DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

September 23, 2026

John Connolly
Deputy Commissioner and State Medicaid Director
Minnesota Department of Human Services
540 Cedar Street
St. Paul, Minnesota 55167-0983

Dear Commissioner Connolly:

The Centers for Medicare & Medicaid Services (CMS) is approving Minnesota's request for a Medicaid section 1115(a) demonstration entitled, "Minnesota Reentry Demonstration" (Project Number 11-W-00505/5, in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective October 1, 2026 through September 30, 2031, upon which date, unless renewed or otherwise temporarily extended, all authorities granted to operate this demonstration will expire.

CMS has determined that the Minnesota Reentry Demonstration is likely to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality, clinically appropriate services and improving care transitions for certain individuals leaving incarceration and entering back into a community setting.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver authorities, 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 not applicable to expenditures under the demonstration.

Program Integrity

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

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a program integrity oversight 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

Approval of this demonstration will enable the state to provide coverage for a targeted set of services furnished to certain incarcerated individuals for up to 60 days immediately prior to the individual's expected release date from jails, prisons, and adult tribal correctional facilities. The state's proposed approach closely aligns with CMS's "Reentry Demonstration Opportunity" as described in State Medicaid Director Letter (SMDL) #23-003[1], released on April 17, 2023, and the recently released Frequently Asked Questions document.

CMS has conducted additional scrutiny of Reentry Demonstration policy to ensure the program is based on evidence and appropriate stewardship of taxpayer dollars. Through evaluation of published research, consultation with states and reentry policy stakeholders, and collaboration with federal partners, CMS has identified specific refinements and enhancements, described below, that will improve transparency, sustainability, and program integrity for newly approved reentry demonstrations.

CMS expects to release further updated reentry demonstration guidance in the next year describing these policy changes, updated monitoring, additional oversight, and strengthened financial requirements to ensure transparency and robust program integrity.

Eligible Individuals

Minnesota will cover a set of pre-release benefits for certain individuals who are inmates residing in jails, prisons, and adult tribal correctional facilities, (hereinafter "correctional facility") and who have been diagnosed with a mental illness, substance use disorder, chronic condition or significant non-chronic clinical condition, or are currently pregnant or within a 6-8 week postpartum period as defined in Attachment C to the demonstration's STCs. To qualify for services covered under the demonstration approval, individuals residing in a correctional facility must have been determined eligible for Medicaid pursuant to an application filed before or during incarceration, and have an expected release date within 60 days from jails, prisons, and adult tribal correctional facilities.

[1] www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf

Medicaid Eligibility and Enrollment
CMS is requiring, as a condition of approval of this demonstration, that the state make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the correctional facilities where the pre-release coverage of demonstration services will be available.

For a Medicaid covered individual entering a correctional facility, the state will not terminate Medicaid coverage, but will suspend the individual's coverage. For individuals not enrolled in Medicaid upon entering a correctional facility, the state will ensure the individual receives assistance with completing and submitting a Medicaid application sufficiently prior to their anticipated release date such that the individual can receive the full duration of pre-release services, unless the individual voluntarily refuses such assistance or chooses to decline enrollment.

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

CMS is authorizing Minnesota to provide coverage for the following services, defined in Attachment D to the demonstration's STCs:

- Case management to assess and address physical and behavioral health needs, and social determinants of health;
- Medication-assisted treatment (MAT) services for all types of substance use disorders (SUD) as clinically appropriate, including coverage for medications in combination with accompanying counseling/behavioral therapies;
- Practitioner office visits (e.g., physical exam; wellness exam; evaluation and management visit; mental health or substance use disorder treatment, therapy, or counseling; or other);
- Family planning services and supplies;
- Peer support services;
- Prescribed drugs (in addition to MAT and the 30-day supply of prescription medications) and medication administration; and
- The state must also provide a 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy.

Under no circumstances should the provision of these services or related policies, procedures, or processes developed to support implementation of this demonstration result in a delay of an individual's release from incarceration or lead to increased involvement in the juvenile or adult justice systems.

Duration of Pre-Release Coverage

Minnesota requested 90 days of pre-release coverage for all eligible beneficiaries. CMS has determined that up to 60 days of pre-release coverage is appropriate for individuals in prisons, and jails, or adult tribal correctional facilities. Available data demonstrate that providing access to services such as MAT in the 60 days leading up to release reduces the risk of overdose, supporting the provision of pre-release coverage for up to 60 days.[2,3,4,5,6,7] Furthermore, 60 days of pre-release coverage helps ensure that incarcerated individuals are stabilized and receive adequate case management and other pre-release services under the demonstration and is likely sufficient to test whether pre-release services improve transitions of care for individuals in adult facilities. Based on ongoing monitoring and rapid cycle reports with approved and pending states, CMS understands that it would be unduly burdensome to offer different lengths of pre-release coverage to individuals incarcerated in the same facility due to significant administrative complexity, and CMS's forthcoming Rapid Cycle Report findings indicate that key state and carceral stakeholders identified reducing complexity in operational and administrative burdens as a key facilitator to success. As such, CMS is approving coverage of these services for up to 60 days for individuals in jails, prisons, and adult tribal correctional facilities.

