

July 31, 2026

Steve Ford
Medicaid Director
Virginia Department of Medical Assistance Services
600 E Broad St
Richmond, VA 23219

Dear Director Ford,

The Centers for Medicare & Medicaid Services (CMS) is approving the Commonwealth of Virginia's request to renew its Medicaid section 1115(a) demonstration entitled, "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" (BTCSSHV) (Project Number 11-W-00297/3), in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective August 1, 2026 through December 31, 2031 upon which date, unless renewed or otherwise amended, all authorities granted to operate this demonstration will expire.

CMS has determined that the Building and Transforming Coverage, Services, and Supports for a Healthier Virginia (BTCSSHV) section 1115(a) demonstration is likely to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality, clinically appropriate treatment to beneficiaries with a substance use disorder (SUD) and/or serious mental illness (SMI) while they are short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD). This approval is in alignment with both State Medicaid Director Letter #17-003 RE: Strategies to Address the Opioid Epidemic¹ and SMDL #18-011: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance² and will continue the SUD authority from the 2019 demonstration approval.

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

Program Integrity

¹ SMDL #17-003: <https://www.medicare.gov/federal-policy-guidance/downloads/smdl17003.pdf>

² SMDL #18-011: <https://www.medicare.gov/sites/default/files/federal-policy-guidance/downloads/smdl18011.pdf>

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 Social Security 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 Renewal and Amendment

With this renewal approval, under the demonstration, Virginia will continue to provide authority for SUD treatment services to individuals who are short-term residents in residential treatment facilities that meet the definition of an IMD and extend eligibility for Medicaid benefits for out of state former foster care youth (FFCY) who are under age 26, who turned age 18 on or before December 31, 2022, who aged out of foster care under the responsibility of another state or tribe and were enrolled in Medicaid while in foster care, currently reside in Virginia, and are not otherwise eligible for Medicaid. Section 1002(a) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, Pub L. No. 115-271), created a new Former Foster Care Children (FFCC) Medicaid state plan eligibility group, providing coverage for individuals who were receiving Medicaid while in foster care under the responsibility of any state; however, the new requirements apply exclusively to those who turn 18 on or after January 1, 2023. As a result, Virginia will still need section 1115 demonstration authority to continue coverage for individuals who turned 18 years old before January 1, 2023. Additionally, this approval will sunset the expenditure authority for the High Needs Supports component of the demonstration that was not implemented.

This approval will amend the demonstration to add the SMI demonstration initiative, to allow Virginia to receive federal financial participation (FFP) for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment facilities that qualify as IMDs. The SMI component of the amendment will expand the settings which are eligible for reimbursement for clinically appropriate short term stays for acute

psychiatric care via psychiatric inpatient treatment and residential crisis stabilization, to include IMDs. Beneficiaries served in IMDs will have access to a full set of Medicaid benefits and will be subject to the same medical necessity requirements. Virginia would not reimburse for stays of more than 60 consecutive days and will maintain an average length of stay of 30 days or less across all applicable settings for eligible members.

All Virginia Medicaid beneficiaries eligible for a mandatory or optional eligibility group receiving full Medicaid coverage, and between the ages of 21-64, will be eligible for acute inpatient stays in an IMD.

Budget Neutrality

This demonstration project is being renewed and amended using CMS’s current approach to determining budget neutrality as described in CMS SMDL #24-003.³ 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 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.⁴ CMS issued state Medicaid Director Letter #26-003⁵ on June 11, 2026 to provide states with early notice regarding the changes to budget neutrality that CMS intends to propose to implement section 1115(g) of the Act, and expects to provide additional guidance to states on implementation of this provision.

Under SMDL #24-003, 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.⁶ The demonstration renewal 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 certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the “without waiver” [WOW] costs). The state will be held to the budget neutrality monitoring and general financial requirements as outlined in the STCs.

Rebasing Without Waiver Baselines

Under this demonstration, for existing Medicaid Expenditure Groups (MEGs) that were implemented, CMS calculated the WOW baseline by using a weighted average of the state’s historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs. The projected demonstration expenditures associated with each MEG in the WOW baseline (except MEGs with aggregate cost limits) have been trended forward using the President’s Budget trend rate to determine the maximum expenditure authority for the new approval period.

³ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf>

⁴ <https://www.congress.gov/bill/119th-congress/house-bill/1/text>

⁵ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf>

⁶ <https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html>

Using the President’s Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Hypothetical Budget Neutrality Treatment

Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as “hypothetical” for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality “supplemental test” for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state’s “with waiver” (WW) hypothetical spending exceeds the supplemental test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS.

