

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



State Demonstrations Group

JUN 16 2017

Shannon McMahan
Deputy Secretary, Health Care Financing
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Ms. McMahan:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved the Assistance in Community Integration Services (ACIS) pilot program protocol. The Maryland HealthChoice section 1115 demonstration special terms and conditions (STCs) have been revised to reflect the addition of the approved ACIS pilot program protocol, which is now Attachment E. The protocol outlines the eligibility, benefits, and payment methodologies for the ACIS program.

Your project officer for this demonstration is Felix Milburn. He is available to answer any questions concerning your section 1115 demonstration.

Mr. Milburn's contact information is as follows:

Centers for Medicare & Medicaid Services
State Demonstration Group
7500 Security Boulevard, Mailstop S2-01-16
Baltimore, Maryland 21244-1850
E-mail: Felix.Milburn@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Felix Milburn and to Francis McCullough, Associate Regional Administrator in our Philadelphia Regional Office. Francis McCullough's contact information is as follows:

Centers for Medicare & Medicaid Services
Philadelphia Regional Office
150 South Independence Mall West, Suite 216
Philadelphia, Pennsylvania 19106
Email: Francis.McCullough@cms.hhs.gov

We look forward to continuing to work the Maryland Department of Health and Mental Hygiene on the HealthChoice section 1115 demonstration.

Sincerely,



Kim Howell
Director
Division of State Demonstration and Waivers

Enclosures

cc: Francis McCullough, Philadelphia Regional Office
Talbatha Myatt, Philadelphia Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health and Mental Hygiene

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 January 1, 2017, through December 31, 2021. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Maryland to carry out the HealthChoice Medicaid Section 1115 Demonstration.

Amount, Duration, and Scope

Section 1902(a)(10)(B)

To enable the state to provide benefits specified in the STCs to demonstration participants in the Rare and Expensive Case Management program which are not available to other individuals under the Medicaid State plan.

Freedom of Choice

Section 1902(a)(23)(A)

- a. To enable the state to restrict freedom of choice of provider, other than for family planning services, for children with special needs, as identified in section 1932(a)(2)(A)(i-v) of the Act, who are participants in the demonstration.
- b. To enable the state to require that all populations participating in the demonstration receive outpatient behavioral health services from providers within the public mental health system.

Retroactive Eligibility

Section 1902(a)(34)

To exempt the state from extending eligibility prior to the date of application to optional targeted low-income children, except for infants under age one (1) described in subsection 1902(a)(10)(A)(i)(IV), or children described in subsections 1902(a)(10)(A)(i)(VI) or 1902(a)(10)(A)(i)(VII).

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health and Mental Hygiene

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Maryland for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Maryland to operate its section 1115 Medicaid HealthChoice demonstration.

The expenditure authorities listed below promote the objectives of title XIX in the following ways:

- Increases overall coverage of low-income individuals in the state and
- Improves health outcomes for Medicaid and other low-income populations in the state.

- 1. Demonstration Population 11 [Family Planning].** Expenditures for family planning and family planning related services for women, of childbearing age, who are not otherwise eligible for Medicaid, CHIP or Medicare, and who have income at or below 200 percent of the federal poverty level (FPL).
- 2. Demonstration Population 12 [Increased Community Services].** Expenditures for home and community-based services provided to individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the State plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, subject to the following conditions:
 - a. Individuals must meet one of the following criteria:
 - i. Is residing (and has resided for at least ninety (90) consecutive days) in a nursing facility and is receiving Medicaid benefits for nursing home services furnished by such nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the ninety (90) day nursing home stay requirement; or

- ii. Is currently receiving services through the Home and Community-Based Options waiver, and whose income exceeds the income eligibility threshold by no more than 5 percent. These individuals would be permitted to transition directly into the Increased Community Program (ICS) program as long as they continued to meet the nursing facility level-of-care standard. The ninety (90) day nursing home stay requirement does not apply to these individuals.
- b. Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act.
- c. The cost to Medicaid for the individual in the community must be less than the cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.
- d. Pursuant to STC 24, the state may not enroll more than 100 participants into the ICS program at any one time.

Allowable expenditures shall be limited to those consistent with statutory post eligibility and spousal impoverishment rules.

- 3. Demonstration Population 13 [Women with Breast and Cervical Cancer].** Expenditures for women with breast and cervical cancer, with incomes above 133 percent and up to 250 percent of the FPL who were enrolled in the Breast and Cervical Cancer Treatment Act Program as of December 31, 2013.
- 4. Demonstration Benefits.** Expenditures for benefits specified in the STCs provided to enrollees participating in the Rare and Expensive Case Management program which are not available to individuals under the Medicaid State plan. This includes the services provided to REM enrollees who remain in the REM program after becoming eligible for Medicare in order to allow them to continue to receive private duty nursing and shift home health aide services until age 65.
- 5. Full Medicaid Benefits for Presumptively Eligible Pregnant Women.** As of January 1, 2014, expenditures to provide full Medicaid State plan benefits to presumptively eligible pregnant women with incomes up to 250 percent of the FPL.
- 6. Demonstration Operations for Automatic Reenrollment into the MCO.** Expenditures for capitation payments made to managed care organizations (MCOs) under a contract that does not require the MCO to:
 - a. Provide an enrollee with the disenrollment rights required by sections 1903(m)(2)(A)(vi) and 1932(a)(4) of the Act, along with 42 CFR 438.56(g), when the enrollee is automatically re-enrolled into the enrollee's prior MCO after an eligibility lapse of no more than 120 days. This expenditure authority does not impact the requirements under 42 CFR 438.56(c)(2)(iii). Section 438.56(c)(2)(iii) allows a beneficiary to request disenrollment if a temporary loss of eligibility caused the beneficiary to miss the annual disenrollment opportunity.

- b. Enforce the requirement that an enrollee’s verbal appeal be confirmed in writing as specified in sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 42 CFR 438.402(b)(3)(ii) and 42 CFR 438.406(b)(1). As of July 1, 2017, the regulations cite changes to 42 CFR 438.402(c)(3)(ii) and 42 CFR 438.406(b)(3). When a beneficiary’s oral request for an appeal is not followed up in writing, the plan will send written confirmation of the appeal request to the beneficiary or the beneficiary’s authorized representative.
- c. Send a written notice of action for a denial of payment [as specified in 42 CFR 438.400(b)(3)] when the beneficiary has no liability, as required by sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 438.404(c)(2). The expenditure authority expires on December 31, 2017.

7. Residential Treatment for Individuals with Substance Use Disorder (SUD).

Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment for SUD and withdrawal management during up to two non-consecutive stays of thirty (30) days or less annually in facilities that meet the definition of an institution for mental disease (IMD).

8. Dental Benefits for Former Foster Care Youth. Expenditures for additional dental benefits beyond those specified in the state plan for former foster care youth ages 21 up to (but not including) age 26.

9. Evidence Based Home Visiting Services Pilot. Expenditures for evidence-based home visiting services by licensed practitioners to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children up to age two (2).

10. Assistance in Community Integration Services Pilot. Expenditures for home and community-based services (HCBS) and related services as described in STC 28.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Demonstration Populations 11, 12, and 13.

Title XIX Requirements Not Applicable to Demonstration Populations 11 (Family Planning) and 12 (Increasing Community Services)

Amount, Duration, and Scope

Section 1902(a)(10)(B)

To the extent necessary, to enable the state to provide a limited benefit package to demonstration participants in the limited benefit family planning.

Title XIX Requirements Not Applicable to Demonstration Population 11 (Family Planning) only:

Methods of Administration: Transportation

Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53

To the extent necessary to enable the state to not assure transportation to and from providers.

Eligibility Procedures

Section 1902(a)(17)

To the extent necessary to allow the state to not include parental income when determining a minor's (an individual age 18 and below) eligibility.

Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics

Section 1902(a)(15)

To enable the state to establish payment rates that differ from the PPS to be used for family planning and family planning-related services furnished to women enrolled in Demonstration Population 11 (Family Planning).

Retroactive Eligibility

Section 1902(a)(34)

To the extent necessary, to exempt the state from extending eligibility prior to the date of application for Demonstration Population 11 (Family Planning).

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Section 1902(a)(43)

To the extent necessary, to exempt the state from furnishing or arranging for EPSDT services for Demonstration Population 11 (Family Planning).