Implementation and Reinvestment Plans

As described in the STCs, as a condition of demonstration approval, Minnesota is required to submit a Reentry Initiative Implementation Plan (here called Implementation Plan) to document how the state will operationalize coverage and provision of pre-release services. The Implementation Plan must be submitted to CMS on a timeline consistent with the STCs, and must describe the milestones and associated actions being addressed under this demonstration and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities, and describe the state's strategic approach for making significant improvements on the milestones and actions, as well as associated timelines for meeting them, for program policy implementation. The Implementation Plan will also outline any potential operational challenges that the state anticipates and the state's intended approach to resolving these and other challenges the state may encounter in implementing the reentry demonstration initiative. The section 5121 operational plan requirement in sections 1902(a)(84)(D) of the Act is satisfied by the state's Implementation Plan. The state is still required to provide coverage and otherwise meet state plan requirements with

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[2] Burns, et al. (2022). Duration of Medication Treatment for Opioid-Use Disorder and Risk of Overdose among Medicaid Enrollees in Eleven States: A Retrospective Cohort Study. Addiction. https://pmc.ncbi.nlm.nih.gov/articles/PMC10683938/

[3] Volkow, N. D., & Wargo, E. M. (2018). *Overdose prevention through medical treatment of opioid use disorders*. *Annals of Internal Medicine, 169*(3), 190–192. https://doi.org/10.7326/M18-1397

[4] Au, V. Y. O., Rosic, T., Sanger, N., Hillmer, A., Chawar, C., Worster, A., Marsh, D. C., Thabane, L., & Samaan, Z. (2021). Factors associated with opioid overdose during medication-assisted treatment: How can we identify individuals at risk? *Harm Reduction Journal, 18*, Article 71. https://doi.org/10.1186/s12954-021-00521-4

[5] Hayes et al. (2026). Evaluating the optimal duration of medication treatment for opioid use disorder. Study for the Society of Addiction. https://onlinelibrary.wiley.com/doi/10.1111/add.70211

[6] Friedmann, P.D., et al. (2025). Medications for Opioid Use Disorder in County Jails—Outcomes After Release. The New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/NEJMsa2415987

[7] Martin, R.A., et al. (2022). Post-incarceration outcomes of a comprehensive statewide correctional MOUD program: a retrospective cohort study. Lancet Regional health. https://pmc.ncbi.nlm.nih.gov/articles/PMC9950664/

respect to any population or service specified in sections 1902(a)(84)(D) of the Act that is not covered under this demonstration.

Minnesota is also required to submit a Reentry Demonstration Initiative Reinvestment Plan (here called Reinvestment Plan) as a condition of demonstration approval. The reentry demonstration initiative is not intended to shift current correctional facility health care costs to the Medicaid program. Section 5032(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (P.L. 115-271) makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of titles XIX, which includes the inmate payment exclusion, in recognition that the correctional authority bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve correctional authorities in Minnesota of their Constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a tribal, state, or local correctional authority to the Medicaid programs.

To the extent that the reentry demonstration initiative newly covers services that are the responsibility of and were previously provided or paid for by the correctional facility with custody of qualifying individuals, Minnesota agrees to reinvest all new federal dollars, equivalent to the amount of federal financial participation expended for such previously existing services, into allowable justice-related activities or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for physical and behavioral health needs that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement and the STCs, Minnesota will develop and submit a Reinvestment Plan to CMS that documents an estimated calculation of the amount of federal dollars the state will receive over the course of the demonstration period, a detailed description of the state's plans to reinvest the required funds into allowable activities, and an assessment of the impact of reinvested funds on privately-owned or -operated carceral facilities and associated safeguards to prevent increasing profit or operating margins for such facilities. In order to ensure state accountability for this requirement, the state must submit annual progress updates on their reinvestment as part of the state's annual monitoring report. The state will also be required to submit a Final Reinvestment Assessment detailing the total amount of FFP received over the demonstration period, the total amount reinvested, and the outcome of those activities.

Interaction between a State's Reentry Demonstration and the CAA, 2023 Mandate
Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) amends section 1902(a)(84) of the Social Security Act (the Act) to describe a mandatory population of eligible juveniles in Medicaid who are incarcerated in a public institution post adjudication of

charges[8] who are to receive a set of pre-release and post-release services. Section 5122 of the CAA, 2023 amends section 1905(a) of the Act to give states the option to receive federal financial participation (FFP) for the full range of coverable services for eligible individuals who are incarcerated in a public institution while pending disposition of charges[9]. The requirements of section 5121 of the CAA, 2023 have a statutory effective date of January 1, 2025. Every state is required to submit a Medicaid State Plan Amendment assuring compliance with these requirements.[10]