The SMI MEG will be treated as hypothetical for budget neutrality purposes. For each of these MEGs, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each of these MEGs in the WOW baseline have been trended forward using the President’s Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President’s Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

CMS has deemed this renewal of the FFCY demonstration to be budget neutral because the demonstration authority to cover the FFCY population is needed for only a temporary period, through 2030, when all FFCY will be covered via the Medicaid state plan FFCC population. Further, through monitoring budget neutrality, CMS determined that the actual experience of states’ covering out-of-state FFCY resulted in limited total expenditures and low enrollment within the demonstrations. CMS generally believes that this FFCY demonstration coverage poses minimal financial risk to the federal government since FFCY demonstration spending is miniscule across states. This decision will increase the administrative ease of maintaining FFCY demonstration coverage in Virginia.

The state will be required to report total expenditures and member months in its demonstration monitoring reports. The state must still report quarterly claims and report expenditures on the CMS 64.9 WAIVER form. Failure to report FFCY expenditures and member months will result in reinstatement of the budget neutrality requirement.

Mid-Course Correction

CMS has included a mid-course correction STC in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies a list

of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment.

Monitoring and Evaluation

Consistent with the demonstration STCs, the state submitted the Interim Evaluation Report for the prior demonstration approval period with the renewal application.⁷ The report evaluated demonstration performance from January 2020 through December 2022⁸ but also included data from the initial demonstration approval period (January 2015 through December 2019) to provide context for demonstration performance in the subsequent approval period against the backdrop of events like the COVID-19 Public Health Emergency and Medicaid expansion. Findings in this report are in support of several demonstration goals and corresponding hypotheses, particularly those associated with increases in access to and utilization of SUD services. For example, the percentage of members with opioid use disorders who received medication for opioid use disorder treatment increased from 43 percent in 2016 to 78 percent in 2022. Additionally, the number of Medicaid members using any addiction and recovery treatment service (ARTS) per 100,000 members increased from 864 in 2017 to 2,911 in 2022. The Interim Evaluation Report also identified opportunities for improvement, for example, in SUD related emergency department visits and inpatient admissions. However, monitoring data through the end of 2024 showed steady decreases in SUD related emergency department visits relative to 2022. Monitoring data from 2023 and 2024 also suggests continued trends of increased access to and utilization of SUD services. For the FFCY policy in the demonstration, the demonstration findings suggest progress toward the demonstration goal that beneficiaries are able to maintain Medicaid coverage and utilize services.

With this renewal of the demonstration, which newly authorizes the SMI program as well, the state is required to continue conducting systematic monitoring and evaluation of the demonstration, consistent with the requirements in the STCs and applicable CMS guidance. In collaboration with CMS, the state must undertake demonstration monitoring, including reporting of relevant metrics data and narrative details describing progress with implementation of all components of the demonstration. The state must conduct an independent mid-point assessment of the SUD and SMI programs, which will help identify any necessary mitigation strategies to ensure ongoing progress toward the SUD and SMI program milestones and goals. Additionally, the state is required to conduct an evaluation of the demonstration to support a comprehensive assessment of whether the demonstration components are effective in producing the desired

⁷ The Interim Evaluation Report is available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/va-gov-access-plan-gap-sud-interim-evaltn-rpt-06122025.pdf>.

⁸ The draft Interim Evaluation Report was first submitted to CMS on January 23, 2024, and due to the state's claims lag and the necessary time to conduct the evaluation, included data through the end of 2022.

outcomes for its beneficiaries. To support the evaluation, the state is required to develop a robust Evaluation Design, including reframing and refocusing as needed the evaluation hypotheses and research questions for policies being extended to account for areas it can reasonably expect continued improvements.

Consideration of Public Comments

The federal comment period for the BTCSSHV demonstration renewal application was open from August 5, 2024, through September 4, 2024, and CMS received two comments that were applicable to the demonstration. Both comments were supportive of Virginia's demonstration renewal, focusing on the state's request to maintain coverage for SUD services at facilities classified as an IMD.

The federal comment period for the SMI amendment application was open from January 16, 2025, through February 15, 2025, and CMS received four comments. All four comments were supportive of the state's request to add the SMI opportunity to the demonstration. One commentor urged the state to incorporate Medicaid coverage of inpatient psychiatric services for individuals under the age of 21 into its SMI program.

CMS has concluded that renewing the BTCSSHV Section 1115(a) demonstration is likely to promote the objectives of Medicaid.

Other Information

CMS's approval of this renewal and amendment is conditioned upon compliance with the enclosed set of expenditure authorities and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer for this demonstration is Anisha Truitt-Joyner, who is available to answer any questions concerning your section 1115 demonstration and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
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7500 Security Boulevard
Baltimore, MD 21244-1850
Email: anisha.truittjoyner@cms.hhs.gov

If you have any 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,



Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

Enclosures

cc: Margaret Kosherzenko, State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00297/3

TITLE: Building and Transforming Coverage, Services, and Supports for a Healthier Virginia Section 1115(a) Demonstration

AWARDEE: Virginia Department of Medical Assistance Services (DMAS)

Under the authority of section 1115(a)(2) of the Social Security Act (“the Act”), expenditures made by Virginia for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from August 1, 2026 through December 31, 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.

