DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

September 25, 2026

Julie Ewing
State Medicaid Director
Division of Integrated Healthcare
Department of Health & Human Services
P.O. Box 143101
Salt Lake City, UT 84114

Dear Director Ewing:

The Centers for Medicare & Medicaid Services (CMS) is approving Utah's application for a section 1115(a) demonstration, titled "Traditional Healing Demonstration" (Project Number 11-W-00513/8), to provide expenditure authority for coverage of traditional health care practices. This approval is effective from October 1, 2026 through September 30, 2031, upon which date, unless renewed or otherwise temporarily extended, all authorities granted to operate this demonstration will expire.

With this approval, Utah will have expenditure authority to provide coverage for traditional health care practices received through Indian Health Service (IHS) facilities, Tribal facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) (here called Tribal facilities), or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act (IHCIA) (here called urban Indian organization facilities). Coverage of these traditional health care practices will be available to Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

This demonstration is expected to promote the objectives of Medicaid by broadening the health coverage that can be furnished by the state to Medicaid beneficiaries who are able to receive services delivered by or through IHS, Tribal, and urban Indian organization facilities. This demonstration coverage is expected to be particularly impactful for American Indian and Alaska Native populations and individuals with physical or behavioral health needs because it is expected to improve their access to coverage of health care. American Indian and Alaska Native traditional health care practices have historically been paid for and delivered by or through IHS, Tribal, or urban Indian organization facilities, but have not until now been covered or paid for by Medicaid. Medicaid payment for these services will promote access to care for American Indian and Alaska Native Medicaid beneficiaries and improve access to services at IHS, Tribal, and urban Indian organization facilities.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached 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 Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures under the demonstration.

Program Integrity

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in title XIX of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of Demonstration

Background

American Indian and Alaska Natives have long recognized the contribution of traditional healers and practitioners are valued for their role in aiding the healing process. There are 575[1] federally recognized Tribes in the United States, each with its own traditional health care practices. Some Tribes, bands, groups, pueblos, rancherias, nations, colonies, or communities, including Alaska Native villages or groups, see traditional health care practices as a fundamental element of health care that can help patients with specific physical and mental ailments.

Compared to the general population, American Indians and Alaska Natives experience higher incidence and prevalence of obesity, diabetes, tobacco addiction, and certain types of cancer.[2,3,4,5] In addition to significant physical health issues, American Indians and Alaska Natives face

[1] https://www.federalregister.gov/documents/2026/01/30/2026-01899/indian-entities-recognized-by-and-eligible-to-receive-services-from-the-united-states-bureau-of

[2] https://minorityhealth.hhs.gov/index%2ephp/obesity-and-american-indiansalaska-natives

[3] https://minorityhealth.hhs.gov/index%2Ephp/diabetes-and-american-indiansalaska-natives

[4] https://minorityhealth.hhs.gov/index%2Ephp/smoking-vaping-and-tobacco-use-and-american-indiansalaska-natives

[5] https://minorityhealth.hhs.gov/index%2Ephp/cancer-and-american-indiansalaska-natives

mental health illnesses, substance use disorders, and suicide rates that impact Tribal communities at rates significantly higher than the general population.[6,7] A number of factors contribute to these persistent burdens, including barriers to quality and timely medical care; geographic isolation; workforce shortages at federally operated and Tribal facilities; and the funding and capacity constraints of the Indian Health Service.[8,9,10] However, several studies have demonstrated that traditional health care practices might help to improve health outcomes across multiple domains. Peer-reviewed research documents improvements in mental health symptoms, including post-traumatic stress, depression, and anxiety, among American Indian and Alaska Native individuals who engage in traditional health care practices alongside conventional care.[11,12] Studies also document reduced substance use, improved treatment retention, and stronger recovery outcomes and quality of life, including with respect to individuals in programs that integrate traditional healing with substance use disorder treatment.[13,14,15] Emerging evidence supports benefits for physical health functioning and chronic disease symptom management as well.[16] Section 1115 demonstrations can therefore further test the effects of providing coverage for traditional health care practices in Medicaid.