To the extent there is overlap between the services required to be covered under section 1902(a)(84)(D) of the Act and coverage under this demonstration, CMS understands that it would be administratively burdensome for a state to identify whether each individual service is furnished to a beneficiary under the state plan or demonstration authority. Accordingly, to eliminate unnecessary administrative burden and ease implementation of statutorily required coverage and in this demonstration, CMS is approving a waiver of the otherwise mandatory state plan coverage requirements to permit the state instead to claim for at least the same pre-release services for the same beneficiaries under this demonstration.[11] This approach will ease implementation, administration, and claiming, and provide a more coherent approach to monitoring and evaluation of the state's reentry coverage under the demonstration. The state will provide pre-release coverage under the reentry demonstration initiative to eligible juveniles described in section 1902(nn) of the Act in alignment with section 1902(a)(84)(D) of the Act, as applicable, at a level equal to or greater than otherwise would be covered under the state plan. Compliance and state plan submission requirements under section 5121 of the CAA, 2023 will remain unchanged. Any required services that are not provided through the demonstration during the pre-release period as well as any post-release services will continue to be covered under the state plan. Additionally, coverage of the population and benefits identified in section 1902(a)(84)(D) of the Act, as applicable, will automatically revert to state plan coverage in the event that this demonstration ends or eliminates coverage of beneficiaries and/or services specified in those provisions. To effectuate this approach, CMS is adding a new waiver of section 1902(a)(84)(D) of the Act.

Requests Not Being Approved

Minnesota also requested transitional non-service expenditures to support implementation of the demonstration. CMS is working with Minnesota on pathways to otherwise allowable administrative claiming such as Implementation Advance Planning Documents to support

[8] Section 1902(nn) of the Act defines "eligible juvenile" as an individual under age 21 determined eligible in any eligibility group or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the mandatory former foster care children group, which includes former foster care children between 18 and 26 years old).

[9] For CHIP, section 2110(b)(7) creates an optional exception to the CHIP eligibility exclusion for inmates of a public institution under section 2110(b)(2)(A) so incarcerated youth who are pending disposition of charges are not excluded from the definition of targeted low-income child.

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

[11] Section 5122 of the CAA, 2023 gives a state the option to cover the full breadth of otherwise-covered Medicaid and CHIP services for eligible juveniles who are incarcerated pending disposition of charges. We have not yet approved this claiming flexibility for Section 5122 services and we are not providing this claiming flexibility in this approval.

implementation costs associated with the reentry demonstration. As a result, we do not anticipate approving the state's request for transitional non-service expenditures as proposed and will no longer consider this an active request.

Budget Neutrality

This demonstration project is being approved using CMS's current approach to determining budget neutrality as described in CMS SMDL #24-003[12]. However, CMS acknowledges that section 71118 of subchapter C of chapter 1 of subtitle B of title VII of Public Law 119-21 the Working Families Tax Cuts (WFTC) legislation adds a new subsection (g) to section 1115 of the Act with budget neutrality requirements that will apply beginning January 1, 2027 to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments[13]. CMS issued SMDL #26-003[14] on June 11, 2026 to provide states with early notice regarding the changes to budget neutrality that CMS intends to propose to implement subsection 1115(g) of the Act, and expects to provide additional guidance to states on implementation of this provision.

Under SMDL #24-003[15], 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. The demonstration 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.

The projected demonstration expenditures associated with each Medicaid Expenditure Group (MEG) 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.

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

[12] https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf
[13] https://www.congress.gov/bill/119th-congress/house-bill/1/text#d3245e38419-intro-1
[14] https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf
[15] https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf

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 Reentry Services MEG will be treated as hypothetical for budget neutrality purposes. For this MEG, 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 this MEG 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.

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

Monitoring and Evaluation

The state is required to conduct systematic monitoring and robust evaluation of the demonstration in accordance with the STCs. An Annual Monitoring Report capturing key metrics and narrative updates will be due to CMS 180 days after the end of each demonstration year. The state must also conduct a Reentry Early Implementation Rapid Cycle Report to assess implementation planning of the demonstration, including operational progress, barriers and facilitators, program integrity, and financial oversight, and to provide timely, actionable insights to support program refinement during the initial implementation phase.

The state is required to incorporate the demonstration into its evaluation activities to support a comprehensive assessment of whether the initiatives approved under the demonstration are effective in producing the desired outcomes for the individuals and the state's overall Medicaid and CHIP program(s). Evaluation of the reentry demonstration initiative must align with the requirements detailed in the STCs, including examining impacts on Medicaid and CHIP

coverage, continuity of care, access to and quality and efficiency of care, utilization of services, health outcomes, and carceral and community coordination in service provision, among others.

The state plan requirements for eligible juveniles under section 1902(a)(84)(D) of the Act for Medicaid, are included under this reentry demonstration initiative and must be included in applicable monitoring and evaluation activities.

Consideration of Public Comments

CMS posted the demonstration application on Medicaid.gov for a 30-day federal public comment period from January 31, 2025 through March 2, 2025. CMS received nine comments. Eight comments were supportive of Minnesota's new demonstration application. One of the commenters highlighted the fact that pre-release coverage is strongly aligned with the goal of mitigating chronic disease, a key priority of the new administration, and noted that these services reduce gaps in coverage that contribute to overreliance on costly emergency care. Another commenter supported the proposal and urged the state to expand demonstration eligibility to all individuals who qualify for Medicaid, regardless of their medical history. One comment was not favorable, arguing that individuals eligible for the demonstration should be held accountable for their role in contributing to their health conditions. A goal of the reentry section 1115 demonstration opportunity is to improve care transitions and quality of care to best meet individuals' needs, regardless of their backgrounds or circumstances.