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

Title XIX Expenditure Authority

- 1. Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution of mental diseases (IMD).
- 2. Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for a serious mental illness (SMI) or serious emotional disturbance (SED) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).
- 3. Expenditures related to Former Foster Care Youth.** Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth (FFCY) who are under age 26, who turned 18 on or before December 31, 2022, who were in foster care under the responsibility of another state or tribe in such other state on the date of attaining 18 years of age (or such higher age as the state has elected for termination of Federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid at any time during the foster care period in which they aged out of foster care, and are now applying for Medicaid in Virginia.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00297/3

TITLE: Building and Transforming Coverage, Services, and Supports for a Healthier Virginia Section 1115(a) Demonstration

AWARDEE: Virginia DMAS

I. PREFACE

The following are the Special Terms and Conditions (STC) for the “Building and Transforming Coverage, Services, and Supports for a Healthier Virginia” (BTCSSHV) section 1115(a) Medicaid demonstration (hereinafter “demonstration”), to enable the Commonwealth of Virginia DMAS (referred to herein as the “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 expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from August 1, 2026, through December 31, 2031, unless otherwise specified.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility and Enrollment
- V. Substance Use Disorder (SUD) Program and Benefits
- VI. Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) Program and Benefits
- VII. Cost Sharing
- VIII. Delivery System
- IX. Monitoring and Reporting Requirement
- X. General Financial Requirements
- XI. Monitoring Budget Neutrality for the Demonstration
- XII. Evaluation of the Demonstration
- XIII. Schedule of Deliverables for the Demonstration Period

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

Attachment A: Evaluation Design (Reserved)

Attachment B: SUD Implementation Plan (Reserved)

Attachment C: SMI/SED Implementation Plan (Reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

Virginia's BTCSSHV section 1115 demonstration provides authority for substance use disorder (SUD) treatment services to individuals who are short term residents in residential treatment facilities that meet the definition of an Institution for Mental Diseases (IMD); and extend Medicaid eligibility for former foster care youth (FFCY) under age 26 who aged out of foster care in another state or tribe and currently reside in Virginia.

In July 2020, CMS approved an amendment to the demonstration for the High Needs Support component to provide certain otherwise allowable 1915(i) state plan amendment (SPA) services, including: housing and employment supports Home and Community Based Services (HCBS) for Medicaid beneficiaries age 18 or older who were eligible under the Medicaid state plan and enrolled in the managed care delivery system and for those who were eligible under the out-of-state FFCY component of the demonstration age 18 up to 26 and enrolled in the managed care delivery system, and who met specific needs based criteria and risk factors.

On July 31, 2026, CMS approved a five-year renewal of the demonstration to allow Virginia to continue the existing demonstration authorities, which provide authority for SUD treatment services to individuals who are short-term residents in residential treatment facilities that meet the definition of an institution for mental diseases in an IMD and extend eligibility for full Medicaid state plan benefits to individuals who qualify as "out-of-state FFCY", meaning individuals who are under age 26 and who turned age 18 on or before December 31, 2022, who aged out of foster care under the responsibility of another state or tribe, were enrolled in Medicaid while in foster care, currently reside in Virginia. The renewal will also remove the High Needs Support component of the demonstration because the state did not implement these services.

Lastly, CMS approved an amendment to add the SMI/SED demonstration opportunity to allow the state to receive federal financial participation (FFP) for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment facilities that qualify as IMDs. The state will maintain and enhance access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment of Medicaid beneficiaries with SUD, serious mental illness (SMI), or serious emotional disturbance (SED). This demonstration will provide the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SUD, SMI, or SED while they are short-term residents in residential and inpatient treatment settings that qualify as

an IMD. It will also support state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT), and improve access to a continuum of SUD, SMI, or SED evidence-based services at varied levels of intensity, including withdrawal management services.

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

FFCY Goals:

The objectives of the FFCY demonstration component are to increase and strengthen overall coverage of former foster care youth and improve health outcomes for this population.

SUD Goals:

1	Increase rates of identification, initiation, and engagement in treatment for SUD
2	Increase adherence to and retention in treatment
3	Reduce overdose deaths, particularly those due to opioids
4	Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
5	Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate
6	Improve access to care for physical health conditions among beneficiaries with SUD

SMI/SED Goals:

1	Reduce utilization and lengths of stay in EDs among beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings
2	Reduce preventable readmissions to acute care hospitals and residential settings
3	Improve availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state
4	Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care
5	Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities

III. GENERAL PROGRAM REQUIREMENTS

- 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).

- 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 document (of which these terms and conditions are part), apply to the demonstration.
- 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 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
- 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 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.
- 5. State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPA) 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.

- 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 7, except as provided in STC 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 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 shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - d. An up-to-date CHIP allotment worksheet, if necessary;
 - e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and monitoring reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

- 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 STC 9.
- 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 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 Section 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.
- 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.
- 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.
- 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 Health 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 7 or extension, are proposed by the state.

