very Low Food Security: Low food security: Reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake. Very low food security: reports of multiple indications of disrupted eating patterns and reduced food intake.
Homeless	Derived from paragraph (1) of the definition of homeless in 24 CFR 91.5: Individuals who lack a fixed, regular, and adequate nighttime residence, meaning: • Has a primary nighttime residence that is a public or private place not meant for human habitation, including a car, park, abandoned building, bus or train station, airport, or camping ground; or • Is living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels or motels paid for by charitable organizations or by federal, state, or local government programs); or • Exiting an institution where individual resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
At risk of homelessness	An individual who: -Does not have sufficient resources or support networks (e.g., family, friends, faith-based or other social networks) immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in 24 CFR 91.5; and -Is exiting a correctional facility

ATTACHMENT H
Reentry Demonstration Initiative Services

Covered Service	Definition
Case Management	Every eligible reentry beneficiary will receive case management services within the 90 day pre-release window including evaluation of most recent needs/risk assessment; goal setting to address any identified gaps; providing access or information on resources/programs to close gaps; preparation for care handoff back into community setting with referrals/appointment setting at community providers; provision of education and informational materials to inmate about MA services eligibility and continued enrollment process within home county of release; verification that beneficiary has completed any outstanding medical and psychiatric follow-up appointments with DOC providers prior to release date; verification of comprehensive release packet at release to include pharmaceutical and medical supplies as ordered.
Medication for Addiction Treatment Services	Assessments, counseling, diagnostics, and medications available in the DOC to treat Opioid Use Disorder and Alcohol Use Disorder: Buprenorphine - OUD (oral/injectable): a long-acting synthetic opiate partial agonist which prevents withdrawal, curbs cravings, and blocks the effects of illicit opioids. Methadone - OUD (oral): a long-acting synthetic opiate agonist which prevents withdrawal, curbs cravings, and blocks the effects of illicit opioids. Naltrexone - OUD/Alcoholism (oral/injectable): a long-acting synthetic opiate antagonist which prevents the euphoric effects of opioids and curbs cravings.
30-day Supply of Prescription Medications	Medications: 30 day supply; Scheduled Controlled Medication: 30 day Supply; 340B Program Medications (Human Immunodeficiency Virus, Hepatitis B Virus, Hepatitis C Virus only): Send 90 day supply of medication and for HCV send all remaining doses to complete treatment; Psychotropic Medication: 60 day supply of medication, unless it is a controlled medication then send 30 day supply; no injectables given); MAT: Bridge medications to continue treatment until first community based appointment (No injectables given); PRN Medications: Only distributed if patient specific ordered (no stock meds distributed); OTC Medications: Only if patient specific ordered (no stock meds distributed).

ATTACHMENT I
Reentry Demonstration Initiative Health-Related Criteria

Qualifying Condition	Definition
One or more substance use disorders (SUD)	Individuals who are preparing for release from correctional setting and have a substance use disorders (as defined by The Pennsylvania adopted version of the ASAM Criteria) in addition to a diagnosis identified on the Department approved SUD ICD 10 codes list.
Serious mental illness (SMI)	Individuals who are preparing for release from correctional setting and meets the criteria for the Adult Priority Group for adults with serious mental illness (SMI) set forth in bulletin OMHSAS-19-03, "Serious Mental Illness: Adult Priority Group," issued August 6, 2019 or most current version.
Eligible for Medicaid funded 1915(c) home and community-based services (HCBS) administered by the Office of Long Term Living or Office of Developmental Programs upon release	Individuals who are preparing for release from correctional setting and are found eligible for Pennsylvania's approved Medicaid funded 1915(c) home and community-based services waivers through the approved 1915 (c) assessments identified in OLTL IEB-19-04, IAE-19-04, 07-19-04 and ODP 00-19-04.
One or more chronic health conditions	Individuals who are preparing for release from correctional setting and have a chronic Health condition with treatment plan of: •End-stage renal disease with active dialysis; •Chronic pulmonary disease requiring oxygen; •Type 1 diabetes; •Type 2 diabetes requiring at least one injectable insulin/day; or •Acute cancer with active chemotherapy.
Pregnant or in the 12-month postpartum period	Individuals who are preparing for release from correctional setting and are pregnant or in the 12-month postpartum period
Autism Spectrum Disorder (ASD)	Individuals who are preparing for release from correctional setting and have a diagnosis of Autism Spectrum Disorder.

ATTACHMENT J
Reserved for HRSN-Related Provider Payment Increase Attestation Table

ATTACHMENT K
Reserved for Monitoring Protocol

ATTACHMENT L
Reserved for Evaluation Design