CMS has concluded that approving the Minnesota Reentry Demonstration is likely to promote the objectives of Medicaid.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed set of waivers, expenditure authorities, and STCs defining the nature, character and extent of anticipated federal involvement in the demonstration. The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer for this demonstration is Amy Schlom, 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
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: amy.schlom@cms.hhs.gov

If you have questions regarding this approval, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,

Dr. Mehmet Oz

Enclosure

Cc: Courtenay Savage, Acting State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: 11-W-00505/5

TITLE: Minnesota Reentry Demonstration

AWARDEE: Minnesota Department of Human Services (DHS)

Under the authority of the Section 1115(a)(1) of the Social Security Act ("the Act"), the following waivers are granted to enable Minnesota (referred to herein as the state or the State) to operate the Minnesota Reentry Section 1115(a) Demonstration**.** These waivers are effective beginning October 1, 2026 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Minnesota Reentry Section 1115(a) Demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of title XIX and XXI of the Act.

Except as provided below with respect to expenditure authority, all requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning October 1, 2026 through September 30, 2031.

Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release — **Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00505/5

TITLE: Minnesota Reentry Demonstration

AWARDEE: Minnesota Department of Human Services (DHS)

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

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

Title XIX Expenditure Authority:

Expenditures for Pre-Release Services. Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid beneficiaries for up to 60 days immediately prior to the expected date of release in jails, prisons, and adult tribal correctional facilities participating in the reentry demonstration initiative.

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

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

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

Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

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

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00505/5

TITLE: Minnesota Reentry Demonstration

AWARDEE: Minnesota Department of Human Services (DHS)

1. PREFACE

The following are the Special Terms and Conditions (STC) for the Minnesota Reentry section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Minnesota Department of Human Services (DHS), (hereinafter "state" or "State") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from October 1, 2026 through September 30, 2031, unless otherwise specified.

The STCs have been arranged into the following subject areas:

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

Attachment A	Evaluation Design [Reserved]
Attachment B	Monitoring Protocol [Reserved]
Attachment C	Reentry Demonstration Initiative Qualifying Conditions
Attachment D	Reentry Demonstration Initiative Services
Attachment E	Reentry Demonstration Initiative Implementation Plan [Reserved]
Attachment F	Reentry Demonstration Initiative Reinvestment Plan [Reserved]
Attachment G	Reentry Demonstration Initiative Final Reinvestments [Reserved]

2. PROGRAM DESCRIPTION AND OBJECTIVES

The Minnesota Department of Human Services (DHS) submitted an application for a new section 1115(a) demonstration entitled "Minnesota Reentry Waiver" on January 16, 2025. The application proposed a new demonstration program to cover services and improve health outcomes for beneficiaries reentering the community from correctional facilities.

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

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

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

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

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

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

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

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

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

i. Decrease disparities in overdoses and deaths following release; and

j. Maximize health and overall community reentry outcomes.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state

plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

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

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and monitoring reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

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

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

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

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

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

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR 431, Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

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

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

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

3.10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

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

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

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

3.13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

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

3.15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. **Eligibility Groups Affected by the Demonstration.** Under the demonstration, all eligibility will be defined under the state plans and the demonstration affects all eligibility groups under the state plan through the provision of additional services. Eligibility requirements for reentry pre-release services are set forth below in STC 5.3.

5. REENTRY DEMONSTRATION INITIATIVE

5.1. Overview of Pre-Release Services and Program Objectives.

This demonstration will provide coverage for pre-release services up to 60 days immediately prior to the expected date of release in jails, prisons, and adult tribal correctional facilities participating in the reentry demonstration initiative. All facilities defined in STC 5.5 Participating Correctional Facilities will hereinafter be called "correctional facilities." To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid as determined pursuant to an application filed before or during incarceration and must have an expected release date specified in STC 4.1 below.

5.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to

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

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

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

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

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

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

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

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

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

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

i. Decrease disparities in overdoses and deaths following release; and

j. Maximize health and overall community reentry outcomes.

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

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 5.5; and

b. Have been determined eligible for Medicaid; and

c. Meet the following criteria to receive the described length of pre-release services:

    i. Be an individual in a jail, prison, or adult tribal correctional facility with an expected release date within 60 days to receive up to 60 days of pre-release services.

d. Meet at least one of the health-related criteria described below and further defined in Attachment E titled "Reentry Demonstration Initiative Qualifying Conditions." Meeting such health-related criteria may be indicated by an individual, found at an initial screening conducted by the correctional facility upon intake, determined during an individual's incarceration, or found during assessment in the process of pre-release planning.

    i. Mental illness, defined as confirmed or suspected mental health diagnosis based on specified criteria

    ii. Substance use disorder, defined as confirmed or suspected diagnoses based on specified criteria

    iii. Chronic condition or significant non-chronic clinical condition, defined as confirmed or suspected diagnoses based on specified criteria, or

    iv. Currently pregnant or within a 6-8 week postpartum period.

e. Have a status of pre- or post-adjudication.