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.
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.
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 services 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).

IV. ELIGIBILITY AND ENROLLMENT

16. **Eligibility Groups Affected by the Demonstration.** Only beneficiaries eligible for Medicaid under an eligibility group listed in Table 1 are subject to the provisions within this demonstration. State plan groups derive their eligibility through the Medicaid state plan, and coverage for these groups is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs.

Table 1 Medicaid Eligibility Groups Affected by the Demonstration			
Demonstration Feature	Eligibility Group	Citations	Income Level
Former Foster Care Youth (FFCY)	Former foster care youth up to age 26 who aged out of foster care in another state and now reside in Virginia	Expenditure Authority	N/A
Substance Use Disorder (SUD)	Adult group	1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	133% FPL

	Aged, blind, and disabled	• 42 CFR 435.121	80% FPL
	Parents and other caretaker relatives	• 1902(a)(10)(A)(i)(I) • 1931 (b) and (d) • 42 CFR 435.110	Dollar amounts by household size • Group 1: ~24% FPL • Group 2: ~32% FPL • Group 3: ~48% FPL
	Pregnant women	• <u>1902(a)(10)(A)(i)(III) and (IV)</u> • <u>1931(b) and (d);</u> • 42 CFR 435.116	143% FPL
	Out of state FFCY (no income limit)	• Expenditure Authority	N/A, no income limit
	Children with Title IV-E adoption assistance, foster care, or guardianship care	• 473(b)(1) • 1902(a)(10)(A)(i)(I) • 42 CFR 435.145	N/A, no income limit
	Children under age 19	• 1902(a)(10)(A)(i)(III) and (IV) • 1931(b) and (d); • 42 CFR 435.118	143% FPL
	Transitional medical assistance	• 1902(a)(52) • 1902(e)(l) • 1925 • 1931(c)(2)	N/A in first six-month extension; 185% FPL average monthly earnings in second six-month extension
	Extended Medicaid due to spousal support collections	• 408(a)(11)(B) • 1902(a)(10)(A)(i)(I) • 1921(c) • 42 CFR 435.115	No limit so long as the reason the family no longer meets the income limit is due to increased spousal support.
	Former foster care youth up to age 26 who aged out of foster care in Virginia	• 42 CFR 435.150 • 1902(a)(10)(A)(i)(IX)	N/A, no income limit

Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)	Low-income Adults and Children		
	Adult group	• 1902(a)(10)(A)(i)(VIII) • 42 CFR 435.119	133% FPL
	Aged, Blind, and Disabled	• 42 CFR 435.121	80% FPL
	Pregnant Women	• 42 CFR 435.116	143% FPL
	Former Foster Care Youth (FFCY)	• Expenditure authority	No income limit
	Former Foster Care Youth up to age 26 who aged out of foster care in Virginia	• 42 CFR 435.150 • 1902(a)(10)(A)(i)(IX)	N/A, no income limit

17. Former Foster Care Youth.

- a. Individuals eligible for this demonstration are limited to “out-of-state former foster care youth” who are defined as individuals under age 26 who meet the following criteria:
 - i. were in foster care under the responsibility of a state other than Virginia or an out of state tribe in such other state when they turned age 18 (or such higher age at which the other state’s foster care assistance ends under title IV-E of the Act);
 - ii. were enrolled in Medicaid at any time during the foster care period in which they aged out of foster care;
 - iii. turned 18 on or before December 31, 2022;
 - iv. are now applying for Medicaid in Virginia; and,
 - v. are not otherwise eligible for Medicaid.
- b. The benefit for out-of-state former foster care youth will be the same Medicaid benefit set provided to the state plan eligibility group serving former foster care children, under section 1902(a)(10)(A)(i)(IX) of the Act.
- c. The cost sharing requirements for out-of-state former foster care youth conform to the requirements implemented for the state plan eligibility group serving former foster care children, under section 1902(a)(10)(A)(i)(IX) of the Act.

V. SUBSTANCE USE DISORDER (SUD) PROGRAM AND BENEFITS

- 18. SUD Program Benefits.** Effective upon CMS's approval of the SUD Implementation Plan, the demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD once CMS approves the state's Implementation Plan. The state will aim for a statewide average length of stay of 30 days or less in residential treatment settings to be monitored pursuant to STC 35, to ensure short-term residential stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing care for these conditions in cost-effective community-based settings.