Title XIX Requirements Not Applicable to the Population in the REM Program

Any Willing Provider

Section 1902(a)(23)(A) insofar as it incorporates 42 CFR 431.55(f)

To the extent necessary, to permit the state to selectively contract with a single entity for the provision of the Rare and Expensive Case Management (REM) benefit as authorized under this demonstration through Expenditure Authority 4. The operation of this selective contracting authority does not affect a beneficiary's ability to select between two or more qualified case managers employed by the selected vendor.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health and Mental Hygiene (DHMH)

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Maryland’s HealthChoice section 1115(a) Medicaid Demonstration extension (hereinafter “HealthChoice”). The parties to this agreement are the Maryland Department of Health and Mental Hygiene (Maryland) to operate this demonstration and the Centers for Medicare & Medicaid Services (CMS) has granted waivers of statutory Medicaid requirements permitting deviation from the approved state Medicaid plan and expenditure authorities authorizing expenditures for cost not otherwise matchable. The waivers and expenditure authorities are separately enumerated. These STCs set forth conditions and limitations on those waiver 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 during the life of the demonstration.

The STCs related to the program for those State Plan and demonstration Populations affected by the demonstration are effective January 1, 2017 through December 31, 2021, unless otherwise noted.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligible Populations Affected and Demonstration Eligibility
- V. Monitoring and Reporting Requirements
- VI. General Financial Requirements Under Title XIX
- VII. General Financial Requirements Under Title XXI
- VIII. Monitoring Budget Neutrality
- IX. Evaluation of the Demonstration
- X. Schedule of State Deliverables for the Demonstration Period

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

Attachment A: Rare and Expensive Case Management (REM) Program and Increased Community Services (ICS) Benefits

Attachment B: Quarterly Report Template

Attachment C: Evaluation Design [Reserved]

Attachment D: Evidence Based Home Visiting Services Pilot Program Protocol

Attachment E: Assistance in Community Integration Services (ACIS) Pilot Program Protocol

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

The HealthChoice section 1115(a) demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage and/or targeted benefits to certain individuals who would otherwise be without health insurance or without access to benefits tailored to the beneficiary's specific medical needs. The initial HealthChoice demonstration was approved in 1996 to enroll most Medicaid beneficiaries into managed care organizations (MCOs) beginning July 1, 1997.

The state's goal in implementing and continuing the demonstration is to improve the health status of low-income Marylanders by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered;
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a primary care provider (PCP); and,
- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care.

Under the statewide health care reform program, the state enrolls individuals affected by or eligible through the demonstration into a managed care organization for comprehensive primary and acute care, and/or one of the demonstration's authorized health care programs. The benefits received may include or be limited to targeted programs authorized solely by the demonstration: the Rare and Expensive Case Management (REM) program, the Family Planning program, and the Increasing Community Services (ICS) program. The Primary Adult Care (PAC) program expired on December 31, 2013. Behavioral health services are provided under the demonstration in a separate fee-for-service (FFS) delivery system managed by an Administrative Services Organization (ASO), and dental services are managed by a dental ASO.

The HealthChoice demonstration continued to evolve during the 2008 to 2011 extension period by providing both eligibility and a benefit expansion, which were approved by the Maryland General Assembly in state fiscal year (SFY) 2008. The eligibility expansion allowed coverage through the Medicaid State plan to categorically eligible parent and caretaker adults with income above 30 percent of the Federal poverty level (FPL) to 116 percent of the FPL. The benefit

expansion added new benefits, on an incremental basis, to the limited benefit package available to PAC program participants.

The state also began applying a lower FPL eligibility limit (200 percent FPL rather than 250 percent FPL) in the Family Planning program to all new potential participants and to all existing participants at the time of eligibility redetermination in order to comply with CMS policy directive beginning September 1, 2008. During the 2011-2013 extension period, the state expanded eligibility to include all women who had a family income at or below 200 percent of the FPL, rather than the previous eligibility that included only women losing Medicaid pregnancy coverage at the conclusion of sixty (60) days postpartum. The state also elected to remove the five (5) year eligibility limit that was previously in place for this demonstration population. In addition to these expansions, the state moved its Employed Individuals with Disabilities (EID) program under the Medicaid State plan, rather than under the demonstration, effective October 1, 2008.

In October 2009, the ICS program was added to the demonstration. It mirrors the state's Community Options 1915(c) waiver in all aspects except eligibility. The ICS program provides cost-effective home and community-based services (HCBS) to certain adults with physical disabilities as an alternative to institutional care in a nursing facility. The goals of the ICS program are to provide quality services for individuals in the community, ensure the well-being and safety of the participants and to increase opportunities for self-advocacy and self-reliance.

In the 2013-2016 extension period, Maryland expanded Medicaid State plan coverage to individuals with incomes up to 133 percent of the FPL effective January 1, 2014 through the Medicaid State plan. Beginning January 1, 2014, the state no longer operated the PAC program and instead covered the population under the Medicaid state plan. Also, beginning January 1, 2014, the state no longer provided Medicaid State plan coverage for new Breast and Cervical Cancer Treatment Act Program applicants with incomes between 133-250 percent of the FPL. During the 2013 extension, the state also began providing full Medicaid State plan benefits to pregnant women during the presumptive eligibility period and the state began claiming REM case management services as medical expenses.

The 2017 extension made the following changes to the demonstration:

- Created a Residential Treatment for Individuals with Substance Use Disorder (SUD) Program as part of a comprehensive SUD strategy;
- Created Community health pilot programs:
 - Evidence based Home Visiting (HV) pilot program for high risk pregnant women and children up to two (2) years of age; and
 - Assistance in Community Integration Services Pilot;
- Raised the enrollment cap for the Increased Community Services Program from 30 to 100; and,
- Expanded dental benefits for former foster youth.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state agrees that it must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and State Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, court order, 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, must apply to the demonstration.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy directive, come into compliance with any changes in federal law, regulation, court order, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is explicitly waived under the STCs herein governing the demonstration.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - a. To the extent that a change in federal law, regulation, final court order, 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, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day, such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments 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 state plan governs.
- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, and budget neutrality must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state

must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

- 7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:
- a. **Demonstration of Public Notice 42 CFR §431.408 and tribal consultation:** The state must provide documentation of the state’s compliance with public notice process as specified in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in STC 15 have been met.
 - b. **Demonstration Amendment Summary and Objectives:** The state must provide a detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming title XIX and/or title XXI state plan amendment, if necessary.
 - c. **Waiver and Expenditure Authorities:** The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment.
 - d. **A data analysis worksheet 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;
 - e. **An up-to-date CHIP allotment neutrality worksheet, if necessary; and**
 - f. **If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.**
- 8. Extension of the Demonstration**
- a. **Should the state intend to request an extension of the demonstration under section 1115(a) or 1115(f), the state must submit an extension request no later than six (6) months prior to the expiration date of the demonstration. A request to extend an existing demonstration under 1115(e) must be submitted at least twelve (12) months prior to the expiration date of the demonstration. The chief executive officer of the state must submit**

to CMS either a demonstration extension request or a phase out plan consistent with the requirements of STC 9 of this section.

- b. **Compliance with Transparency Requirements of 42 CFR 431.412:** As part of the demonstration extension requests, the state must provide documentation of compliance with the transparency requirements of 42 CFR 431.412 and the public notice and tribal consultation requirements outlined in STC 14 of this section regarding Public Notice, Tribal Consultation and Consultation with Interested Parties. The financial data described in 42 CFR 431.412(c)(2)(v) must include five (5) years of recent historical expenditure and enrollment data for the Medicaid and demonstration populations that are to be included in the demonstration extension, and a proposed budget neutrality test for the extension period based on recent data.

9. Demonstration Phase Out. The state may 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 phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the thirty (30) day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.
- b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than fourteen (14) days after CMS approval of the phase-out plan.
- c. **Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- d. **Phase-out Procedures:** The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they

qualify for Medicaid eligibility under a different eligibility category as described in 42 CFR section 435.916.

- e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g): CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR section 431.416(g).
- f. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. Enrollment Limitation During Demonstration Phase Out. If the state elects to suspend, terminate, or not renew this demonstration as described in STC 9, during the last six (6) months of the demonstration, the state may choose to not enroll individuals into the demonstration who would not be eligible for Medicaid under the current Medicaid state plan. Enrollment may be suspended if CMS notifies the state in writing that the demonstration will not be renewed.

11. Expiring Demonstration Authority and Transition. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration expiration plan to CMS no later than six (6) months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a. Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- b. Expiration Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.
- c. Federal Public Notice: CMS will conduct a thirty (30) day federal public comment period consistent with the process outlined in 42 CFR §431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the thirty (30) day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration

expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) days after CMS approval of the plan.

- d. Federal Financial Participation (FFP): FFP must be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

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

13. Finding of Non-Compliance. The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

14. Withdrawal of Waiver Authority. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or would promote the objectives of titles XIX and 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' 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 and administrative costs of disenrolling participants.

15. 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.

16. Public Notice, Tribal Consultation and Consultation with Interested Parties. The state must continue to comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the review and approval process for section 1115 demonstrations at 42 CFR §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 7, are proposed by the state. In states with federally recognized Indian tribes, Indian health programs, and/or urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration.