The Indian Health Care Improvement Act (IHCIA) (25 U.S.C. 1601 *et seq*.) serves as one of the federal government's statutory authorities for IHS's provision of health care to American Indians and Alaska Natives and is based on the unique government-to-government relationship between the federal government and Indian Tribes. The United States Department of Health and Human Services promotion of traditional health care practices is authorized in the IHCIA at 25 U.S.C. 1680u.[17] Over the years, the provision of traditional health care practices has been supported

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[6]https://www.ihs.gov/newsroom/factsheets/behavioralhealth

[7]https://minorityhealth.hhs.gov/index%2ephp/mental-and-behavioral-health-american-indiansalaska-natives

[8] https://minorityhealth.hhs.gov/american-indianalaska-native-health

[9] https://ncuih.org/wp-content/uploads/Trad-Foods-Model-NCUIH-D514_1F.pdf

[10] Assistant Secretary for Planning and Evaluation (ASPE). (2022). *How increased funding can advance the mission of the Indian Health Service to improve health outcomes for American Indians and Alaska Natives* (Report No. HP-2022-21). https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[11] Beals, J., Novins, D. K., Whitesell, N. R., Spicer, P., Mitchell, C. M., & Manson, S. M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations. *American Journal of Psychiatry, 162*(9), 1723–1732. https://doi.org/10.1176/appi.ajp.162.9.1723

[12] Mehl-Madrona, L. (2009). What traditional Indigenous elders say about cross-cultural mental health training. *Explore: The Journal of Science and Healing, 5*(1), 20–29. https://doi.org/10.1016/j.explore.2008.10.003

[13] Coyhis, D., & Simonelli, R. (2008). The Native American healing experience. *Substance Use & Misuse, 43*(12–13), 1927–1949. https://doi.org/10.1080/10826080802292584

[14] Rowan, M., Poole, N., Shea, B., Gone, J. P., et al. (2014). Cultural interventions to treat addictions in Indigenous populations. *Substance Abuse Treatment, Prevention, and Policy, 9*, Article 34. https://doi.org/10.1186/1747-597X-9-34

[15] Novins, D. K., Beals, J., Moore, L. A., Spicer, P., & Manson, S. M. (2004). Use of biomedical services and traditional healing options among American Indians. *Medical Care, 42*(7), 670–679. https://doi.org/10.1097/01.mlr.0000129902.29132.a6

[16] Hewson, M. G., Hamber, B., & Pretorius, L. (2014). Healing ceremonies and quality of life in Native American communities. *Journal of Alternative and Complementary Medicine, 20*(5), 1–8. https://doi.org/10.1089/acm.2013.0104

[17] 25 U.S.C. 1680u specifically provides that "the Secretary may promote traditional health care practices, consistent with the [IHS] standards for the provision of health care, health promotion, and disease prevention under [title 25, chapter 18 of the U.S. Code]."

primarily through IHS appropriations and Tribal resources, including pilot programs and grant funding. The existence of HCPCS code H0051, which describes traditional healing services, reflects CMS's prior operational recognition of traditional healing as a billable service type and provides existing billing infrastructure for states and facilities implementing Traditional Health Care Practices coverage under demonstration authority.[18] Additionally, Medicaid is the largest source of third-party payment for services billed by IHS and Tribal facilities, accounting for nearly two-thirds of health coverage payments to these facilities.[19] Given the significant role of Medicaid as a payer for services at IHS, Tribal facilities, and urban Indian organization facility services, authorizing Medicaid payment to these facilities for traditional health care practices that address documented physical and behavioral health needs, may increase patient access to culturally appropriate practices and support these facilities' abilities to serve their patients.