- 19. SUD Implementation Plan.** Given that CMS's requirements for the SUD Implementation Plan have changed since the state's original submission, the state must submit a revised implementation plan to CMS no later than 90 days post approval of this demonstration extension. The revised implementation plan will be affixed to the STCs as Attachment B. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 32. The SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD project:

a. *Access to Critical Levels of Care for OUD and other SUDs.* Coverage of SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management, within 12-24 months of demonstration approval;

b. *Use of Evidence-based SUD-specific Patient Placement Criteria.*

- i. Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and

- placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of demonstration approval;
- ii. Utilization Management. Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;
- c. *Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.*
- i. Implementation of residential treatment provider qualifications. Currently, residential treatment service providers must be licensed by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Substance Abuse Residential Treatment Services (RTS). The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;
 - ii. Standards of Care. Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;
 - iii. Availability of MAT. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;
- d. *Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OD.* An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;
- e. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OD.
- i. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;
 - ii. Expand coverage of and access to naloxone for overdose reversal.

- iii. Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;
- f. *Improved Care Coordination and Transitions between Levels of Care.* Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval;
- g. *SUD Health IT Plan.* Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes milestones and metrics are detailed in STC 20 and Attachment B.

20. SUD Health Information Technology Plan (“Health IT Plan”). The SUD Health IT plan applies to all states where the health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) (see STC 19[g]), to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

The Health IT Plan should describe how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, standards adopted by the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT (ASTP/ONC) in accordance with 45 CFR part 170, subpart B.

- a. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Report (see STC 35).
- b. As applicable, the state should advance HHS-adopted standards in 45 CFR 170 Subpart B in developing and implementing the state’s SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.¹
- c. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds to acquire, upgrade, or implement health IT that can be supported by standards

¹ Where the plan involves health IT that is acquired, upgraded, or implemented by health care providers that have been eligible for CMS incentives to adopt health IT certified under the ONC Health IT Certification Program, states should advance the use of certified health IT, as applicable. Certified health IT incorporates the standards in 45 CFR 170 Subpart B.

referenced in 45 CFR 170, Subpart B, the state should use the federally recognized standards.

- d. Where there are opportunities at the state- and provider-level to leverage federal funds to acquire, upgrade, or implement health IT that cannot be supported using a standard in 45 CFR 170, Subpart B the state should seek to use other non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ASTP/ONC Interoperability Standards Advisory (ISA).²
- e. Specific components of the Health IT Plan are listed below:
 - i. The Health IT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP).³
 - ii. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders⁴. States should favor procurement strategies that incorporate Qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in open interfaces and exposed application program interfaces.
 - iii. The Health IT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.
 - iv. In developing the Health IT Plan, states should use the following resources:
 1. States may use federal resources available on Health IT.Gov including Behavioral Health IT resources (<https://www.healthit.gov/topic/behavioral-health>), Opioid Epidemic and Health IT (<https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/>), and the HHS Health IT Alignment Program (<https://www.healthit.gov/topic/hhs-health-it-alignment-program>).
 2. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

² <https://www.healthit.gov/isp/>

³ Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

⁴ *Ibid.*

3. States should review the ASTP/ONC's Interoperability Standards Advisory (<https://www.healthit.gov/isa/>) for information on additional non-proprietary standards and implementation specifications developed by consensus-based standards development organizations not included in 45 CFR part 170, Subpart B that can support health IT investments.

21. **Unallowable Expenditures Under the SUD Expenditure Authority.** The state may not receive FFP for room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

VI. SERIOUS MENTAL ILLNESS (SMI)/SERIOUS EMOTIONAL DISTURBANCE (SED) PROGRAM AND BENEFITS

22. **SMI/SED Program Benefits.** Under this demonstration, beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI/SED treatment services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. These SMI/SED services will range in intensity from short-term acute care in inpatient settings for SMI/SED, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days for beneficiaries receiving treatment in an IMD treatment setting through this demonstration's SMI/SED Program, to be monitored pursuant to STC 35.

23. SMI/SED Implementation Plan.

- a. The state must submit the SMI/SED Implementation Plan within 90 calendar days after approval of the demonstration for CMS review and comment. If applicable, the state must submit a revised SMI/SED Implementation Plan within 60 calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI/SED under expenditure authority until CMS has approved the SMI/SED Implementation Plan and the SMI/SED financing plan described in STCs 23(d). After approval of the required Implementation Plan and Financing Plan, FFP will be available prospectively, but not retrospectively.
- b. Once approved, the SMI/SED Implementation Plan will be incorporated into the STCs as Attachment C, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI Implementation Plan, within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 32.

- c. At a minimum, the SMI Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:
 - i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.
 - 1. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS
 - 2. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
 - 3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
 - 4. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
 - 5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing

regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues)

6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).
- ii. Improving Care Coordination and Transitions to Community-Based Care.
1. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of these settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);
 2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available;
 3. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider the person was referred to;
 4. Implementation of strategies to prevent or decrease the length of stay in emergency departments (ED) among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric

consultants in EDs to help with discharge and referral to treatment providers);

5. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

1. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability (the state must provide a yearly update on the availability of mental health services via the Annual Monitoring Report);
2. Commitment to implementation of the SMI financing plan described in STC 25. The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 35;
3. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
4. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association [e.g., Level of Care Utilization System (LOCUS) or the Child and Adolescent Service Intensity Instrument (CASII)] to determine appropriate level of care and length of stay.

vi. Earlier Identification and Engagement in Treatment and Increased Integration.