17. Compliance with Managed Care Regulations. The state must comply with all of the managed care regulations published at 42 C.F.R. §438 et. seq., except as expressly identified as not applicable in the STCs. The per member, per month fixed amount must be developed and certified as actuarially sound in accordance with 42 C.F.R. §438.4. Procurement and the subsequent final contracts developed to implement selective contracting by the state with an MCO must be subject to CMS approval prior to implementation. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, must not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

18. Federal Funds Participation (FFP). No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

19. Deferral for Failure to Submit Timely Demonstration Deliverables. The state agrees that CMS has the authority to issue deferrals in the amount of \$5,000,000 (federal share) when deliverables are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

- a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
- c. CMS may agree to a corrective action as an interim step before applying the deferral, if requested by the state.
- d. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
- e. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
- f. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required reports, evaluations, and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

- g. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state’s existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

IV. ELIGIBLE POPULATIONS AFFECTED AND ELIGIBILITY UNDER THE DEMONSTRATION

Under the Maryland HealthChoice demonstration, state plan beneficiaries are enrolled in a Managed Care Organization (MCO) or in the REM program. Participation in HealthChoice is mandatory for the majority of Maryland’s Medicaid eligible population. Certain individuals otherwise ineligible for Medicaid may be determined eligible for the Family Planning or ICS programs.

Eligibility Overview. Participation in HealthChoice is mandatory for the majority of Maryland’s Medicaid eligible population. Medicaid, Maryland Children’s Health Program (MCHP) and MCHP Premium eligibles who participate in HealthChoice are enrolled in MCOs or in the REM Program. In addition, certain populations otherwise ineligible for Medicaid are eligible for demonstration benefits.

20. Eligibility Groups Affected by the Demonstration. Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived to the extent necessary to permit the state to carry out the demonstration as described in these STCs. Any Medicaid state plan amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration. These state plan eligible beneficiaries are included in the demonstration for use of the managed care network and access to additional benefits not described in the state plan. Groups which are made demonstration eligible by virtue of the expenditure authorities expressly granted in this demonstration are subject to all applicable Medicaid laws or regulations in accordance with the Medicaid state plan, except as specified as not applicable in the expenditure authorities for this demonstration.

21. Maryland Health Choice Comprehensive for the Medicaid and CHIP State Plan Mandatory and Optional Groups.

Participating Groups. The criteria for HealthChoice participation are outlined below in a chart that summarizes each specific group of individuals; under what authority they are eligible for coverage; and the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed.

Medicaid State Plan Mandatory Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Expenditure and CMS-64 Eligibility Group Reporting
New Adult Group	Childless adults and non-custodial parents ages 19-64 with	New Adult Group

	income up to 133 percent of the FPL as defined in section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, pursuant to the approved state plan.	
TANF adults, pregnant women, parents, and caretaker adults	Families with dependent children and foster children with incomes less than 116 percent of the FPL, including individuals with incomes below the pre-July 1, 2008, TANF income thresholds.	TANF Adults 0-116
Medicaid Child	Children up to 21 years of age.	Medicaid Child
SOBRA Adults	Pregnant women with incomes above the pre-July 1, 2008, standard up to and including 250 of the FPL who are not enrolled in the TANF group.	SOBRA Adults
Non-Dual Blind and Disabled	Individuals whose Medicaid eligibility derives from their status as blind or disabled and who are not entitled to Medicare.	SSI/BD Adults or SSI/BD Children
Medicaid State Plan Optional Group	FPL and/or Other Qualifying Criteria	Expenditure and CMS-64 Eligibility Group Reporting
Medically Needy Adults and Children	Families with dependent children, or foster children, whose gross income and resources exceed 116 percent of the FPL but who incur medical expenses such that their income is equal to or less than 116 percent FPL.	MN Adults or MN Children
Optional targeted low income children through age 18.	Up to first birthday: Between 185 and 200 percent of the FPL; On first birthday through age 5: between 133 and 200 percent of the FPL; and Upon sixth birthday through age 18: between 100 and 200 percent of the FPL.	MCHP (Only during periods when title XXI funding is exhausted)
Optional targeted low income children through age 18	Between 200 percent of the FPL and 300 percent of the FPL who pay a premium.	MCHP Premium (Only during periods when title XXI funding is exhausted)
Demonstration Eligible Groups	FPL and/or Other Qualifying Criteria	Expenditures and CMS-64 Eligibility Group Reporting.
Family Planning	Women of childbearing age who are not otherwise eligible for Medicaid, CHIP, or Medicare, and who have a family income at or below 200 percent of the FPL.	Family Planning
Increased Community Services (ICS)	Medicaid eligible individuals over the age of 18 residing in a nursing home at the time initially determined eligible for ICS, with an income level at or below 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR).	ICS
Women with Breast and Cervical Cancer	Women diagnosed with breast or cervical cancer with incomes between 133-250 percent of the FPL and who were in active treatment under the Breast & Cervical Cancer	WBCCTP

	Treatment program as of December 31, 2013.	
Presumptively Eligible Pregnant Women	Presumptively eligible pregnant women with incomes up to 250 percent of the FPL who receive full Medicaid state plan benefits through this demonstration.	PEPW
Demonstration Programs	FPL and/or Other Qualifying Criteria	Expenditures and CMS-64 Eligibility Group Reporting.
Residential Treatment for Individuals with Substance Use Disorder *Effective July 1, 2017	Effective July 1, 2017, expenditures for SUD treatment in IMDs.	SUD
Assistance in Community Integration Services Pilot *Effective July 1, 2017	Effective July 1, 2017, expenditures for the ACIS Pilot as described in STC 28.	ACIS
Evidence Based Home Visiting Services (HV) Pilot Program *Effective July 1, 2017	Effective July 1, 2017, expenditures for evidence based home visiting services to promote enhanced health outcomes, whole person care, and community integration for high risk pregnant women and children up to 2 years old.	Home Visiting
Enhanced Dental Services for Former Foster Youth *January 1, 2017	Effective January 1, 2017, expenditures for enhanced dental services for former foster care youth up to 26 years old.	Former Foster Dental

- b. HealthChoice Benefits. The HealthChoice program provides comprehensive Medicaid state plan benefits to demonstration participants. The new adult group receives benefits provided through the state’s approved alternative benefit plan (ABP) state plan.
- c. Health Choice Cost Sharing. All cost-sharing must be in compliance with Medicaid requirements for state plan populations that are set forth in statute, regulation and policies and all demonstration participants must be limited to a five percent aggregate cost sharing limit per family. Cost sharing must be equal to or less than:
- i. Copayments of \$3.00 per prescription and refill for brand name drugs.
 - ii. Copayments of \$1.00 per prescription and refill for generic drugs.

- iii. Copayments of \$1.00 per prescription and refill for preferred drugs provided on a fee-for-service basis (outside of the MCO prescription drug benefit).
 - iv. Premiums for children through age 18 with incomes between 200 percent up to and including 250 percent of the FPL – is calculated at two percent of a family household income of two at 200 percent of the FPL per family per month.
 - v. Premiums for children through age 18 with incomes between 251 percent up to and including 300 percent – is calculated at two percent of a family household income of two at 250 percent of the FPL per family per month.
- d. Redetermination and Disenrollment. Redeterminations and disenrollment are made in accordance with the Medicaid state plan.
- e. Delivery System. Physical health and vision benefits are rendered through one of eight Medicaid MCOs; rehabilitation services (occupational therapy, physical therapy, and speech) are rendered on a fee for service basis for children (20 years old and under); dental services are rendered through a dental Administrative Services Organization (ASO); and behavioral health benefits (mental health and substance use disorder benefits) are rendered through an ASO. The managed care authority applies to all populations except for those listed in STC 23.

22. Rare and Expensive Case Management (REM) Program for Maryland Health Choice Comprehensive Participants and Certain Medicare Beneficiaries

- a. Maryland HealthChoice participants including the New Adult Group, who have specified conditions that are expensive and require complex medical treatment may be enrolled in a special case management program operated by the state. The REM case management program includes certain optional services, not otherwise provided under the Medicaid program, to assist with the special needs of this population. To qualify, individuals must continue to meet eligibility diagnosis criteria for REM services. Should an individual no longer meet the diagnostic criteria for REM, that individual will be disenrolled from the REM program. The state may also enroll individuals who are not otherwise participating in the demonstration, who are under age 65 and receiving Medicare benefits in the REM program, if the individual was previously enrolled in the REM program and receiving private duty nursing services or home health aide services. REM services are reimbursed at the medical assistance rate. The state is allowed to contract with a single agency for the provision of the REM benefit as authorized under this demonstration through Expenditure Authority 4. The operation of this selective contracting authority does not affect a beneficiary's ability to select between two or more qualified case managers.
- b. Benefits. Specific benefits provided to beneficiaries enrolled in the REM program are described in Attachment A. Benefits for Medicare beneficiaries will be limited to services not available under Medicare.

