DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

APR 30 2018

Lynne A. Valenti
Cabinet Secretary
South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291

Dear Ms. Valenti:

The Centers for Medicare & Medicaid Services (CMS) approves South Dakota's request for a new five-year Medicaid demonstration pursuant to section 1115(a) of the Social Security Act (the Act), entitled "South Dakota Former Foster Care Youth" (Project Number: 11-W-00319/8). This approval is effective May 1, 2018 through April 30, 2023.

This demonstration approval authorizes South Dakota to provide Medicaid State Plan coverage to former foster care youth under age 26 with income up to 182 percent of the Federal Poverty Level, who were in foster care under the responsibility of another state or tribe when they "aged out" of foster care at age 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), and were enrolled in Medicaid on the date of aging out of foster care.

All Medicaid title XIX requirements as expressed in law, regulation and policy statement not expressly waived or identified as not applicable in these approval documents shall apply to this demonstration. South Dakota's authority to deviate from Medicaid requirements is limited to the specific authorities described in the enclosed approval documents and to the purpose indicated.

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility, and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstration is likely to assist with promoting the objectives of Medicaid. Consistent with federal transparency requirements, CMS also considers all public comments received during both the state and federal public input periods when evaluating whether the demonstration project as a whole will likely assist in promoting the objectives of Medicaid. The state received one public comment in support of this demonstration project and CMS did not receive any public comments during the federal public comment period. After review of all the materials submitted by the state, as well as all public comments received, CMS has determined that South Dakota's demonstration will promote the objectives of Medicaid by increasing and strengthening overall coverage of former foster care youth and improving health outcomes for this population.

CMS's approval of this demonstration also is conditioned upon compliance with the enclosed set of special terms and conditions (STCs) and associated expenditure authority defining the nature, character, and extent of anticipated federal involvement in this demonstration project. This award is subject to the state's written acknowledgement of the award and acceptance of the enclosed STCs and associated expenditure authority within 30 days of the date of this letter. Your CMS project officer for this demonstration is Mr. Emmett Ruff. He is available to answer any questions you may have related to this demonstration. Mr. Ruff can be reached at (410)786-4252 or Emmett.ruff@cms.hhs.gov. Correspondence concerning the demonstration can be mailed to Mr. Ruff at:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mailstop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communications regarding demonstration program matters should be sent simultaneously to Mr. Ruff and to Mr. Richard Allen, Associate Regional Administrator (ARA) for the Division of Medicaid and Children's Health Operations in our Denver Regional Office. Mr. Allen's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health
1961 Stout Street, Room 08-148
Denver, CO 80294

If you have questions regarding this correspondence, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid & CHIP Services, at (410) 786-9686.

Sincerely

[redacted]

Seema Verma

Enclosures

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00319/8**

TITLE: **South Dakota Former Foster Care Youth**

AWARDEE: **South Dakota Department of Social Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by South Dakota for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities, except those specified below as not applicable to these expenditure authorities.

The following expenditure authority shall enable the state to operate its Former Foster Care Youth section 1115 Medicaid demonstration through April 30, 2023 and also assists the state with meeting the intended Medicaid program objectives of this demonstration, which are to increase and strengthen overall coverage of former foster care youth and improve health outcomes for this population.

Title XIX Expenditure Authority

Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are under age 26 with household income up to 182 percent of the Federal Poverty Level (FPL), were in foster care under the responsibility of another state or tribe 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 on the date of aging out of foster care, and are now applying for Medicaid in South Dakota.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00319/8**

TITLE: **South Dakota Former Foster Care Youth**

AWARDEE: **South Dakota Department of Social Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the South Dakota Former Foster Care Youth section 1115(a) Medicaid demonstration (hereinafter referred to as "demonstration"). The parties to this agreement are the South Dakota Department of Social Services ("South Dakota" or "the state") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and South Dakota's obligations to CMS during the life of the demonstration. The STCs are effective May 1, 2018 through April 30, 2023.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

This section 1115(a) demonstration enables South Dakota to provide Medicaid coverage to former foster care youth under age 26 with income up to 182 percent of the Federal Poverty Level (FPL), who were in foster care under the responsibility of another state or tribe 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 on the date of aging out, and are now applying for Medicaid in South Dakota. The Medicaid program objectives of this demonstration are to increase and strengthen overall coverage of former foster care youth and improve health outcomes for this population.