As noted above, with this demonstration approval, Utah will have expenditure authority to provide coverage for traditional health care practices received through IHS, Tribal facilities, or urban Indian organization facilities by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.[20] CMS expects that this approval will broaden the health coverage that can be furnished by Utah to these Medicaid beneficiaries. Given the scope of the American Indian and Alaska Native population covered by Medicaid, this approval can play a significant role in enhancing health care for these populations. CMS first approved section 1115 Traditional Health Care Practices demonstrations for Arizona, California, New Mexico, and Oregon in 2024.

Scope of Approval

Traditional health care practices vary widely by Tribe, facility, and geographic area. Under this demonstration, traditional health care practices received through IHS, Tribal or urban Indian organization facilities will be covered when provided to a Medicaid beneficiary who is able to receive services delivered by or through these qualifying providers. Whether a beneficiary is able to receive services from a qualifying provider will be determined by the applicable provider.

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https://uscode.house.gov/view.xhtml?req=(title:25%20section:1680u%20edition:prelim)%20OR%20(granuleid:USC-prelim-title25-section1680u)&f=treesort&edition=prelim&num=0&jumpTo=true.

[18] American Academy of Professional Coders. (n.d.). *HCPCS code H0051: Traditional healing services*. AAPC. https://www.aapc.com/codes/hcpcs-codes/H0051

[19] Assistant Secretary of Planning and Evaluation (ASPE), *How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives*, Report No. HP-2022-21, (Washington, DC, 2022), https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[20] Whether a beneficiary is able to receive services from a qualifying facility will be determined by the applicable facility. Under IHS authorities, IHS and Tribal facilities serve Medicaid and CHIP beneficiaries who are able (authorized) to receive services from the facility under IHS regulations at 42 CFR part 136, and also may serve other Medicaid and CHIP beneficiaries under 25 U.S.C. 1680c. Under IHS authorities, urban Indian organization facilities that receive funding from IHS are authorized to use the IHS funding to serve urban Indians (as defined in 25 U.S.C. 1603(28)), residing in the urban centers (as defined in 25 U.S.C. 1603(27)) in which such organizations are situated, including Medicaid and CHIP beneficiaries who also meet those definitions. Urban Indian organization facilities may also serve other Medicaid and CHIP beneficiaries with non-IHS funds, such as those that are dual funded by IHS and the Health Resources & Services Administration's Health Center Program. https://www.hrsa.gov/about/organization/offices/hrsa-iea/tribal-affairs/tribal-urban-indian-health-centers (including, for example, the urban Indian organization Native American Rehabilitation Association).

Purchased/referred care under 25 U.S.C. 1603(5) and 42 CFR 136.21(e) is included in this coverage. To be covered, the traditional health care practices must be provided by practitioners or providers who are employed by or contracted with one of these facilities (which could include an urban Indian organization contracted with an IHS or Tribal facility), in order to ensure that the practices are provided by qualified practitioners at facilities that are enrolled in Medicaid. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to the state, upon request. Each qualifying facility is responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices: 1) is qualified to provide traditional health care practices to the qualifying facility's patients; and 2) has the necessary experience and appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request.

Because some of the traditional health care practices covered under this demonstration may be considered religious or may contain elements of religious or spiritual practices, the state must attest, as a condition of receiving federal matching funds for its expenditures under this approval, to: 1) providing adequate access to secular alternatives, including but not limited to preventive services, primary care, pharmacy services, mental health and substance use disorder services, as approved in its state plan, 1115 demonstration(s), or 1915 waiver(s), and in compliance with federal laws and regulations; 2) for any condition(s) addressed by and through covered traditional health care practices, ensuring beneficiaries have a genuine, independent choice to use other Medicaid-covered services; and 3) ensuring that traditional health care practices may not be used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered under the state plan, 1115 demonstration(s), or 1915 waiver(s) and that the state will not deny access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. Provided that all other applicable requirements for claiming Federal financial participation (FFP) have been met, the state may begin claiming FFP for its expenditures on traditional health care practices only after submitting this attestation to CMS. The state must notify beneficiaries of their rights to file grievances, complaints, and appeals related to this attestation and take any needed actions or monitoring, consistent with federal laws and regulations regarding grievances, complaints, and appeals. As per the STCs, the state must report any such grievances, complaints, and appeals to CMS in Monitoring Reports. CMS will review all reports and will follow up on credible concerns in those reports, as well as any credible concerns raised by members of the public. If the state is found to be out of compliance with the attestation and related STCs, CMS may: 1) require the state to submit a corrective action plan, 2) issue a deferral, or 3) withdraw authority for traditional health care practices.