- c. Cost Sharing. Applicable state plan cost sharing requirements apply.
- d. Redetermination and Disenrollment. Redetermination and disenrollment decisions must be made in accordance with the Medicaid State plan.
- e. Delivery System. An individual choosing to enroll in the REM program is prohibited from enrolling in an MCO. Services are delivered on a FFS basis.

23. Family Planning Program

Family planning and family planning-related services are available to all women of childbearing age who are not otherwise eligible for Medicaid, CHIP, or Medicare, and who have a family income at or below 200 percent of the FPL.

Family planning services and supplies described in section 1905(a)(4)(c) and are limited to those services and supplies whose primary purpose is family planning and are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:

- a. Approved methods of contraception;
- b. Sexually transmitted infection (STI)/ sexually transmitted disease (STD) testing, pap smears, and pelvic exams in conjunction with the family planning method of choice;
 - i. Note: The laboratory tests done during an initial family planning visit for contraception include a pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.
- c. Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets that state's provider enrollment requirements (subject to the national drug rebate program requirements); and,
- d. Contraceptive management, patient education, and counseling.

Family planning related services and supplies are defined as those services provided as part of or as follow up to a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning related services and supplies include:

- a. Colposcopy (and procedures done with/during a colposcopy) or repeat pap smear performed as a follow up to an abnormal pap smear which is done as part of a routine/periodic family planning visit.
- b. Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/diagnosed during a routine/periodic family planning visit. A follow up visit/encounter for the treatment/drugs and subsequent follow up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
- c. Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow up visit/encounter for the treatment/drugs may also be covered.
- d. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
- e. Treatment of major complications arising from a family planning procedure such as:
 - i. Treatment of a perforated uterus due to an intrauterine device insertion;
 - ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
 - iii. Treatment of surgical or anesthesia related complications during a sterilization procedure.

Primary care referrals to other social services and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they care access primary care services. There is no cost sharing requirement for this population.

The state must ensure that redeterminations of eligibility for the family planning program are conducted at least every twelve (12) months. Redetermination may be administrative in nature. If a woman becomes pregnant while enrolled in the family planning program, she may be determined eligible for Medicaid under the state plan. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid state plan. In addition, women who receive a sterilization procedure and complete

all necessary follow up procedures will be disenrolled from the family planning program. Services provided for this demonstration population are paid fee for service (FFS)

24. Increased Community Services (ICS) Program

- a. Participation. Expenditures for home and community-based and state plan services provided to individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the state plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, subject to the following conditions:
 - i. Individuals must meet one of the following criteria:
 - a. Is residing (and has resided for at least ninety (90) consecutive days) in a nursing facility and is receiving Medicaid benefits for nursing home services furnished by such nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the ninety (90) day nursing home stay requirement; or
 - b. Is currently receiving services through the Home and Community-Based Options waiver, and whose income exceeds the income eligibility threshold by no more than 5 percent. These individuals would be permitted to transition directly into the ICS program as long as they continued to meet the nursing facility level-of-care standard. The ninety (90) day nursing home stay requirement does not apply to these individuals.
 - ii. Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act; and,
 - iii. The cost to Medicaid for the individual in the community must be less than the cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.
- b. Benefits. This program provides Medicaid state plan benefits and home and community-based services identical to those provided under the Community Options 1915(c) waiver. These services enable the participant to live at home with appropriate supports rather than in a nursing facility.
- c. Enrollment Cap. The number of participants that may be enrolled in the ICS program at any one time is limited to 100. The state will create a registry that identifies all

individuals eligible for the program who have indicated interest in receiving home and community-based services. The registry will be sorted based on date and time of interest. As slots become available, the state shall will notify individuals on the registry in numerical order of the opportunity to participate in the ICS program. Interested individuals will have fifteen (15) days to indicate whether or not they are still interested in participating. If after fifteen (15) days an individual fails to respond, a second letter will be mailed to the individual. If state receives no response in seven (7) days after the second letter is mailed, the state will remove the individual's name from the registry, and offer that slot to the next person on the registry.

- d. Assurances. For the ICS population the state will comply with the HCBS assurances contained in 42 C.F.R. §441.302.
- e. Cost Sharing. All cost-sharing must be in compliance with Medicaid requirements for state plan populations that are set forth in statute, regulation and policies and all demonstration enrollees must be limited to a five percent aggregate cost sharing limit per family. Cost sharing must be equal to or less than:
 - i. \$3.00 per prescription and refill for brand name drugs;
 - ii. \$1.00 per prescription and refill for generic and HIV drugs; and,
 - iii. \$1.00 per prescription and refill for preferred drugs provided on a fee-for-service basis (outside of the MCO prescription drug benefit).
- f. Delivery System. The state will operate the ICS program in a manner consistent with its approved Community Options 1915(c) waiver program and must meet all quality, administrative, operational, and reporting requirements contained therein.
- g. Redetermination and Disenrollment. Redetermination and disenrollment decisions will be made in accordance with the Medicaid State plan.

25. Breast and Cervical Cancer Treatment Act Program (BCCTP)

As of January 1, 2014, the state no longer provides Medicaid state plan coverage for new Breast and Cervical Cancer Treatment Act Program (BCCTP) applicants with incomes between 133-250 percent of the FPL. Those individuals now receive coverage through a Qualified Health Plan (QHP) in the marketplace. After December 31, 2013, the state no longer enrolled individuals into BCCTP. For continuity of care purposes those individuals who were enrolled and in active treatment prior to January 1, 2014, were grandfathered into the program and receive coverage under this demonstration effective January 1, 2014. The state submitted a conforming State Plan Amendment (SPA) to reflect this change.

- 26. Eligibility Exclusions.** The following persons shall not be eligible to participate in the managed care component of the HealthChoice demonstration, and will receive benefits unaffected by the state demonstration unless otherwise indicated.
- a. Individuals with dual Medicare/Medicaid coverage except those participating in the REM Program pursuant to STC 22.
 - b. Individuals over 65 years old.
 - c. Individuals determined Medically Needy under a spend-down.
 - d. Individuals expected to be continuously institutionalized for more than ninety (90) successive days in a long-term care or skilled nursing facility except individuals transitioning to community placement under the ICS program.
 - e. Beneficiaries enrolled in the Home Care for Disabled Children under a Model Waiver.
 - f. Individuals expected to be continuously institutionalized for more than thirty (30) successive days in a Psychiatric Institution for Mental Disease (IMD) (this includes only psychiatric diagnoses, not SUD diagnoses that would be eligible under the SUD component of the demonstration).
 - g. Beneficiaries enrolled in the Breast and Cervical Cancer Treatment Program (BCCTP) until December 31, 2013. Beginning January 1, 2014 this population will be covered through the demonstration as described in STC 19.
 - h. Employed Individuals with Disabilities (EID) participants as of October 1, 2008.
 - i. Certain foster care groups:
 - i. A child receiving an adoption subsidy who is covered under the parent's private insurance;
 - ii. A child under State supervision receiving an adoption subsidy who lives outside the state; and
 - iii. A child under State supervision who is in an out-of-state placement.

27. Residential Treatment for Individuals with Substance Use Disorder (SUD) Program

Effective July 1, 2017, the demonstration benefit package for individuals age 21 through 64 will include SUD treatment in certain IMDs, which are not otherwise included as expenditures under section 1903 of the Act. Such services will be delivered by the ASO through the FFS delivery system. The SUD program will be available to all full-benefit Medicaid beneficiaries beginning July 1, 2017. The state will offer the SUD benefit to dual eligibles no later than January 1, 2020.

The coverage of residential treatment and withdrawal management services will expand Maryland's current SUD benefit package to cover the full continuum for care for SUD treatment as described in the national treatment guidelines published by the American Society of Addiction Medicine (ASAM Criteria). SUD services approved through the state plan as well as residential treatment and withdrawal management services approved through this demonstration will be available to all Maryland Medicaid recipients (with the exception of dual eligibles) as outlined in Table One.