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

a. The covered pre-release services are:

    i. Case management to assess and address physical and behavioral health needs, and social determinants of health;

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

    iii. Practitioner office visit (e.g., physical exam; wellness exam; evaluation and management visit; mental health or substance use disorder treatment, therapy, or counseling; or other);

    iv. Family planning services and supplies

    v. Peer support services;

vi. Prescribed drugs (in addition to MAT and the 30-day supply of prescription medications) and medication administration; and

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

b. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule. Accordingly, other benefits and services covered under the Minnesota Medicaid State Plan, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT treatment services for qualifying Medicaid beneficiaries under age 21) are not available to qualifying individuals through the reentry demonstration initiative.

5.5. **Participating Correctional Facilities.** The pre-release services will be provided at jails, prisons, and adult tribal correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to Minnesota Department of Human Services approval of a facility's readiness, according to the implementation timeline described in STC 5.11. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the reentry demonstration initiative.

5.6. **Participating Providers.**

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

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

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

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

e. Minnesota must develop processes and policies to ensure that case managers coordinate with providers of pre-release services and community-based providers (if they are different providers) and facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care.

f. Minnesota must develop processes to facilitate coordination between case managers and community-based providers in communities where individuals will be living upon release or ensure individuals have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar.

g. Minnesota must develop policies so that case managers are engaged and have the necessary time needed to respond effectively to individuals who are incarcerated and transitioning back into the community.

5.7. **Suspension of Coverage.** Upon entry of a Medicaid-enrolled individual into a correctional facility, Minnesota Department of Human Services must not terminate and generally shall suspend their Medicaid coverage, in accordance with sections 1902(a)(84)(A) and 2102(d)(1)(A) of the Act.

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

5.8. **Opportunity to Enroll in Medicaid or CHIP.** Any Medicaid or CHIP-eligible person who is incarcerated at a participating facility but not yet enrolled must be afforded the opportunity to apply for Medicaid or CHIP in the most feasible and efficient manner and must be offered assistance with the Medicaid application process in accordance with 42 CFR 435.906, 435.908, and 457.340(a). The state must accept an application submitted via any of the methods described at 42 CFR 435.907 and 457.330.

a. All individuals who are incarcerated at a participating facility must be allowed to access and complete a Medicaid or CHIP application and must be assisted in this process, including by providing information about where to complete the Medicaid or CHIP application for another state (e.g., relevant state Medicaid agency website), if the person plans to live in a different state after release.

b. All individuals enrolled in Medicaid or CHIP during their incarceration must be provided with a Medicaid, CHIP, or managed care plan card or some other Medicaid, CHIP, or managed care enrollment documentation upon release, along with information on how to use their coverage.

5.9. **Managed Care Contract Requirements.** If Minnesota elects to implement the demonstration through managed care, managed care plan contracts must reflect clear requirements and processes for transfer of a member's relevant health information upon release to another managed care plan or, if applicable, state Medicaid agency (e.g., if the beneficiary is moving to region of the state served by a different managed care plan or to another state after release) to ensure continuity of coverage and care.

5.10. **Interaction with Mandatory State Plan Benefits for Eligible Juveniles and Targeted Low-Income Children.** To the extent Minnesota includes coverage in the reentry demonstration initiative that is otherwise required to be provided under section 1902(a)(84)(D) of the Act, and may include this coverage in the base expenditures used to determine the budget neutrality expenditure limit, the state may claim for these expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

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

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

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

c. The provision or facilitation of pre-release services for a period of time immediately prior to the expected date of release, as described in STC 5.1 and 5.3, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;

d. If Minnesota optionally elects to phase in pre-release services, Minnesota will require participating facilities to select a Service Level for implementation. Service Level One consists of the minimum benefit package pre-release services identified in STC 5.4 a and b, and must be the first Service Level category that is implemented. The state may define additional Service Level categories in its Implementation Plan. As applicable, additional service levels may be phased-in by facilities in any order, e.g., Service Level Two would not be a prerequisite for phasing-in Service Level Three, except that no facility may be a participating correctional facility that does not at least achieve and maintain provision of Service Level One. A facility must

demonstrate to the state that it is prepared to implement all the services in Service Level One and within any chosen Service Level, if applicable.

e. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments, and managed care plans (as applicable).

f. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the up to 60-day pre-release period, as described in STC 5.3(c), and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply of the medications as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

g. Operational approaches related to implementing certain Medicaid and CHIP requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

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

i. Reporting of data requested by Minnesota to support program monitoring, evaluation, and oversight; and

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

5.12. **Reentry Demonstration Initiative Implementation Plan.** The state is required to submit a Reentry Demonstration Initiative Implementation Plan for CMS approval that will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60

calendar days after receipt of CMS feedback. The finalized Implementation Plan, subject to CMS approval, will be incorporated into the STCs as Attachment E titled "Reentry Demonstration Initiative Implementation Plan."

CMS will provide the state with a template to support developing the Implementation Plan.