Consistent with CMS's longstanding interpretation of section 1905(b) of the Act, the state will receive a 100 percent federal medical assistance percentage (FMAP) for its expenditures on the services for which coverage is authorized under this approval when those services are received

through IHS or Tribal facilities by Medicaid beneficiaries who are American Indians or Alaska Natives.[21] State expenditures for these services when delivered to Medicaid beneficiaries by or through urban Indian organization facilities, and state expenditures for these services when delivered by or through qualifying facilities to Medicaid beneficiaries who are not American Indians or Alaska Natives will be federally matched at the otherwise applicable state service match. Utah is approved to cover traditional health care practices for any Medicaid beneficiary who is able to receive services delivered by or through IHS, Tribal facilities, or urban Indian organization facilities. Implementation of the demonstration will be subject to the approval of the state legislature if the state is required to secure non-federal share for the expenditures authorized by this approval.

As discussed in State Health Official letter #16-002[22], IHS facilities and facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act "may enter into care coordination agreements with [non-IHS or Tribal] providers to furnish certain services for their patients who are [American Indian and Alaska Native] Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching…of 100 percent."[23]

Budget Neutrality

This demonstration project is being approved using CMS's current approach to determining budget neutrality as described in CMS SMDL #24-003.[24] However, CMS acknowledges that section 71118 of subchapter C of chapter 1 of subtitle B of title VII of Public Law 119-21, which CMS refers to as the Working Families Tax Cuts (WFTC) legislation adds a new subsection (g) to section 1115 of the Act with budget neutrality requirements that will apply beginning January 1, 2027 to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments. [25] CMS issued SMDL #26-003[26] on June 11, 2026 to provide states with early notice regarding the changes to budget neutrality that CMS intends to propose to implement subsection 1115(g) of the Act, and expects to provide additional guidance to states on implementation of this provision.

Under SMDL #2-003, as a condition of demonstration approval, demonstrations must 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. [27] The demonstration approval is projected to be budget neutral to the federal government. 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

[21] Section 1905(b) of the Social Security Act (third sentence). Under CMS's longstanding interpretation of this statutory language, the 100 percent FMAP applies only when services are received through IHS and Tribal facilities by American Indian or Alaska Native Medicaid beneficiaries.
[22] https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf
[23] ibid
[24] https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf
[25] https://www.congress.gov/bill/119th-congress/house-bill/1/text
[26] https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf
[27] https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

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 general financial requirements as outlined in the STCs.

As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to-government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authority. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid payment rate for most of these services will be the IHS All-Inclusive Rate that is published annually in the Federal Register.[28] CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral under existing budget neutrality requirements and will not require a specific budget neutrality expenditure limit. The state will be held to the general monitoring and reporting requirements, as per the STCs. Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in a budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.7.

Monitoring and Evaluation

The state must conduct systematic monitoring and robust evaluation of the demonstration in accordance with the STCs. This includes the submission of Annual Monitoring Reports that contain relevant metrics as well as narrative descriptions of progress across demonstration components. The state must also submit an Evaluation Design for CMS approval to guide Interim and Summative Evaluation Reports assessing whether demonstration initiatives are effective in achieving their intended outcomes for beneficiaries and the state's overall Medicaid program. Evaluation activities must meet STC requirements and examine beneficiary awareness and understanding of traditional health care practices; access to, utilization and cost of traditional health care practices; quality and experience of care; and physical and behavioral health outcomes.