Table One: Maryland SUD Benefits (with Expenditure Authority)

ASAM Level of Care	Service	Service Definition	Expenditure Authority
0.5	Early Intervention		State plan
1	Outpatient Service	Counseling services are provided to recipients with an SUD diagnosis (up to 9 hours per week for adults, and less than 6 hours per week for adolescents) when determined to be medically necessary and in accordance with an individualized treatment plan.	State plan
2.1	Intensive Outpatient Service	Structured programming services provided to recipients with an SUD diagnosis (a minimum of 9 hours with a maximum of 19 hours per week for adults, and a minimum of 6 hours with a maximum of 19 hours per week for adolescents) when determined to be medically necessary and in accordance with an individualized treatment plan.	State plan
2.5	Partial Hospitalization	Structured programming services provided to recipients with an SUD diagnosis (20 or more hours of clinically intensive programming per week) when determined to be medically necessary and in accordance with an individualized treatment plan.	State plan
3.1	Clinically Managed Low-Intensity Residential Services	Supportive living environment with 24-hour staff that provides rehabilitation services to recipients with an SUD diagnosis (5 or more hours of low-intensity treatment per week) when determined to be medically and in accordance with an individualized treatment plan.	Section 1115 demonstration (Covered for recipients aged 21 to 64)
3.3	Clinically Managed Population-Specific High Intensity Residential Services	Clinically managed therapeutic rehabilitative facility for adults with cognitive impairment including developmental delay that provides rehabilitation services to recipients with an SUD when determined to be medically and in accordance with an individualized treatment plan. Staffed by credentialed addiction professionals, physicians/physician extenders, and credentialed mental health professionals.	Section 1115 demonstration (Covered for recipients aged 21 to 64)
3.5	Clinically	Clinically managed therapeutic community or residential	Section 1115

	Managed High Intensity Residential Services	treatment facility providing high intensity services for adults or medium intensity services for adolescents when determined to be medically and in accordance with an individualized treatment plan. Staffed by licensed/credentialed clinical staff, including addiction counselors, licensed clinical social workers, licensed professional counselors, physicians/physician extenders, and credentialed mental health professionals.	demonstration (Covered for recipients aged 21 to 64)
3.7	Medically Monitored Intensive Inpatient Services	Medically monitored inpatient services in a freestanding residential facility or inpatient unit of an acute care hospital or psychiatric unit when determined to be medically and in accordance with an individualized client plan. Includes 24-hour clinical supervision including physicians, nurses, addiction counselors and behavioral health specialists.	Section 1115 demonstration (Covered for recipients aged 21 to 64)
4.0	Medically Managed Intensive Inpatient	Acute care general or psychiatric hospital with 24/7 medical management and nursing supervision and counseling services (16 hours per day). Managed by addiction specialist physician with interdisciplinary team of credentialed clinical staff knowledgeable of biopsychosocial dimensions of addictions.	State plan
Opioid Treatment Services	Opioid Maintenance Therapy	Physician-supervised daily or several times weekly opioid agonist medication and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder in Department of Health and Mental Hygiene (DHMH) licensed methadone clinics in accordance with an individualized client plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of Maryland requirements.	State plan
Opioid Treatment Services	Office Based Opioid Treatment	Physician-supervised medication and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder by primary care providers and other physician offices in accordance with an individualized client plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of Maryland requirements.	State plan
1 WM	Ambulatory Withdrawal Management Without Extended On-Site Monitoring	Ambulatory withdrawal management without extended on-site monitoring with specialized psychological and psychiatric consultation and supervision.	State plan
2 WM	Ambulatory Withdrawal	Ambulatory withdrawal management with extended on-site monitoring with clinical (medical) consultation and	State plan

	Management With Extended On-Site Monitoring	supervision.	
3.7 WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary, unlikely to complete withdrawal management without medical, nursing monitoring.	Section 1115 demonstration (Covered for recipients aged 21 to 64)

Residential Treatment Services

Rehabilitation services are provided to Maryland Medicaid recipients with an SUD diagnosis when determined to be medically necessary by the ASO utilization management staff and in accordance with an individualized treatment plan.

- a. Residential services are provided in a DHMH licensed residential facility that has been enrolled by DHMH as a Medicaid provider and issued a certification by DHMH as capable of delivering care consistent with the ASAM Criteria as a Level 3.1, 3.3, 3.5 and/or 3.7 program.
- b. Residential services can be provided in settings of any size.
- c. Only a two (2) - 30-day residential stays will be covered in a one (1) year period. Extended lengths of stay can be provided if medically necessary using other identified funds.
- d. Effective July 1, 2017, services will be covered for ASAM Levels of Care 3.3, 3.5, 3.7 and 3.7 WM. Effective January 1, 2019, services will be covered for ASAM Levels of Care 3.1.
- e. Through revisions to the state’s program standards for SUD, including but not limited to the Administrative Service Organization (ASO) provider handbook, DHMH will update its standards of care for residential treatment programs to further incorporate industry standard benchmarks from the ASAM Criteria for defining provider and service specifications. These revisions are expected to be completed prior to July 1, 2017.
- f. Each residential treatment provider will be assessed to meet the provider and service specifications described in the ASO provider handbook consistent with the ASAM Criteria for the requisite level or sublevel of care prior to participating in the Maryland Medicaid program under this section 1115 demonstration. Prior to enrolling a residential treatment provider in Medicaid and prior to service provision under this demonstration, DHMH will conduct site visits and certify residential treatment providers as ASAM Level 3.1, 3.3, 3.5 and/or 3.7 programs. The ASO will provide preliminary credentialing for ASAM Levels 3.1, 3.3, 3.5 and/or 3.7 contingent on the providers receiving certification from the state. The ASO will finalize its credentialing after the providers submit their site visit reports verifying they are ASAM Level 3.1, 3.3, 3.5 and/or 3.7 programs.
- g. Prior authorization is required for residential services. For ASAM Levels 3.1 to 4.0, providers

will complete a preadmission assessment of the member’s clinical needs and submit the clinical information to the ASO for prior authorization. Utilization management staff or a licensed physician employed by the ASO will document the use of the ASAM multidimensional assessment and matrices for matching severity with type and intensity of services. Each prior authorization review will assess service needs, coordination needs and ensure appropriate placement in the appropriate level of care based on the member’s needs as demonstrated in the ASAM Criteria multidimensional assessment. The ASO must provide prior authorization for residential services within twenty-four (24) hours of the prior authorization request being submitted by the provider.

Integration with Physical Health

DHMH is embarking on a strategy to integrate physical and behavioral health care services delivered to beneficiaries in order to improve health outcomes for beneficiaries with SUD and reduce costs in the Maryland Medicaid program. DHMH will explore options for identifying the best integration strategy upon approval of this waiver amendment and will commit to specifying an integration approach by January 1, 2018. DHMH will produce a concept design for an integrated care model by July 1, 2018, with the goal of implementing physical and behavioral health integration by January 1, 2019.

Quality Measurement and Evaluation

An independent evaluation will evaluate if the SUD program reforms and services delivered through this demonstration are effective in improving health outcomes and decreasing health care costs and utilization. The evaluation is designed to demonstrate achievement of Maryland’s goals, objectives, and metrics for the demonstration. Thus, the specific aims of the evaluation, which align with the demonstration’s goals and objectives, are to capture the impact of the demonstration on increased access to clinically appropriate care; reduced substance use related deaths; and reduced emergency department visits. In addition, researchers will assess the impact of providing the full continuum of SUD services, especially residential treatment, on emergency department utilization, inpatient hospital utilization, and readmission rates to the same level of care or higher.

Table Two: Medicaid Adult Core Set Quality Measures to be Reported

Source	Measure	Collection Mechanism
NQF #0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims/encounter data
NQF#1664	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	Electronic clinical data/clinical paper chart review
NQF #2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or	Claims/encounter data

- 28. Community Health Pilot Program: Assistance in Community Integration Services (ACIS) Pilot Program.** Under this program, the state will provide a set of HCBS services under a pilot that is capped at 300 individuals annually. These services include:
1. One-time community transition services to individuals moving from institutional to community settings and those at imminent risk of institutional placement.
 - a. Eligibility for these services include individuals who would be eligible under a section 1915(c) waiver program. (For example, those at imminent risk of institutionalization include those individuals with a disabling condition who meet an institutional level of care.)
 - b. The post-approval ACIS protocol, which will be subject to CMS approval, will include the service definitions for the one-time transition services and payment methodologies.
 2. HCBS that could be provided to the individual under a 1915(c) waiver or 1915(i) SPA.
 - a. Eligibility for these services include individuals who would be eligible under a section 1915(c) waiver or 1915(i) SPA program.
 - b. The post-approval ACIS protocol, which will be subject to CMS approval, will include the content that would otherwise be documented in a 1915(c) waiver and/or 1915(i) SPA, and will include service definitions and payment methodologies.

The state will submit the protocol for services identified in 1 and 2 above to CMS for review by January 11, 2017, and will not implement ACIS until receiving CMS approval.