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, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the expenditure authority document (which is a part of these terms and conditions), must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.

   CMS reserves the right to amend these STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration per STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to align with mandated changes in Medicaid law, regulation, and policy that directly impact this demonstration program.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

   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 this demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

b) If mandated changes in the federal law require state legislation, the changes must 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 law.

5. **Changes Subject to the Amendment Process.** Changes related to demonstration features such as eligibility, enrollment, benefits, 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 Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below, except as provided in STC 3.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 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 failure by the state to submit deliverables required by these STCs according to the deadlines specified therein. Amendment requests must minimally include the following:

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

    b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit;

    c) An explanation of the public process used by the state consistent with the requirements of STC 14; and,

    d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase-out plan consistent with the requirements of STC 8.

8. **Demonstration Transition and Phase-Out.** The state may suspend or terminate this demonstration, in whole or in part, at any time prior to the date of expiration.

a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination. At least six months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with the requirements of STC 14. Once the 30-day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the comments received into the transition and phase-out plan submitted to CMS.

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 administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

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

d) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the state must assure all appeal and hearing rights are afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as found in 42 CFR §435.916.

e) Exemption from Public Notice Procedures: CMS may expedite or waive the federal and state public notice requirements in the event it determines that the objectives of titles XIX or XXI would be served or under circumstances described in 42 CFR §431.416(g).

f) Enrollment Limitation during Demonstration Phase-Out: If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. **CMS Right to Amend, Suspend, or Terminate.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

10. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue a deferral up to an amount that is the lesser of total federal share of demonstration expenditures incurred in the demonstration year or of $1,000,000 (federal share) when items required by these STCs (e.g., monitoring reports, evaluation design documents, required data elements and analyses, presentations, and any other deliverable specified in these STCs (hereafter singly or collectively referred to as "deliverable(s))") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

    a) Thirty days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

    b) For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).

        i. CMS may decline the extension request.
        ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
        iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

    c) When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

    d) As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from extending a demonstration or obtaining a new demonstration.

    e) CMS will consider with the state an alternative set of operational steps for implementing the deferral associated with this demonstration to align the process with any existing deferral process the state is undergoing (e.g., the quarter the deferral applies to and how the deferral is released).

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

12. **Withdrawal of Waiver/Expenditure Authority.** CMS reserves the right to amend or withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the amendment or withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, 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 participants.

13. **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 applicable to the demonstration; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other demonstration components.

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

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

15. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter associated with these STCs.

IV. ELIGIBILITY AND BENEFITS

16. **Eligibility for the Demonstration.** Individuals eligible for this demonstration are limited to "out-of-state former foster care youth" who are defined as individuals under age 26 that meet the following criteria:

    a) have household income up to 182 percent of the FPL;

b) were in foster care under the responsibility of a state other than South Dakota or a tribe in such other state when they turned age 18 (or such higher age as the state has elected for termination of Federal foster care assistance under title IV-E of the Act);
c) were enrolled in Medicaid at the time of aging out of foster care ;
d) are now applying for Medicaid in South Dakota; and,
e) are not otherwise eligible for Medicaid.

17. Benefits and Cost-sharing provided under the Demonstration. Out-of-state former foster care youth will receive the same Medicaid State Plan benefits and be subject to the same cost-sharing requirements effectuated by the state for the mandatory title IV-E foster care youth eligibility category enacted by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272).