Consideration of Public Comments

CMS posted the application on Medicaid.gov for a 30-day federal public comment period from December 3, 2024 through January 1, 2025. CMS received two comments. Both commenters were supportive of the Traditional Healing Demonstration and believe it will support health outcomes for AI/AN patients cross Utah. One commentor strongly supports language in Utah's waiver request that establishes the authority of Qualifying Entities to define what constitutes as

[28] See https://www.ihs.gov/businessoffice/reimbursement-rates/.

traditional healing services and identify what traditional healing providers are qualified to be reimbursed under this waiver. The other recommends Utah consider the unique needs of pregnant and parenting individuals and those seeking reproductive health care.

After carefully reviewing the demonstration proposal and public comments received during the federal comment period, CMS has concluded that approving the Traditional Healing Demonstration is likely to promote the objectives of Medicaid.

Other Information

CMS's approval of this new demonstration is conditioned upon compliance with the enclosed set of expenditure authorities, and 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 within 30 days of the date of this approval letter.

Your project officer for this demonstration is Julia Buschmann. She is available to answer any questions concerning this approval, and her 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, MD 21244-1850
Email: Julia.Buschmann@cms.hhs.gov

We appreciate your state's commitment to improving the health of people in Utah, and we look forward to partnering with you on the Utah Traditional Healing section 1115(a) demonstration. If you have questions regarding this approval, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,

[redacted]

Dr. Mehmet Oz

Enclosures

Cc: Tyler Deines, State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00513/8

TITLE: Traditional Healing Demonstration

AWARDEE: Utah Department of Health & Human Services

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Utah for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from October 1, 2026 through September 30, 2031, unless otherwise specified, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities, except those specified below as not applicable to these expenditure authorities.

The following expenditure authorities and the provisions specified as "not applicable" may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Utah to operate the above-identified section 1115(a) demonstration.

1. **Traditional Health Care Practices.** Expenditures for traditional health care practices received through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act, by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

Title XIX requirements not applicable to these demonstration expenditures.
All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly identified as not applicable to these expenditure authorities shall apply to the demonstration for the remaining period of this demonstration.

1. **Comparability; Freedom of Choice** **Section 1902(a)(23)**
Section 1902(a)(10)(B)

To the extent necessary to allow the state to offer the coverage described in Expenditure Authority #1 only if the covered traditional health care practices are received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act, by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00513/8

TITLE: Traditional Healing Demonstration

AWARDEE: Utah Department of Health & Human Services

1. PREFACE

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

The STCs related to the programs for those populations affected by the demonstration are effective from October 1, 2026 through September 30, 2031, 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	Evaluation Design [Reserved]

2. PROGRAM DESCRIPTION AND OBJECTIVES

On September 23, 2026, CMS approved a demonstration to provide expenditure authority for coverage of traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by Urban Indian Organizations under Title V of the Indian Health Care Improvement Act by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

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

- Increase access to traditional health care practices for Medicaid beneficiaries;
- Increase beneficiary awareness and understanding of traditional health care practices as covered Medicaid services;
- Improve behavioral health outcomes, including mental health and substance use disorder outcomes and treatment retention, among Medicaid beneficiaries receiving traditional health care practices;
- Improve physical health outcomes, including physical health functioning and chronic disease symptom management for conditions such as diabetes and cardiovascular disease, among Medicaid beneficiaries receiving traditional health care practices; and
- Improve quality and experience of care among Medicaid beneficiaries receiving traditional health care practices.

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 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 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; and

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 monitoring 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 advance notice requirements and fair hearing rights described at 42 CFR 431, Subpart E. 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 and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. **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, managed care organizations (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, there is no change to Medicaid eligibility and the standards and methodologies for eligibility remain set forth under the state plan and the populations in the Utah Medicaid Reform 1115 Demonstration.