- 29. Community Health Pilot Program: Evidence-Based Home Visiting Services Pilot Program.** Under this program, the state will provide evidence-based home visiting services by licensed practitioners to promote enhanced health outcomes, whole person care, and community-integration for high-risk pregnant women and children up to two (2) years old. The program is aligned with two evidence-based models focused on the health of pregnant women. Additional information regarding this pilot program can be found in Attachment D.
- a. Nurse Family Partnership (NFP): The NFP is designed for reinforces maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The HealthChoice section 1115 demonstration NFP pilot program will adhere to the NFP national program standards and service will be suspended once the child reaches two (2) years old.
 - b. The Healthy Families America (HFA). The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, SUD, mental health issues, and domestic violence.

- 30. Dental Expansion for Former Foster Youth.** The demonstration provides dental benefits for former foster youth ages twenty-one (21) up to (but not including) age twenty-six (26). Former foster youth ages twenty (20) and under receive full dental benefits under EPSDT.

V. MONITORING AND REPORTING REQUIREMENTS

- 31. Quarterly Monitoring Calls.** CMS will convene quarterly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration, including planning for future changes in the program. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda prior to the calls. Areas to be addressed during the monitoring call include, but are not limited to:

Operations and performance:

- a. Transition and implementation activities;
 - b. Stakeholder concerns;
 - c. Enrollment;
 - d. Cost sharing;
 - e. Quality of care;
 - f. Beneficiary access;
 - g. Benefit package and wrap around benefits;
 - h. Audits;
 - i. Lawsuits;
 - j. Financial reporting and budget neutrality issues;
 - k. Progress on evaluation activities and contracts;
 - l. Related legislative developments in the state; and,
 - m. Any demonstration changes or amendments the state is considering
- 32. Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of

the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) 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 report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments and how they have been addressed in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

- 33. Submission of Post-approval Deliverables.** The state shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs (“deliverables”). The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.
- 34. Compliance with Federal Systems Innovation.** As federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state will work with CMS to:

 - a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
 - b. Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to are provided; and,
 - c. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.
- 35. Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully and timely with CMS and its contractors' evaluation activities. 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 by the state under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in Section III, STC 19.
- 36. Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS.

37. Quarterly and Annual Progress Reports.

- a. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The Quarterly Reports are due no later than sixty (60) days following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90) days following the end of the DY.
- b. The Quarterly and Annual Reports shall provide sufficient information for CMS to understand implementation progress of the demonstration including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The reports will include all required elements 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).
- c. The Quarterly and Annual Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.
 - i. Operational Updates. The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.
 - ii. Performance Metrics. Progress any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.
 - iii. Budget Neutrality and Financial Reporting Requirements. The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.
 - iv. Evaluation Activities and Interim Findings. 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. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of

reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycles assessment in trends for monitoring and evaluation of the demonstration.

- v. The Annual Report must include all items outlined in STC 48. In addition, the Annual Report must at a minimum include the requirements outlined below:
 - a) All items included in the Quarterly Reports must be summarized to reflect the operation/activities throughout the DY;
 - b) Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
 - c) Yearly unduplicated enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

38. Compliance with Managed Care Reporting Requirements. The state must comply with all managed care reporting regulations at 42 C.F.R. § 438 et. seq., except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.

39. Managed Care Data Requirements. All managed care organizations must maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438.242 and 42 CFR 438.818. This system must include encounter data that can be reported in a standardized format. Encounter data requirements must include the following:

- a. Encounter Data (Health Plan Responsibilities) – The health plan must collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.
- b. Encounter Data (State Responsibilities) – The state must, in addition, develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan’s encounter data are timely, complete and accurate. The state will take appropriate actions to identify and to correct deficiencies identified in the collection of encounter data. The state must have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state must contract with its EQRO to validate encounter data through medical record review.
- c. Encounter Data Validation Study for New Capitated Managed Care Plans – If the state contracts with new managed care organizations, the state must conduct a validation study eighteen (18) months after the effective date of the contract to

determine completeness and accuracy of encounter data. The initial study must include validation through a sample of medical records of demonstration enrollees.

- d. **Submission of Encounter Data to CMS** – The state must submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS as is consistent with federal law. The state must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the state.

40. Reporting Requirements Relating to Budget Neutrality. The state shall comply with all reporting requirements for monitoring budget neutrality as set forth in section XI.

41. Title XXI Reporting Requirements. The state will provide CMS on a quarterly basis, an enrollment report for the title XXI populations showing end of quarter actual and unduplicated ever enrolled figures. This data will be entered into the Statistical Enrollment Data System within thirty (30) days after the end of each quarter.

42. Annual Report. The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. Additionally, this report must contain a discussion of the items that must be included in the quarterly operational reports required under STC 37. The state must submit the draft annual report no later than October 1 of each year. Within thirty (30) days of receipt of comments from CMS, a final annual report must be submitted.

- a. The state must report the number of actual births that occur to Family Planning Demonstration participants. (Participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year.)
- b. Yearly enrollment reports for demonstration eligibles for each DY (eligibles include all individuals enrolled in the demonstration).
- c. Total number of participants for the DY (participants include all individuals who obtain one or more covered family planning services through the demonstration).
- d. The average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age one (1). (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)

VI. GENERAL FINANCIAL REQUIREMENTS

43. Reporting Expenditures under the Demonstration. In order to track expenditures under this demonstration, Maryland must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine

CMS-64 reporting instructions outlined in section 2500 and section 2115 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Expenditures for optional targeted low income children (MCHP and MCHP Premium children) claimed under the authority of title XXI must be reported each quarter on forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver. For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, “expenditures subject to the budget neutrality limit,” is defined below in Section VIII

- 44. Premium and Cost Sharing Contributions.** Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
- 45. Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
- 46. Pharmacy Rebates.** Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form CMS-64.9 or CMS-64.9P Waiver.
- 47. Use of Waiver Forms for Medicaid.** For each demonstration year, separate Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver shall be completed to report expenditures for the following demonstration populations and demonstration services. The waiver names to be used to identify these separate forms CMS-64.9 Waiver and/or CMS-64.9P Waiver appear in quotation marks following the colon. Expenditures should be allocated to these forms based on the guidance found below.

- a. Demonstration Population 1: “New Adult Group” – EG consists of childless adults, ages 19-64, with income up to 133 percent of the FPL, and adults whose Medicaid eligibility derives from their status as a relative caring for a child, or a pregnant woman whose income is 116 percent through 133 percent FPL.
- b. Demonstration Population 2: “TANF Adults 0-116” – EG consists of adults whose Medicaid eligibility derives from their status as a relative caring for a child, or a pregnant woman whose income is 31 percent through 116 percent FPL.
- c. Demonstration Population 3: “Medicaid Children” – EG consists of children whose Medicaid eligibility derives from their status as a minor child up to 21 years of age.
- d. Demonstration Population 4: “SOBRA Adults” – EG consists of income eligible pregnant women.
- e. Demonstration Population 5: “SSI/BD Adults” – EG consists of adults whose Medicaid eligibility derives from their status as blind or disabled.
- f. Demonstration Population 6: “SSI/BD Children” – EG consists of children whose Medicaid eligibility derives from their status as blind or disabled.
- g. Demonstration Population 7: “MN Adults” – EG consists of adults whose income and resources exceed the categorically needy limits but are within Medicaid State plan limits.
- h. Demonstration Population 8: “MN Children” – EG consists of children whose income and resources exceed the categorically needy limits but are within Medicaid State plan limits.
- i. Demonstration Population 9: “MCHP” – EG consists of optional targeted low income children with incomes up to and including 200 percent of the FPL who do not pay premiums and who are eligible to claim title XIX funds under the state’s approved title XIX State plan only when the state has exhausted its title XXI allotment and only until the next title XXI allotment becomes available to the state.
- j. Demonstration Population 10: “MCHP” Premium – EG consists of optional targeted low income children with incomes above 200 percent up to and including 300 percent of the FPL who pay premiums and who are eligible to claim title XIX funds under the state’s approved title XIX State plan only when the State has exhausted its title XXI allotment and only until the next title XXI allotment becomes available to the state.
- k. Demonstration Population 11: “Family Planning” – The EG is eligible for only family planning and family planning related services and the EG consists all women, of childbearing age, who are not otherwise eligible for Medicaid, the Children’s

Health Insurance Program (CHIP) or Medicare, with income at or below 200 percent of the FPL.

1. Demonstration Population 12: “Increased Community Services (ICS) program” – The EG consists of individuals over the age of eighteen (18) who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the state plan resources limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, subject to the following conditions:
 - i. Individuals must have resided in a nursing facility for at least six (6) months, and been eligible for Medicaid for at least thirty (30) consecutive days immediately prior to being enrolled in this program;
 - ii. Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act; and
 - iii. The cost to Medicaid for the individual in the community must be less than cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.

- m. Demonstration Population 13: “Breast and Cervical Cancer Treatment Program (BCCTP)” – The EG consists of women diagnosed with breast or cervical cancer with incomes between 133-250 percent of the FPL and who were in active treatment under the BCCTP as of December 31, 2013.