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI in treatment sooner, including through supported employment and supported education programs;
2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;

3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.
 - d. The Implementation Plan must also include sections containing the SMI Health IT Plan and the SMI Financing Plan. Further information which describes the requirements are detailed in STC 24, STC 25 and Attachment C.
- 24. SMI/SED Health Information Technology (Health IT) Plan.** The state will provide CMS with an assurance that it has a sufficient health IT infrastructure “ecosystem” at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration.

The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment C) and must be aligned with the state’s broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state’s Behavioral Health (BH) IT Health Plan.

- a. The state will monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Report (see STC 35).
- b. As applicable, the state should advance the HHS-adopted standards in 42 CFR 170 Subpart B in developing and implementing the state’s SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
- c. Where there are opportunities at the state- and provider-level (up to and including usage in managed care organization (MCO) or Accountable Care Organization (ACO) participation agreements) to leverage federal funds to acquire, upgrade, or implement health IT that can be supported by standards referenced in 45 CFR 170 Subpart B the state should use the federally recognized standards.
- d. Where there are opportunities at the state- and provider-level to leverage federal funds to acquire, upgrade, or implement health IT that cannot be supported using a standard in 45 CFR 170, Subpart B the state should seek to use other non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ASTP/ONC Interoperability Standards Advisory (ISA).
- e. Specific components of the Health IT Plan are listed below
 - i. The Health IT Plan will, as applicable, describe the state’s capabilities to leverage a master patient index (or master data management service, etc.) in support of SMI/SED care delivery. The state will also indicate current efforts or plans to

develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

- ii. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: (1) Referrals, (2) Electronic care plans and medical records, (3) Consent, (4) Interoperability, (5) Telehealth, (6) Alerting/analytics, and (7) Identity management.
- iii. In developing the Health IT Plan, states should use the following resources:
 1. States may use federal resources available on Health IT.gov including behavioral health IT (<https://www.healthit.gov/topic/behavioral-health>), "Section 34: Opioid Epidemic and Health IT" (<https://www.healthit.gov/playbook/opioid-epidemic-and-health-it>), and the HHS Health IT Alignment Program (<https://www.healthit.gov/topic/hhs-health-it-alignment-program>).
 2. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.
 3. States should review the ASTP/ONC's Interoperability Standards Advisory (<https://www.healthit.gov/isa/>) for information on additional non-proprietary standards and implementation specifications developed by consensus-based standards development organizations not included in 45 CFR part 170, Subpart B that can support health IT investments.

25. SMI/SED Financing Plan. As part of the SMI/SED implementation plan referred to in STC 23(d), the state must submit, within 90 calendar days after approval of the demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment C and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI/SED Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Components of the financing plan must include:

- a. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

- b. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;
- 26. **Maintenance of Effort (MOE).** The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 35.
- 27. **Average Length of Stay Requirements and FFP.** Federal Financial Participation is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD primarily to receive treatment for mental illness. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its Mid-Point Assessment that it is meeting the requirement of a 30-day average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services under the demonstration. Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.
- 28. **Unallowable Expenditures Under the SMI/SED Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:
 - a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
 - b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
 - c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
 - d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the “inpatient psychiatric services for individuals under age 21” benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

VII. COST SHARING

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

VIII.DELIVERY SYSTEM

30. **Delivery System.** The demonstration will utilize the current statewide managed care delivery system and fee for service (FFS) delivery system. Beneficiaries may be enrolled in FFS prior to being enrolled into managed care.

IX. MONITORING AND REPORTING REQUIREMENTS

31. **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 singularly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or are 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. 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) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state’s anticipated date of submission. Should CMS agree to the state’s request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action 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 steps or still fails to submit the overdue deliverable(s) that meets 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.

- 32. Deferral of Federal Financial Participation from IMD Claiming for Insufficient Progress Toward Milestones.** Up to \$5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones as evidenced by reporting on the milestones in the Annual Monitoring Report. Once CMS determines the state has not made adequate progress, up to \$5,000,000 will be deferred in the next calendar year and each calendar year thereafter until CMS has determined sufficient progress has been made.
- 33. 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.
- 34. Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 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 1115, 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.
- 35. Monitoring Reports.** The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than the first business day following 180 calendar days after the end of the DY. The state must submit a revised Annual Monitoring Report no later than the first business day following 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. The operational updates will focus on progress towards meeting the milestones identified in CMS' framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, 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 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 per applicable CMS guidance, and including but not limited to as described below:

- i. For the SUD and/or SMI/SED component(s), the state's monitoring must cover metrics in alignment with CMS guidance and the demonstration's milestones as outlined in the SUD State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17-003) and/or the SMI/SED SMDL dated November 13, 2018 (SMDL #18-011).