5. TRADITIONAL HEALTH CARE PRACTICES

5.1. **Traditional Health Care Practices Program Overview.** This component of the demonstration will provide federal financial participation (FFP) for state expenditures on traditional health care practices received through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) (here called Tribal facilities), and facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act (IHCIA) (here called urban Indian organization or UIO facilities) by Medicaid beneficiaries who are able to receive services by or through those facilities. Because some of the traditional health care practices covered under this demonstration may be considered religious or may contain elements of religious or spiritual practices, the state must attest, as a condition of receiving federal matching funds for its expenditures under Expenditure Authority #1, to: 1) providing adequate access to secular alternatives, including but not limited to preventive services, primary care, pharmacy services, mental health and substance use disorder services, as approved in its

state plan, 1115 demonstration(s), or 1915 waiver(s), and in compliance with federal laws and regulations; 2) for any condition(s) addressed by and through covered traditional health care practices, ensuring beneficiaries have a genuine, independent choice to use other Medicaid services; and 3) ensuring that traditional health care practices may not be used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered under the state plan, 1115 demonstration(s), or 1915 waiver(s) and that the state will not deny access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. Provided that all other applicable requirements for claiming FFP have been met, the state may begin claiming FFP for its expenditures on traditional health care practices only after submitting this attestation to CMS. The state must notify beneficiaries of their rights to file grievances, complaints, and appeals related to this attestation and take any needed actions or monitoring, consistent with federal laws and regulations regarding grievances, complaints, and appeals. As per STC 8.5 (b) the state must report any such grievances, complaints, and appeals to CMS in Monitoring Reports. CMS will review all reports and will follow up on credible concerns in those reports, as well as any credible concerns raised by members of the public. If the state is found to be out of compliance with the attestation and related STCs, CMS may: 1) require the state to submit a corrective action plan, 2) issue a deferral, or 3) withdraw authority for traditional health care practices.

5.2. **Criteria for Receiving Coverage for Traditional Health Care Practices.** To receive coverage for traditional health care practices under this component of the demonstration, a beneficiary must meet the following criteria:

a. Is a Medicaid beneficiary, and

b. Is able to receive services delivered by or through IHS, Tribal or UIO facilities, as determined by the facility.[1]

5.3. **Scope of Traditional Health Care Practices.** The state may claim FFP for its expenditures on any traditional health care practice that is delivered by or through an IHS, Tribal, or UIO facility to a beneficiary meeting the criteria in STC 5.2.

a. The state will be required to report traditional health care practices provided and utilization in the Annual Monitoring Report.

b. Consistent with CMS's longstanding interpretation of section 1905(b) of the Act, the state will receive a 100 percent federal medical assistance percentage (FMAP) for its expenditures on the services for which coverage is authorized under Medicaid

[1] Under IHS authorities, IHS and Tribal facilities serve Medicaid beneficiaries who are eligible to receive services from the facility under IHS regulations at 42 CFR part 136, and also may serve other Medicaid beneficiaries under 25 U.S.C. 1680c. Under IHS authorities, UIO facilities that receive funding from IHS are authorized to use the IHS funding to serve urban Indians (as defined in 25 U.S.C. 1603(28)), residing in the urban centers (as defined in 25 U.S.C. 1603(27)) in which such organizations are situated, including Medicaid beneficiaries who also meet those definitions. UIO facilities may also serve other Medicaid beneficiaries with non-IHS funds.

Expenditure Authority #1 when those services are received through IHS and Tribal facilities by Medicaid beneficiaries who are American Indians or Alaska Natives.[2] State expenditures for these services when delivered to Medicaid beneficiaries by UIO facilities, and state expenditures on these services when provided by or through qualifying facilities to Medicaid beneficiaries who are not American Indians or Alaska Natives will be federally matched at the otherwise applicable state service match.

c. Excluded items, services, and activities that are not covered as part of the scope of traditional health care practices include, but are not limited to:

   i. Construction costs (including building modification and building rehabilitation);

   ii. Room and board;

   iii. Costs for services in prisons or correctional facilities, or services for people who are civilly committed and unable to leave an institutional setting;

   iv. Services that cannot be federally matched under section 1903(v) of the Act;

   v. Capital investments; and

   vi. Research grants and expenditures not related to monitoring and evaluation.