5.13. **Reentry Demonstration Initiative Reinvestment Plan.** To the extent that the reentry demonstration initiative newly covers services that are the responsibility of and were previously provided or paid for by the correctional facility with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP expended for such previously existing service(s), into allowable justice-related activities defined below. FFP projected to be expended for new services covered under the reentry demonstration initiative or state plan services required under this demonstration to meet the requirements of section 1902(a)(84)(D) of the Act are not required to be reinvested pursuant to this STC. New services are defined as 1) services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the reentry demonstration initiative or 2) any additional increases in expenditures for existing services that have been expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative. For services that were previously provided prior to the demonstration and now, under the demonstration, have been expanded, augmented, or enhanced, the state must calculate the proportion of FFP attributed to existing services, and reinvest an amount equivalent to the amount of FFP.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments may only include:

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

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

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

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

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

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

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

b. Within 180 days of approval of the reentry demonstration initiative, the state will submit a reentry demonstration initiative Reinvestment Plan (Attachment F) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan must include:

i. An assessment of each authorized pre-release service, the extent to which it is a new or existing service, and a calculation of the projected amount of FFP required to be reinvested for each existing service per year;

ii. A description of the allowable activities described above in which the state plans to reinvest the required dollars, a timeline of when those reinvestments will occur, and the goals and outcomes for those activities. The state cannot use reinvested funds to build new or conduct capital improvements for existing correctional facilities.

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

c. The state will be required to include updates on reinvestment as part of the annual monitoring report. The state must describe the actual amount of required reinvestment based on actual FFP received, the amount the state has already reinvested and into what activities, and an update on how the Plan is progressing. The state must also include outcomes from the activities the state reinvested in.

d. No later than one year after the expiration of the demonstration period, the state will submit to CMS a Final Reinvestment Assessment (Attachment G) that will fully describe the final amount of required reinvestment based on actual FFP received, the amount the state reinvested and into what activities, and the outcomes of those activities.

6. COST SHARING

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

7. DELIVERY SYSTEM

7.1. The services provided under the Minnesota Reentry Demonstration will be in addition to the services provided through the Medicaid and CHIP state plans. All demonstration beneficiaries will continue to receive non-demonstration services through the same delivery system arrangements as authorized in the state. Pre-release services approved through this demonstration will be delivered through a fee-for-service delivery system and through managed care, with details to be specified in the Reentry Demonstration Initiative Implementation Plan (Attachment E).

8. MONITORING AND REPORTING REQUIREMENTS

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

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

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

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

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that 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.

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

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

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

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

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

8.4. **Monitoring Reports.** The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring

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

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

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

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

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

   i. For the reentry demonstration initiative, the state must report on metrics that track implementation progress and milestones. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 5.4 provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of

data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in the Annual Monitoring Report narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

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

c. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

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

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

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

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement

with CMS, the evaluation requirement may be satisfied through the Interim or Summative Evaluation Reports stipulated in STCs 9.8 and 9.9, respectively.

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

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

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

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 8.1.

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

a. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access, and progress on evaluation activities.

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

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

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

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

9. EVALUATION OF THE DEMONSTRATION

9.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration.

This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 8.1.

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

9.3. **Evaluation Design.** The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with 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 9.8 and 9.9.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

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

9.5. **Evaluation Questions and Hypotheses.** Consistent with the STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include 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; and/or measures endorsed by National Quality Forum (NQF).

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

   In instances where the state is testing services beyond the minimum benefit package or providing coverage for a period over 30 days and up to 90 days immediately prior to a beneficiary's expected release date, the state is required to incorporate additional hypotheses to describe those tests. The state must also provide a comprehensive

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

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

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

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

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

9.7. **Reentry Early Implementation Rapid Cycle Report.** The state must conduct and submit a Rapid Cycle Report (RCR) to CMS as a required evaluation deliverable for this demonstration. The purpose of the RCR is to assess implementation planning of the demonstration, including operational progress, barriers and facilitators, program integrity, and financial oversight, and to provide timely, actionable insights to support program refinement during the initial implementation phase.

The state must submit the RCR no later than 180 calendar days following the onset of claiming for demonstration services ("go-live"). The state must notify CMS of the anticipated go-live date no later than 30 calendar days in advance. CMS may, at its discretion, approve an alternative submission timeline if warranted by the state's implementation schedule or operational milestones.

The RCR must use a mixed-methods approach, incorporating both qualitative and quantitative information, and must assess implementation progress and key milestones, including the status of data-sharing agreements, provider onboarding, systems readiness, and care coordination processes, as well as a comparison of planned versus actual implementation timelines and approaches for service delivery and operations, including explanations for any deviations from the approved implementation plan. The RCR must also highlight any known gaps in data needed for future evaluations and potential mitigation strategies.

The RCR must also assess early operational experiences, including successes and challenges associated with coordination across correctional facilities and community-based providers, and must identify mitigation strategies where appropriate. The RCR must further include early financial information, including expenditures and any identified claiming considerations, as feasible, and an assessment of data infrastructure, reporting capabilities, and data quality, including limitations that may affect future evaluation activities. The RCR must make the methodology clear (e.g., financial analyses, interviews, focus groups) as well as the sources of the data (e.g., carceral facilities, community providers, state staff/contractors). The RCR may also include recommendations for refining the state's CMS-approved Evaluation Design, including identification of feasible outcome measures, data sources, and analytic approaches based on actual implementation experience.