- n. Demonstration Population 14: “Presumptive Eligibility for Pregnant Women (PEPW)” – The EG consists of presumptively eligible pregnant women who receive full Medicaid state plan benefits through demonstration.

- o. “Residential Treatment for Individuals with Substance Use Disorder (SUD) program” – The EG consists of expenditures for individuals 21 through 64 who are receiving residential treatment SUD services as outlined in these STCs.

- p. “Dental Expansion for Former Foster Youth (Former Foster Dental)” – The EG consists of additional expenditures for dental services for the former foster youth ages 21 up to (but not including) age 26.

- q. “Home Visiting” – The EG consists of expenditures for evidence-based home visiting services to high risk pregnant women and children up to two (2) years of age.

- r. “Assistance in Community Integration Services Pilot (ACIS)” – The EG consists of expenditures for the ACIS Pilot Program.

48. Specific Reporting Requirements for Demonstration Populations 09 and 10.

- a. The state is eligible to receive title XXI funds for expenditures for these children, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver in accordance with the instructions in section 2115 of the State Medicaid Manual.
- b. Title XIX funds are available under this demonstration if the state exhausts its title XXI allotment once timely notification as described in subparagraph (c) has been provided.
- c. If the state exhausts its title XXI allotment prior to the end of a federal fiscal year, title XIX federal matching funds are available for MCHP and MCHP Premium children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver. To initiate this:
 - i. The state must provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for this demonstration population; and,
 - ii. The state must submit:
 - a) An updated budget neutrality assessment that includes a data analysis which identifies the specific “with waiver” impact of the proposed change on the current budget neutrality expenditure cap. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current extension 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 result of the proposed change which isolates (by Eligibility Group) the impact of the change.
 - b) An up-to-date Children’s Health Insurance Program (CHIP) allotment neutrality worksheet.
 - c) Expenditures subject to the budget agreement. For purposes of this section, the term “expenditures subject to the budget neutrality agreement” must include all title XIX expenditures provided to individuals who are enrolled in this demonstration as described in STC 48(c)(i-xv). All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or CMS-64.9P Waiver.

49. Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or CMS-64.10P Waiver.

- 50. Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two (2) 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 (2) years after the conclusion or termination of the demonstration. During the latter two (2) year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- 51. Reporting Member Months.** For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 37, the actual number of eligible member months for the demonstration populations defined in STC 47. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.
- a. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
 - b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three (3) months contributes three (3) eligible member months to the total. Two individuals who are eligible for two (2) months each contribute two (2) eligible member months to the total, for a total of four (4) eligible member months.
- 52. Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS must make federal funds available based upon the state’s estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS must reconcile expenditures reported on the 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.
- 53. Extent of (Federal Financial Participation) FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in STC 61:
- 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. Net medical assistance expenditures authorized under section 1115 demonstration for the HealthChoice program.
- d. CMS must provide FFP for family planning and family planning-related services and supplies at the applicable federal matching rates described in STC 22, subject to the limits and processes described below:
 - i. For family planning services, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.
 - ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in STC 23, should be entered in Column (D) on the Forms CMS-64.9 Waiver.
 - iii. Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in STC 23, should be entered in Column (B) on the Forms CMS-64.9 Waiver.
 - iv. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them.

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

- a. CMS must review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

55. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. 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.

56. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

VII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

57. Expenditures Subject to the Allotment Neutrality Limit. Eligible title XXI demonstration expenditures subject to the allotment neutrality agreement are expenditures for services provided through this demonstration to title XXI children with FPL levels within the approved CHIP state plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the state's available title XXI funding.

58. **Quarterly Expenditure Reporting through the MBES/CBES.** In order to track title XXI expenditures under this demonstration, the state must report quarterly demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual.
59. **Title XXI expenditures** must be reported on separate forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Once the appropriate waiver form is selected for reporting expenditures, the state is required to identify the program code and coverage (i.e., children).
60. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two (2) year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver.
61. **Standard Medicaid Funding Process.** The standard CHIP funding process will be used during the demonstration. The state must estimate matchable Medicaid expansion CHIP (MCHP) expenditures on the quarterly Form CMS-37.12 (Narrative) for both Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). On the form CMS-37.12, the state must separately identify estimates of expenditures for the demonstration population. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 waiver forms with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.
62. **Administrative Costs.** Administrative costs under title XXI may be claimed on the CMS-21 for the enhanced match or the CMS-64.21 at the regular FMAP if the state has met the title XXI ten percent cap or if the state is concerned about having sufficient title XXI funds for services. If title XXI funding is ever exhausted, administrative costs will be claimed on the CMS-64 at the regular FMAP.
63. **State Certification of Funding Conditions.** The state will certify that state/local monies are used as matching funds for the demonstration. The state further certifies that such funds must not be used as matching funds for any other federal grant or contract, except as permitted by federal law. All sources of non-federal share of funding and distribution of monies involving federal match are subject to CMS approval. Upon review of the sources of the non-federal share of funding and distribution methodologies of funds under

the demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS must be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

- 64. Limitation on Title XXI Funding.** Maryland will be subject to a limit on the amount of federal title XXI funding that the state may receive for demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including currently available reallocated funds. Should the state expend its available title XXI federal funds for the claiming period, no further enhanced federal matching funds will be available for costs of the demonstration children until the next allotment becomes available.
- 65. Exhaustion of Title XXI Funds.** After the state has exhausted Title XXI funds, expenditures for optional targeted low income children within CHIP state plan-approved income levels, may be claimed as Title XIX expenditures as approved in the Medicaid state plan. The state must report expenditures for these children, identified as MCHP and MCHP Premium, as waiver expenditures on the Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver in accordance with STC 48.
- 66. Exhaustion of Title XXI Funds Notification.** The state must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures. The state must follow Medicaid state plan criteria for the beneficiaries unless specific waiver and expenditure authorities are granted through this demonstration.

VIII. MONITORING BUDGET NEUTRALITY

- 67. Limit on Title XIX Funding.** The state must be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
- 68. Risk.** The state must be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality agreement, but not for the number of demonstration eligibles. Because CMS provides FFP for all demonstration eligibles, Maryland must not be at risk for changing economic conditions that impact enrollment levels. However, by placing Maryland at risk for the per capita costs for current eligibles, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

69. Demonstration Populations Used to Calculate the Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit for the demonstration.

70. For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each EG described as follows:

- a. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under STC 51 for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below.
 - i. The PMPM costs in this subparagraph reflect the agreed-upon case-mix adjustment that was applied for each year of the budget neutrality agreement.
 - ii. In addition, the Family Planning population is structured as a “pass-through” or a “hypothetical state plan population.” Therefore, the state may not derive savings from this component.
 - iii. The annual budget neutrality expenditure cap for the demonstration is the sum of the annual EG estimate for each EG calculated in subparagraph i above as well as, the *actual* expenditures for the MCHP and MCHP Premium EGs claimed as title XIX expenditures as approved in the Medicaid State plan when the state has exhausted title XXI funding.

Demonstration Eligibility Groups	Trend Rate	DY20 01/01/17 – 06/30/17 6 Months	DY21 07/01/17 – 06/30/18 12 Months	DY22 07/01/18 – 06/30/19 12 Months	DY23 07/01/19 – 06/30/20 12 Months	DY24 07/01/20 – 06/30/21 12 Months	DY25 07/01/21 – 12/31/21 6 Months
TANF Adults 0-123	4.9%	\$979.91	\$1,027.92	\$1,078.29	\$1,131.13	\$1,186.55	\$1,244.69
Medicaid Children	4.4%	\$530.22	\$553.55	\$577.91	\$603.34	\$629.88	\$657.60
Medically Needy Adult	4.0%	\$5,602.84	\$5,826.95	\$6,060.03	\$6,303.43	\$6,554.53	\$6,816.71
Medically Needy Children	4.0%	\$2,562.44	\$2,664.93	\$2,771.53	\$2,882.39	\$2,997.69	\$3,117.59

SOBRA Adults	5.1%	\$4,456.21	\$4,683.47	\$4,922.33	\$5,173.37	\$5,437.21	\$5,714.51
SSI/BD Adults	4.0%	\$2,305.65	\$2,397.87	\$2,493.79	\$2,593.54	\$2,697.28	\$2,805.17
SSI/BD Children	4.0%	\$2,089.58	\$2,173.16	\$2,260.09	\$2,350.49	\$2,444.51	\$2,542.29

The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality cap calculated in subparagraph iii, that includes the *actual* expenditures for the MCHP and MCHP Premium EGs claimed as title XIX expenditures as approved in the Medicaid State plan when the state has exhausted title XXI funding. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations reported under the following Waiver Names (TANF Adults 0-116, Medicaid Children, SSI/BD Adults, SSI/BD Children, MN Adults, MN Children, SOBRA Adults, PAC, MCHP and MCHP Premium, ICS, PEPW and WBCCTP), plus any excess from the Supplemental Tests described below. Each DY, the net variance between the without-waiver cost and actual with-waiver cost will be reduced. The Each DY, the net variance between the without-waiver cost and actual with-waiver cost will be reduced. The reduced variance, to be calculated as a percentage of the total variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) The formula for calculating the reduced variance is, reduced variance equals total variance times applicable percentage.