5.4. **Participating Facilities.** Traditional health care practices are covered only when received through IHS, Tribal, or UIO facilities.

5.5. **Participating Providers.** Practitioners or providers of traditional health care practices must be employed by or contracted with IHS, Tribal, or UIO facilities, which could include an urban Indian organization contracted with an IHS or Tribal facility. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to the state, upon request. Each qualifying facility is responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices 1) is qualified to provide traditional health care practices to the qualifying facility's patients; and 2) has the necessary experience and appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request.

5.6. **Payment Methodology.** The state must comply with the payment rate-setting requirements in 42 CFR Part 447, Subpart B, as though a state plan amendment were

[2] Section 1905(b) of the Social Security Act (third sentence).

required, to establish a payment rate or methodology for traditional health care practices as approved through demonstration expenditure authority traditional health care practices Expenditure Authority #1. The state must conduct state-level public notice under 42 CFR 447.205 prior to using the applicable payment methodologies to pay for traditional health care practices and must maintain documentation of the payment methodologies on its website described in 42 CFR 447.203. The state is encouraged to engage with CMS on the development of all new and modified fee-for-service or non-risk rate contract payment methodologies if the state is not using the IHS All-Inclusive Rate (AIR)[3] when paying for traditional health care practices. Provided that all other requirements for claiming FFP have been met, (including submission of the attestation described in STC 5.1), the state may draw FFP for traditional health care practices after using the payment methodologies to pay providers (and can use them to pay providers only subsequent to conducting notice under 42 CFR 447.205, as described above).

6. COST SHARING

6.1 Cost Sharing. Cost sharing imposed upon individuals receiving services under the demonstration is consistent with the provisions of the approved state plan.

7. DELIVERY SYSTEM

7.1. **Delivery System.** The services provided under the Traditional Healing Demonstration will be reimbursed through fee for service.

8. MONITORING AND REPORTING REQUIREMENTS

8.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (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 calendar 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 (b) below; or 2) 30 calendar 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:

[3] See https://www.ihs.gov/businessoffice/reimbursement-rates/.

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

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), 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) that meet the 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 Expenditure 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 for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a 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 application for an extension, amendment, or for a new demonstration.

8.2. **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.

8.3. **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 systems;
b. Ensure all section 1115 demonstration, 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.

8.4. **Monitoring Reports.** The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar

days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report 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 Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and must be provided in a structured manner that supports federal tracking and analysis

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

b. Performance Metrics. The performance metrics will provide data to demonstrate the state's progress towards meeting the demonstration's goals and any applicable milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

   The state and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

In addition, the state is expected to report monitoring metrics for the following demonstration initiative, as described below and per applicable CMS guidance:

The state's selection and reporting of metrics for traditional health care practices are expected to include, but not be limited to: the number of facilities providing traditional health care practices under the demonstration, the number of traditional health care practices provided under the demonstration, and the number of individuals receiving traditional health care practices under the demonstration. The Annual Monitoring Report must also include beneficiary grievances, complaints, and appeals related to the attestation described in STC 5.1.

The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population.

c. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Annual Monitoring Report 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.

8.5. **Corrective Action Plan Related to 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 state 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 might withdraw an authority, as described in STC 3.10, if metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals and desired directionality, and the state has not implemented corrective action, and the circumstances described in STC 3.10, are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

8.6. **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 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 or Summative Evaluation Reports stipulated in STCs 9.7 and 9.8, 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 into 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 8.1.

8.7. **Monitoring Calls.** CMS will convene, no less frequently than quarterly, monitoring calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, 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, eligibility and access, and progress on evaluation activities.

b. These calls will follow the structure of and focus on the topics in the Annual Monitoring Report.

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

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

8.8. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six 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 announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

9. EVALUATION OF THE DEMONSTRATION

9.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall 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 shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f). 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 STC 8.1.

9.2. **Independent Evaluator.** The state must use an independent entity (herein referred to as the Independent Evaluator) 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 Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance 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.