The state must participate in discussions with CMS to review RCR findings and must identify and implement programmatic improvements, as appropriate. The state must document any changes made in response to RCR findings in subsequent monitoring

reports. The state must publish the final RCR on its public website within 30 calendar days of CMS approval. The Rapid Cycle Report must incorporate structured input from key demonstration interest holders (e.g., correctional facilities, community-based providers, and other partners). The report must address core implementation questions aligned with CMS evaluation guidance.

The report must also include a structured assessment of implementation plan activities, including the status of key milestones, explanations for deviations from planned timelines, and recommended modifications to implementation strategies.

9.8. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

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

b. For demonstration authority or any component within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

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

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

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

9.9. **Summative Evaluation Report.** The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

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

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

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

9.11. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, or the Summative Evaluation Report.

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

9.13. **Additional Publications and Presentations**. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

10. GENERAL FINANCIAL REQUIREMENTS

10.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

10.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) 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.

10.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms, and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

10.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for

expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

10.5. **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.

b. For non-risk-based PIHPs 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.

10.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

10.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 8.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

10.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs.

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

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

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

10.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

10.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 1: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Reentry Services	Hypo 1	X		X	Expenditures for pre-release services provided to qualifying beneficiaries for up to 60 days immediately prior to release from participating facilities.
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

10.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00510/8). 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 11, 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 per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

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 2: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expen. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Reentry Services	Report all expenditures for pre-release services provided to qualifying beneficiaries for up to 60 days immediately prior to release from participating facilities.		Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	October 1, 2026	September 30, 2031
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	October 1, 2026	September 30, 2031

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

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

Table 3: Demonstration Years

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

10.13. **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.

10.14. **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.

10.15. **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 10.15.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 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is

not a new demonstration-covered service or population and that is likely to further strengthen access to care.

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.

11. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

11.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit

consists of a Hypothetical Budget Neutrality Test, 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.

11.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart and Table 2, 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.

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

11.4. **Main Budget Neutrality Test.** This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under any of the Hypothetical Budget Neutrality Tests must be returned to CMS.

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

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

11.6. **Hypothetical Budget Neutrality Test 1: Reentry.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit.

Table 4: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
Reentry Services	PC	Both	6.0%	$1,300.69	$1,378.73	$1,461.46	$1,549.14	$1,642.09

11.7. **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.

11.8. **Budget Neutrality Monitoring Tool and Reporting Requirements.** Per 42 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 the 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 described 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 8. CMS will provide technical assistance, upon request.

11.9. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 10/1/2026 to 9/30/2031. If at the end of the demonstration approval period the Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

11.10. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 5: Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

12. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 1: Schedule of Deliverables for the Demonstration Period

Deliverable	Timeline	STC Reference
Reentry Demonstration Initiative Implementation Plan	120 days after reentry demonstration approval	STC 5.12
Reentry Demonstration Initiative Reinvestment Plan	180 days after reentry demonstration approval	STC 5.13
Evaluation Design	No later than 180 calendar days after approval of the demonstration Revised no later than 60 days after receipt of CMS comments	STCs 9.3 and 9.4
Reentry Demonstration Initiative Rapid Cycle Report	180 days after reentry go-live	STC 9.7
Reentry Demonstration Initiative Final Reinvestment Assessment	One year after end of demonstration period	STC 5.13.d
Summative Evaluation Report	No later than 18 months after the end of the demonstration period Revised no later than 60 calendar days after receipt of CMS comments	STC 9.9
Annual Monitoring Report	No later than 180 calendar days after the end of each demonstration year	STC 8.4
CMS-64 Quarterly Medicaid Expenditure Report	30 calendar days after the end of each quarter	STC 10.2
Quarterly Budget Neutrality Monitoring Report	60 calendar days after the end of each demonstration quarter except the 4th quarter which is due 90 days after the end of each DY	STC 11.8

Attachment A: Evaluation Design [Reserved]

Attachment B: Monitoring Protocol [Reserved]

Attachment C: Reentry Demonstration Initiative Qualifying Conditions

To qualify to receive services under the Reentry component of the demonstration, an individual must meet the following qualifying criteria:

Qualifying Condition	Definition
Mental Illness	An individual who receives or is eligible to receive mental health services or medications and meets one of the following criteria: 1) The individual has one or both of the following: a) Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; AND/OR b) A reasonable probability of significant deterioration in an important area of life functioning. 2) The individual's condition as described in paragraph (1) is due to either of the following: a) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; OR b) A suspected mental health disorder that has not yet been diagnosed. 3) The individual has a suspected mental health diagnosis that is currently being assessed through either the Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder (GAD-7), General Health Questionnaire (GHQ), Depression, Anxiety and Stress Scale (DASS-21), or other state approved screening tools.
Substance Use Disorder	An individual who either: 1) Meets SUD criteria, according to the criteria of the current editions of the Diagnostic and/or Statistical Manual of Mental Disorders and/or the International Statistical Classification of Diseases and Related Health Problems; OR 2) Has a suspected SUD diagnosis that is currently being assessed through either National Institute of Drug Abuse (NIDA)-modified