18. State Plan Amendments. As outlined in CMS' November 21, 2016 CMCS Informational Bulletin to *Allow Medicaid Coverage to Former Foster Care Youth Who Have Moved to a Different State*, the state shall submit conforming amendment(s) to the Medicaid State Plan for the Former Foster Care Youth affected by the implementation of this demonstration. After the associated Medicaid State Plan amendments are effectuated, the state will not be required to submit title XIX State Plan amendments (SPAs) for changes affecting any populations made eligible solely through this demonstration.

19. Delivery System. Enrollees in this demonstration will receive services through the state's fee-for-service delivery system.

V. GENERAL REPORTING REQUIREMENTS

20. Annual Monitoring Report. No later than 90 days following the end of each demonstration year, the state must submit an annual monitoring report that represents the status of the demonstration's various operational areas and any state analysis of program data collected for the demonstration year. The annual monitoring report will include all elements required by 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 state must submit the annual monitoring report through CMS' designated system using the framework incorporated in these STCs as "Attachment A," which is subject to change as monitoring systems are developed and/or evolve, and will be provided in a structured manner that supports federal tracking and analysis. Each annual monitoring report must minimally include the following:

a) Data on enrollment, participation, disenrollment, and demographics, associated with the demonstration population. There will also be an accompanying narrative for each of these areas;
b) Utilization monitoring that includes summaries of encounter data;
c) Grievances and appeals filed, reported by demonstrations quarter and by type, highlighting any patterns that are concerning; and actions being taken to address any significant issues evidenced by patterns of complaints, grievances or appeals;

d) Summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. The discussion shall also include interim findings when available;
e) A summary of the annual post award public forum conducted by the state as required by 42 CFR §431.420(c);
f) Budget neutrality monitoring spreadsheet updated with actual demonstration expenditures as reported on CMS 64.9 waiver forms; and,
g) Summary of quality assurance monitoring activities for the demonstration; and,
h) Summary of program integrity and related audit activities for the demonstration.

The state's demonstration years are as follows:

Demonstration Year 1 = May 1, 2018 through April 30, 2019
Demonstration Year 2 = May 1, 2019 through April 30, 2020
Demonstration Year 3 = May 1, 2020 through April 30, 2021
Demonstration Year 4 = May 1, 2021 through April 30, 2022
Demonstration Year 5 = May 1, 2022 through April 30, 2023

21. Annual Monitoring Calls. CMS and South Dakota will participate in annual conference calls following CMS' receipt and acceptance of the annual progress report, unless CMS determines that more frequent calls are necessary to adequately monitor the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, anticipated or proposed changes in payment rates, audits, lawsuits, changes in state sources of funding for financing this demonstration, progress on evaluations, state legislative developments, and any demonstration amendments the state is considering submitting. CMS will update the state on any amendments under review as well as Federal policies and issues that may affect any aspect of the demonstration. South Dakota and CMS will jointly develop the agenda for the calls.

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

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

VI. MONITORING BUDGET NUETRALITY FOR THE DEMONSTRATION

23. Budget Neutrality Expenditure Limit. The budget neutrality test for this demonstration is constructed as a hypothetical or "pass-through" services model since the services provided to this population will mirror Medicaid state plan benefits formerly authorized through CMS' January 22, 2013 Notice of Proposed Rulemaking for several Affordable Care Act provisions related to Medicaid and CHIP eligibility and enrollment, but subsequently found to be not permitted through CMS Final Rule published November 30, 2016, entitled "Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP" (81 FR 86382, 86405). The budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The expected costs and growth trend comprising the "without-waiver" budget neutrality expenditure limit are reflected in the table below. The state is not permitted to utilize or accrue budget neutrality "savings" from a hypothetical budget model.

MBES Waiver Name	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
FFCY	2.1%	$420.39	$429.26	$438.32	$447.57	$457.01

24. Reporting Member Months. For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the annual report required by STC 20, the actual number of eligible member months for demonstration enrollees. The state must include a statement in the annual report certifying the accuracy of this information.

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.

25. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

26. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Demonstration Year	Cumulative target definition	Percentage
DY 1	DY1 plus:	3.0%
DY 2	DY1 and DY2 combined budget limit amount plus:	1.5%
DY 3	DY1 through DY3 combined budget limit amount plus:	1.0%
DY 4	DY1 through DY4 combined budget limit amount plus:	0.5%
DY 5	DY1 through DY5 combined budget limit amount plus:	0%

27. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit 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, an evaluation of this provision will be based on the time elapsed through the termination date.

VII. GENERAL FINANCIAL REQUIREMENTS

28. Reporting Expenditures Subject to the title XIX Budget Neutrality Agreement. The following describes the reporting of expenditures subject to the budget neutrality limit:

a) **Tracking Expenditures.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES). All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made (e.g., For expenditures incurred with dates of service from May 1, 2018 – April 30, 2019, the state will use the project number extension "01" for reporting on the CMS 64 waiver forms).

b) **Use of Waiver Forms.** The state must report demonstration expenditures on separate forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report title XIX expenditures for demonstration services. The state will use the waiver name "FFCY" to report expenditures in the MBES/CBES system.

c) **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded 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.

29. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative

costs that are directly attributable to the demonstration. All administrative costs must be identified on Form CMS-64.10.

30. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made 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 must 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.

31. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must 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 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 must submit Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. Subject to the payment deferral process set out in STC 10, 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.

32. **Sources of Non-Federal Share.** The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a) CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

    b) Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

33. **Extent of Federal Financial Participation (FFP) for the Demonstration.** CMS shall provide FFP for expenditures incurred for providing Medicaid State Plan coverage to out-of-state former foster care youth under this demonstration, at the applicable federal matching rate.

34. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration. The state must confirm its process for ensuring there is no duplication of federal funding in each annual report as specified in STC 20.

VIII. EVALUATION

35. Evaluation Design Plan Approval. Within 120 days of the demonstration award, the state must submit to CMS for comment and approval a Draft Evaluation Design Plan for testing hypotheses aimed at evaluating the extent to which the demonstration increases and strengthens overall coverage of out-of-state former foster care youth and improves health outcomes for these youth. The state must submit a revised Draft Evaluation Design Plan within 60 days after receipt of CMS' comments. The state's Draft Evaluation Design Plan may be subject to multiple revisions until a format is agreed upon by CMS. Upon CMS approval of the state's Evaluation Design Plan, the document will be included as Attachment B to these STCs. Per 42 CFR section 431.424(c), the state will publish the approved Evaluation Design Plan within 30 days of CMS approval. The state must implement the evaluation research and submit their evaluation implementation progress in the Annual Reports required in accordance with STC 20.

36. Evaluation Requirements. The demonstration evaluation will meet the prevailing standards of scientific evaluation and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results. The outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the state met the demonstration goal, with recommendations for future efforts regarding all components.

37. Draft and Final Interim Evaluation Reports. In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit a draft interim evaluation report for the completed years of the approval period represented in these STCs, as outlined in 42 CFR section 431.412(c)(2)(vi). The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design. If the state requests changes to the demonstration, it must identify research questions and hypotheses related to the changes requested and an evaluation design for addressing the proposed revisions. The state will provide a Final Interim Evaluation Report 30 days after receiving comments from CMS.

38. Summative Evaluation Report. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period represented in these STCs within 18 months following the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved evaluation design. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 30 days of receiving comments from CMS.

39. Public Access. The state shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the state Medicaid website within 30 days of approval by CMS.

For a period of 24 months following CMS approval of the Interim and Summative Evaluation Reports, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the state, contractor or any other third party directly connected to the demonstration. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

40. Draft and Final Close-out Report. Within 120 days after the expiration of the demonstration, the state must submit a draft Close-out Report to CMS for comments.

a) The draft report must comply with the most current guidance from CMS.
b) The state will present to and participate in a discussion with CMS on the close-out report.
c) The state must take into consideration CMS' comments for incorporation into the final close-out report.
d) The final close-out report is due to CMS no later than 30 days after receipt of CMS' comments.
e) A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 10.