9.3. **Evaluation Design.** The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with these STCs and any applicable CMS 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.

The state is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 9.7 and 9.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. 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. The amendment components of the Evaluation Design must also be reflected

in the state's Interim and Summative Evaluation Reports, described below.

9.4. **Evaluation Design Approval and Updates.** The state must submit a revised Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the Evaluation Design, the document will be posted to Medicaid.gov. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the state wishes to make changes and the changes are substantial in scope, the state must submit a revised Evaluation Design to CMS for approval; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in an Annual Monitoring Report.

9.5. **Evaluation Questions and Hypotheses.** Consistent with the STCs and applicable CMS guidance, 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 of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum (NQF).

The state must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. Specifically:

Evaluation of the traditional health care practices demonstration initiative must be designed to examine whether the initiative increases access to traditional health care practices for beneficiaries served by or through IHS, Tribal, or UIO facilities. In evaluating the effectiveness of the initiative, the state must capture the perspectives of IHS, Tribal, and UIO facilities through qualitative data collection efforts. The state is also strongly encouraged to consult with IHS, Tribal, and UIO facilities, participating providers, and beneficiaries in the development of the evaluation design. The evaluation must address topics that include but are not limited to: beneficiary awareness and understanding of traditional health care practices; reasons for individuals receiving the

traditional health care practices; access to, utilization and costs of traditional health care practices; quality and experience of care; and physical and behavioral health outcomes.

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. 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.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care. 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—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. 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.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, as well as help inform how the demonstration's various policies support improving outcomes

9.6. **Evaluation Budget.** A budget for the evaluations must be provided with the 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 evaluations 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 or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

9.7. **Interim Evaluation Report.** 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). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

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 component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of

the expiration/phase-out, 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, or one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment. If the state does not request an extension for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised 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.

9.8. **Summative Evaluation Report.** The state must submit the 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 alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

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

9.9. **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.

9.10. **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 Report, or the Summative Evaluation Report.

9.11. **Public Access.** The state shall post the final documents (e.g., Annual Monitoring Report, Close-Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

9.12. **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 these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or 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.

10. GENERAL FINANCIAL REQUIREMENTS

10.1. **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.

10.2. **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) 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.

10.3. **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.

10.4. **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.

10.5. **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.

10.6. **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 8.1. 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.

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

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

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

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

10.8. **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.

10.9. **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.

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

Table 1: Demonstration Years

Demonstration Year 1	October 1, 2026, to September 30, 2027	12 months
Demonstration Year 2	October 1, 2027, to September 30, 2028	12 months
Demonstration Year 3	October 1, 2028, to September 30, 2029	12 months
Demonstration Year 4	October 1, 2029, to September 30, 2030	12 months
Demonstration Year 5	October 1, 2030, to September 30, 2031	12 months

11. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

11.1. **Monitoring Budget Neutrality for Traditional Health Care Practices.** As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to-government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authorities. This expenditure authority is not likely to increase overall expenditures beyond what those expenditures could have been without the demonstration. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid payment rate for most of these services will be the IHS AIR. CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral and will not require a specific budget neutrality expenditure limit. The state will be held to the general monitoring and reporting requirements, as per the STCs. Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in a budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.7. The state must still report quarterly claims and report expenditures on the CMS 64.9 form.

12. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 3: Schedule of Deliverables for the Demonstration Period

Deliverable	Timeline	STC Reference
Evaluation Design	No later than 180 calendar days after approval of the demonstration. Revised no later than 60 days after receipt of CMS comments.	STCs #9.3 and #9.4
Interim Evaluation Report	One year prior to the end of the demonstration period, or when the extension application is submitted, whichever is sooner. Revised no later than 60 calendar days after receipt of CMS comments.	STC #9.7
Summative Evaluation Report	No later than 18 months after the end of the demonstration period. Revised no later than 60 calendar days after receipt of CMS comments.	STC #9.8
Annual Monitoring Report	No later than 180 calendar days after the end of each demonstration year.	STC #8.4

Attachment A
Evaluation Design