	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), American Society of Addiction Medicine (ASAM) criteria, or other state approved screening tool.
Chronic Condition or Significant Non-Chronic Clinical Condition	An individual with a chronic condition or a significant non-chronic clinical condition shall have ongoing and frequent medical needs that require treatment and can include one of the following diagnoses, as indicated by the individual, and may be receiving treatment for the condition, as indicated: 1) Active respiratory conditions (examples include chronic obstructive pulmonary disease, emphysema, and others) 2) Diabetes (Type 1 and 2; including any diabetes-related complications like retinopathy or renal disease) 3) Cardiovascular disease (examples include high blood pressure, heart disease, high cholesterol, stroke, those with a history of heart failure or heart attack) 4) Communicable disease (ex. hepatitis, human immunodeficiency virus, tuberculosis, sexually transmitted illnesses, coronavirus and others) 5) Active cancer 6) Advanced liver and/or renal disease 7) Severe chronic pain
Pregnant or Postpartum	A person who is pregnant or postpartum is a person who is either currently pregnant or within the 6-8 weeks postpartum period following the end of the pregnancy.

Attachment D: Reentry Demonstration Initiative Services

To qualify to receive services under the Reentry component of the demonstration, an individual must meet the following qualifying criteria:

Covered Service	Definition
Case Management	Case Management activities to address physical and behavioral health needs, including comprehensive assessment, development of a person-centered care plan, referrals, monitoring and follow-up.
Medication Assisted Treatment (MAT) Services	Medication Assisted Treatment (MAT) uses medication as a therapeutic support in conjunction with individual and group therapy. MAT includes treatment for opioid use disorder, and includes assessment, prescribing, induction or continuation, and coordination with community MOUD providers. MAT is authorized under the State Plan coverage for the 1905(a)(29) Medication Assisted Treatment benefit. The state assures coverage of naltrexone, buprenorphine, and methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).
30-day Supply of Prescription Medications	A 30-day supply of clinically appropriate medications to support ongoing treatment upon reentry. Prescription medications are authorized under State Plan section 12.a. Prescribed Drugs.
Practitioner Office Visit	Physical Health Well-being and Screenings, as authorized under State Plan sections 13.b. Screening Services and 13.d. Rehabilitative Services. Physical health well-being and screenings for adults and youth include activities that: • Conduct age- and condition-appropriate physical health screenings (e.g., vitals, chronic condition checks, infectious disease risk review);

	• Identify urgent or emerging medical needs requiring follow-up before or after release; • Provide education on health conditions, medications, and preventive care; and • Support continuity of care planning, including referrals or coordination with community medical providers upon reentry. Substance Use Disorder Comprehensive Assessment, as authorized under State Plan section 13.d. Rehabilitative Services. This is a comprehensive assessment to determine clinical needs, level of care, and service recommendations. Mental Health Diagnostic Assessment, as authorized under State Plan sections 6.d. Other Practitioners' Services and 13.d. Rehabilitative Services. This written report documents clinical and functional face-to face evaluation of an individual's mental health, including the nature, severity and impact of behavioral difficulties, functional impairment, and subjective distress of the person, and identifies the person's strengths and resources. Substance Use Disorder Treatment Coordination, as authorized under State Plan section 13.d Rehabilitative Services. Treatment coordinators synchronize health services with identified patient needs to facilitate the aims of the care plan. Activities include treatment follow-up, on-going needs assessments, life skills advocacy, education service referral, and documentation. Substance Use Disorder Individual and Group Counseling, as authorized under State Plan section 13.d. Rehabilitative Services. Counseling services that provide a person with professional assistance to support assessment, treatment and stabilization in managing SUD and co-occurring conditions either individually or in a group setting. Group and Individual Psychotherapy to support an individual's identified mental health and ongoing stability. Family, group, and individual psychotherapy is authorized under State Plan sections 13.d Rehabilitative Services and 5.a. Physicians' Services. Obstetric and Gynecological Evaluation and Treatment, consistent with Minnesota covered medical care and reproductive health standards.

Family Planning Services and Supplies	Family Planning Services and Supplies are provided to prevent or delay pregnancy and provide infertility treatment. Covered services are authorized under State Plan section 4.c. Family Planning Services and Supplies and Family Planning Related Services ACA (4)(C)(ii).
Peer Support Services	Peer Recovery Support Services provide mentoring, education, advocacy and nonclinical recovery support to the individual to promote a person's recovery goals, self-sufficiency, self-advocacy, and development of natural supports; and support a person's maintenance of skills learned from other services. This is authorized under State Plan section 13.d. Rehabilitative Services. Mental Health Peer Specialist Services are delivered by certified peer specialists to support engagement, skill development, stabilization, and transition planning within a person-centered mental health treatment framework. These services utilize lived experience to promote motivation, resilience, and successful engagement with community mental health care following release. This is authorized under State Plan sections 6.d. Other Practitioners' Services and 13.d Rehabilitative Services.
Prescribed Drugs and Medication Administration	Medications and Medication Administration during the pre-release period, as clinically appropriate, consistent with Medicaid and State Plan coverage.

Attachment E: Reentry Demonstration Initiative Implementation Plan [Reserved]

Attachment F: Reentry Demonstration Initiative Reinvestment Plan [Reserved]

Attachment G: Reentry Demonstration Initiative Final Reinvestments [Reserved]