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.

36. Mid-Point Assessment. The state must contract with an independent entity (herein referred to as the Independent Assessor) to conduct an independent Mid-Point Assessment and submit to CMS by December 31, 2029. This timeline will allow for the Mid-Point Assessment to capture approximately the first two and a half years of program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and execution of the Mid-Point Assessment, the state must require that the Independent Assessor consult with key stakeholders such as, representatives of MCOs, health care providers, beneficiaries, community groups, and other key partners.

- a. The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. If requested, the state must brief CMS on the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment no later than the first business day following 60 calendar days after receipt of CMS's comments, if any.
- b. Elements of the Mid-Point Assessment must include:
 - 1. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plan;
 - 2. A determination of factors that affected achievement on the milestones and performance metric gap closures to date;

3. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
 4. For milestones or targets identified by the Independent Assessor as at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to pertinent factors that the state can influence that will support improvement.
- 37. Corrective Action.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS might 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 10. CMS might withdraw an authority, as described in STC 10, if metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, the state has not implemented corrective action, and the circumstances described in STC 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.
- 38. Close Out Report.** No later than the first business day following 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 73 and 74, 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 the first business day following 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 31.

39. 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.
- 40. 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.

X. GENERAL FINANCIAL REQUIREMENTS

- 41. 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.
- 42. Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM).

CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

43. 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.

44. 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.

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

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.
- b. For non-risk-based PIHP and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR 447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

- 46. 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.
- 47. 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 31. 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.
- 48. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section XI
- 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.
- 49. 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.
- 50. Medicaid Expenditure Groups (MEG).** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2. Master MEG Chart					
MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
SUD	Hypo 1	X		X	All expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment, described in Section V.

SMI/SED	Hypo 2	X		X	All expenditures for services provided to an individual while they are a patient in an IMD for SMI/SED treatment described in Section VI.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality

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

51. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00297/3). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. To assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures

incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

- c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.
- d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCS in section XI, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
- e. **Member Months.** Using the Budget Neutrality Monitoring Tool, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
- f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3. MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS- 64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
SUD	Report all medical assistance		Follow standard CMS		MAP	Y	12/15/16	12/31/31

	expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment.	Refer to STC 21 for unallowable expenditures	64.9 Category of Service Definitions	Date of Service				
SMI/SED	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SMI/SED.	Refer to STC 28 for unallowable expenditures	Follow standard CMS 64.9 Category of Service Definitions	Date of Service	MAP	Y	08/01/26	12/31/31
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	12/15/16	12/31/31

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

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

Table 4. Demonstration Years		
Demonstration Year 13	August 1, 2026, to December 31, 2026	5 months
Demonstration Year 14	January 1, 2027, to December 31, 2027	12 months
Demonstration Year 15	January 1, 2028, to December 31, 2028	12 months
Demonstration Year 16	January 1, 2029, to December 31, 2029	12 months
Demonstration Year 17	January 1, 2030, to December 31, 2030	12 months
Demonstration Year 18	January 1, 2031 to December 31, 2031	12 months

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

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

- a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
- b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the

changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

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

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

- a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 55(c). If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. After acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
- b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
 - i. Provider rate increases that are anticipated to further strengthen access to care;
 - ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

- iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
 - iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
 - v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
 - vi. High-cost innovative medical treatments that states are required to cover; or,
 - vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.
- c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:
- i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,
 - ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 56. Monitoring Budget Neutrality for FFCY.** CMS has determined that FFCY demonstration coverage is budget neutral based on CMS's assessment that the expenditure authority granted for the demonstration has minimal federal Medicaid expenditures and these populations could have been covered through waiver only authority. The state will not be allowed to obtain budget neutrality "savings" from FFCY demonstration coverage. The demonstration will not include a budget neutrality expenditure limit for FFCY; however, the state is required to report total expenditures and member months in their demonstration monitoring reports, per STC 35. The state must still report quarterly claims and report expenditures on the CMS 64.9 WAIVER form. Failure to report FFCY expenditures and member months will result in reinstatement of the budget neutrality requirement. CMS reserves the right to request budget neutrality worksheets, requirements, limits, and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 7.
- 57. Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of one or more Hypothetical Budget Neutrality Tests, as described below. CMS's

assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

- 58. Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 2, Master MEG Chart and Table 3, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.
- 59. Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
- 60. Main Budget Neutrality Test.** This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.
- 61. Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the

expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

- 62. Hypothetical Budget Neutrality Test: SUD #1 and SMI/SED #2.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 5. Hypothetical Budget Neutrality Test

MEG	PC or Ag g*	WOW Only, WW Only, or Both	Trend Rate	DY 13	DY 14	DY 15	DY 16	DY 17	DY 18
SUD	PC	Both	6.0%	\$4,507.63	\$4,697.57	\$4,979.42	\$5,278.19	\$5,594.88	\$5,930.57
SMI/SED	PC	Both	5.0%	\$6,755.97	\$6,993.96	\$7,344.15	\$7,711.87	\$8,097.46	\$8,502.33