IX. SCHEDULE OF DELIVERABLES

Deliverable	Timeline	STC Reference
Annual Report	Within 90 days following the end of each demonstration year.	STC 20
Draft Evaluation Design Plan	Within 120 days after the approval of this demonstration project.	STC 35
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design.	STC 35
Interim Evaluation Reports	With submission of a demonstration extension request.	STC 37
Summative Evaluation Report	Within 18 months following the end of the demonstration approval period identified in these STCs.	STC 38

Attachment A –

ANNUAL REPORT TEMPLATE

State: _____
Demonstration Year: _____
Approved start and end date of the Demonstration _____

A. Introduction

Please describe the goal(s) and objectives of the demonstration and status of key operational milestones.

B. Eligibility and Enrollment Information, including member month reporting

Topic	Measure [Reported for each month included in the annual report]	Narrative
Total Enrollment	Total number unduplicated enrolled[as of the last day of the month]	Describe the percent increase or decrease (or no change) from these quarters compared to the previous quarters. If this is the first annual report of your demonstration, describe whether or not the number of enrollees aligns with your expectations.
New Enrollment	Total number of new enrollees [as of the last day of the month]	Describe the percent increase or decrease (or no change) from these quarters compared to the previous quarters. If this is the first annual report of your demonstration, describe whether or not the number of new enrollees aligns with your expectations. Please also describe any outreach methods the state is currently using or plans to use in the future to identify and enroll this population.
Re-Enrollment	Total number of beneficiaries who disenrolled and later reenrolled [as of the last day of the month]	Describe the percent increase or decrease (or no change) from these quarters compared to the previous quarters. If this is the first annual report of your demonstration, describe whether or not the number of reenrollees aligns with your expectations.
Disenrollment	Total number of beneficiaries who disenrolled [as of the last day of the month]	Please describe the trend (percent increase or decrease, or no change) for these quarters compared to the previous quarters. If this is the first annual report of your demonstration, please describe whether or not the number of disenrollees aligns with your expectations. Please also describe major reasons for to disenrollment (if known) and any actions taken to mitigate inappropriate disenrollment.

C. Utilization Monitoring

The state will summarize utilization through a review of claims/encounter data for the demonstration population. This includes the following:

Topic	Measure [Reported for each month included in the annual report]
Utilization Monitoring	Total number of beneficiaries with any claim
	Total number of beneficiaries with primary care appointments
	Total number of beneficiaries with behavioral health appointments
	Total number of beneficiaries with emergency department visits
	Total number of beneficiaries with inpatient visits

D. Grievances and Appeals

Describe any grievances and appeals filed during the quarters by the demonstration population by type, highlighting any patterns that are concerning. Describe actions being taken to address any significant issues evidenced by patterns of appeals.

E. Operational/Policy/Systems/Fiscal Developments/Issues and Action Plans

Identify and describe any other significant program developments/issues/problems that have occurred in the current quarters or are anticipated to occur in the near future that affect the operation or evaluation of the demonstration, including but not limited to program development, access to care, quality of care, approval and contracting with Managed Care Entities, managed care contract compliance, fiscal issues, systems issues, and pertinent legislative or litigation activity.

Please provide a description of each issue as well as any immediate and long-term action plans to address any problems identified. Include a discussion of the status of action plans implemented in previous periods until resolved.

F. Demonstration Evaluation Activities and Interim Findings

Please provide a summary of the progress of evaluation activities, including key milestones accomplished. Include:

- Status of progress against timelines outlined in the approved Evaluation Design.
- Any challenges encountered and how they are being addressed.
- Status of any evaluation staff recruitment or any RFPs or contracts for evaluation contractual services (if applicable).
- Description of any interim findings or reports, as they become available.

ATTACHMENT B –

EVALUATION DESIGN PLAN

(reserved pending CMS approval)