- 63. Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim

monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

- 64. Budget Neutrality Monitoring Tool and Reporting Requirement.** Per 4 CFR 431.428, the state must document the financial performance of the demonstration. The state must provide quarterly budget neutrality status updates that meet all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs (including submission of corrected budget neutrality data upon request), using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing the demonstration’s actual expenditures to the budget neutrality expenditure limits describe in the Monitoring Budget Neutrality for the Demonstration section. The quarterly budget neutrality status updates are due no later than 60 calendar days following the end of each demonstration quarter, while the fourth-quarter information is due no later than 90 calendar days following the end of the DY. These monitoring reports are subject to the deferral as described in STC 31. CMS will provide technical assistance upon request.⁵
- 65. Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from August 1, 2026 to December 31, 2031. If at the end of the demonstration approval period the Hypothetical Budget Neutrality Test(s) has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.
- 66. Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

⁵ Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS’s current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

Table 6. Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	Cumulative Target Definition	Percentage
DY 13	Cumulative budget neutrality limit plus:	2.0 percent
DY 13 through DY 14	Cumulative budget neutrality limit plus:	2.0 percent
DY 13 through DY 15	Cumulative budget neutrality limit plus:	1.5 percent
DY 13 through DY 16	Cumulative budget neutrality limit plus:	1.0 percent
DY 13 through DY 17	Cumulative budget neutrality limit plus:	0.5 percent
DY 13 through DY 18	Cumulative budget neutrality limit	0.0 percent

XII. EVALUATION OF THE DEMONSTRATION

- 67. Cooperation with Federal Evaluators.** 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 31.
- 68. 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.

- 69. Evaluation Design.** The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline no later than the first business day following 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with the 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 73 and 74.

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 the first business day following 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.

- 70. Evaluation Design Approval and Updates.** The state must submit a revised Evaluation Design no later than the first business day following 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 no later than the first business day following 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.
- 71. 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:

- a. Hypotheses for the SUD component of the demonstration must align with the goals of the program, including increasing rates of identification and initiation of and engagement in treatment as well as adherence to and retention in treatment, reducing overdose deaths, reducing utilization of emergency departments and inpatient hospitalizations as well as readmissions to the same or higher levels of care, and improving access to care for physical health conditions.
- b. Hypotheses for the SMI/SED component must map to the goals of the program, including reducing utilization and lengths of stay in emergency departments, reducing preventable readmissions to acute care hospitals and residential settings, improving the availability of crisis stabilization services, improving access to community-based services, and improving care coordination.

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.

- 72. 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.
- 73. 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 no later than the first business day following 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 no later than the first business day following 30 calendar days after CMS approval.

74. Summative Evaluation Report. The state must submit the draft Summative Evaluation Report for the demonstration's current approval period no later than the first business day following 18 months after 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 no later than the first business day following 60 calendar days after 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 no later than the first business day following 30 calendar days after CMS approval.

75. 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 10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

76. 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, and/or the Summative Evaluation Report.

77. 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 no later than the first business day following 30 calendar days of approval by CMS.

78. 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.

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 9. Schedule of Deliverables for the Demonstration Period		
Deliverable	Timeline	STC
Annual Monitoring Report	No later than the first business day following 180 calendar days after the end of each demonstration year.	STC 35
Mid-Point Assessment	No later than December 31, 2029 Revised no later than the first business day following 60 days after receipt of CMS comments.	STC 36
Evaluation Design	No later than the first business day following 180 calendar days after approval of the demonstration. Revised no later than the first business day following 60 days after receipt of CMS comments.	STCs 69, 70, 71
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 the first business day following 60 calendar days after receipt of CMS comments.	STC 73
Summative Evaluation Report	No later than the first business day following 18 months after the end of the demonstration period. Revised no later than the first business day following 60 calendar days after receipt of CMS comments.	STC 74
SUD Implementation Plan (including Health IT Plan)	90 calendar days after demonstration approval Revised no later than the first business day following 60 calendar days after receipt of CMS comments.	STC 19 and 20

SMI/SED Implementation Plan (including Health IT Plan and Financing Plan)	90 calendar days after demonstration approval Revised no later than the first business day following 60 calendar days after receipt of CMS comments.	STC 23, 24, and 25
CMS-64 Quarterly Medicaid Expenditure Report	30 calendar days after the end of each quarter	STC 42
Quarterly Budget Neutrality Monitoring Report	60 calendar days after the end of each demonstration quarter except the 4 th quarter which is due 90 days after the end of each DY	STC 64

**Attachment A:
Evaluation Design (RESERVED)**

**ATTACHMENT B:
SUD Implementation Plan (RESERVED)**

**ATTACHMENT C:
SMI/SED Implementation Plan (RESERVED)**