The percentages for each EG and DY are determined based on how long the associated population has been enrolled in managed care subject to this demonstration; lower percentages are for longer established managed care populations. In the Maryland demonstration, the percentages below apply to all EGs in the same manner.

Demo Years	DY20 (6 months)	DY21 (12 months)	DY22 (12 months)	DY23 (12 months)	DY24 (12 months)	DY25 (6 months)
Savings Percentage	25%	25%	25%	25%	25%	25%

- b. Supplemental Budget Neutrality Tests: Hypothetical Groups.** The budget neutrality test for this demonstration includes an allowance for hypothetical populations, which are optional populations that could have been added to the Medicaid program through the state plan, but instead will be covered in the demonstration only. The expected costs of hypothetical populations are reflected in the “without-waiver” budget neutrality expenditure limit. The state must not accrue

budget neutrality “savings” from hypothetical populations. To accomplish these goals, a separate expenditure cap is established for the hypothetical groups, to be known as Supplemental Budget Neutrality Tests.

Supplemental Budget Neutrality Test 1: Family Planning.

The MEG listed in the table below are for the Supplemental Budget Neutrality Test 1.

MEG	Trend Rate	DY20 – PMPM	DY21 – PMPM	DY22 – PMPM	DY23– PMPM	DY24 - PMPM	DY25 - PMPM
Family Planning	5.2%	\$54.69	\$57.54	\$60.53	\$63.68	\$66.99	\$70.47

- i. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for each group in the above table in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of Supplemental Cap 1 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 1.
 - ii. Supplemental Budget Neutrality Test 1 is a comparison between the federal share of Supplemental Cap 1 and total FFP reported by the state for hypothetical groups under the following Waiver Name (Family Planning).
 - iii. If total FFP for hypothetical groups should exceed the federal share of Supplemental Cap 1, the difference must be reported as a cost against the budget neutrality limit described in STC 67.
- c. **Supplemental Budget Neutrality Test 2: New Adult Group.** Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in the budget neutrality.

The state will not be allowed to obtain budget neutrality “savings” from this population. Therefore, a separate expenditure cap is established for this group, to be known as Supplemental Budget Neutrality Test 2.

The MEG listed in the table below is included in Supplemental Budget Neutrality Test 2.

MEG	Trend Rate	DY20 – PMPM	DY21 – PMPM	DY22 – PMPM	DY23– PMPM	DY24 - PMPM	DY25 - PMPM
New Adult Group	4.7%	\$907.68	\$950.34	\$995.01	\$1,041.77	\$1,090.74	\$1,142.00

- i. If the state’s experience of the take up rate for the New Adult Group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical

assistance for the New Adult group, the state may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

- ii. The Supplemental Cap 2 is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The Federal share of the Supplemental Cap 2 is obtained by multiplying total computable Supplemental Cap 2 by the Composite Federal Share 3.
- iii. Supplemental Budget Neutrality Test 2 is a comparison between the Federal share of the Supplemental Cap 2 and total FFP reported by the state for New Adult Group.
- iv. If total FFP for New Adult Group should exceed the Federal share of Supplemental Cap 2 after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit described in these STCs.

d. Supplemental Budget Neutrality Test 3: SUD Component

The MEG listed in the table below is included in Supplemental Budget Neutrality Test 3.

MEG	Trend Rate	DY20 – PMPM	DY21 – PMPM	DY22 – PMPM	DY23– PMPM	DY24 - PMPM	DY25 - PMPM
SUD	5.2%	N/A	\$5,750.40	\$6,049.42	\$6,363.99	\$6,694.92	\$7,043.05

e. Supplemental Budget Neutrality Test 4: Expanded Dental for Former Foster Youth.

The MEG listed in the table below is included in Supplemental Budget Neutrality Test 4.

MEG	Trend Rate	DY20 – PMPM	DY21 – PMPM	DY22 – PMPM	DY23– PMPM	DY24 - PMPM	DY25 - PMPM
Dental for Former Foster Youth	5.2%	\$22.01	\$23.15	\$24.36	\$25.63	\$26.96	\$28.36

71. Composite Federal Share Ratio. The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite 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, as reported through MBES/CBES and summarized on Schedule C with consideration of additional

allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms. 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-upon method.

- 72. Enforcement of Budget Neutrality.** CMS must enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Expenditure Cap Definition	Percentage
DY20	DY20 budget estimate plus	1 percent
DY21	DY20 and DY21 combined budget estimates plus	1 percent
DY22	DY20 through DY22 combined budget estimates plus	1 percent
DY23	DY20 through DY23 combined budget estimates plus	1 percent
DY24	DY20 through DY24 combined budget estimates plus	0.5 percent
DY25	DY20 though DY25 combined budget estimates plus	0 percent

In addition, the state may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure limit indicates a possibility that the demonstration will exceed the limit during this extension.

- 73. Exceeding Budget Neutrality.** If, at the end of this demonstration period, the budget neutrality expenditure limit has been exceeded, the excess Federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision must be based on the time elapsed through the termination date.

IX. EVALUATION OF THE DEMONSTRATION

- 74. Independent Evaluator.** At the beginning of the demonstration period, the state must acquire an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft evaluation plan. For scientific integrity, every effort should be made to follow the approved methodology, but requests

for changes may be made in advance of running any data or due to mid-course changes in the operation of the demonstration.

- 75. Evaluation Design Approval and Updates.** The state must submit its draft evaluation design to CMS no later than 120 days after the award of the demonstration extension. The state's Draft Evaluation Design may be subject to multiple revisions until a format is agreed upon by CMS. The state must submit a revised Draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the Draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation research and submit their evaluation implementation progress in each of the Quarterly Reports and Annual Reports (per STC 37), including any required Rapid Cycle Assessments (per as outlined in STC 37(c)).
- 76. Evaluation Budget.** A budget for the evaluation shall 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 evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.
- 77. Evaluation Requirements.**
- a. The demonstration evaluation will meet the prevailing standards of scientific evaluation and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings.
 - i. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.
 - ii. The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.
 - b. The state shall also conduct an evaluation pursuant to STC 27 which shall include an investigation of the impact of providing Medicaid reimbursement for IMD services on the following outcomes among beneficiaries in need of acute mental health or substance use disorder treatment:

- i. Emergency room utilization for consequences of substance use disorders including opioid overdoses;
- ii. Access to acute inpatient treatment and residential treatment for substance use disorders;
- iii. Lengths of stay in acute inpatient and residential settings for treatment for treatment of substance use disorder;
- iv. Access to acute inpatient and residential treatment for substance use disorders;
- v. Quality of substance use disorder treatment including medication assisted treatment;
- vi. Quality of discharge planning in making effective linkages to community-based care;
- vii. Readmissions to the same level of care or higher;
- viii. Cost of treatment for substance use disorder conditions;
- ix. Overall cost of care for individuals with substance use disorders including co-morbid physical and mental health conditions;
- x. Opioid prescribing patterns; and,
- xi. Drug overdose deaths.

78. State Must Separately Evaluate Components of the Demonstration. The outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the state met the demonstration goal, with recommendations for future efforts regarding all components.

- a. At a minimum, the Draft Evaluation Plan must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those outlined in the goals of the demonstration outlined in Section II. The draft design shall discuss:
 - i. The outcome measures that must be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population;
 - ii. It shall discuss the data sources and sampling methodology for assessing these outcomes; and,
 - iii. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration are isolated from other

initiatives occurring in the state.

- b. The evaluation must outline and address evaluation questions for all of the following components:
 - i. Substance use disorder demonstration component;
 - ii. Community health pilots;
 - iii. Expanded dental for former foster care youth;
 - iv. Increased Community Services;
 - v. Assistance in Community Integration Pilot; and
 - vi. Family planning component.

79. Evaluation Standards. The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

80. Draft Interim Evaluation Reports. In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit a draft interim evaluation report for the completed years of the approval period represented in these STCs, as outlined in 42 CFR 431.412(c)(2)(vi). The state will provide a final report thirty (30) days after receiving comments from CMS.

- a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
- b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. If the state requests changes to the demonstration, it must identify research questions and hypotheses related to the changes requested and an evaluation design for addressing the proposed revisions.

81. Summative Evaluation Report. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period represented in these STCs within eighteen (18) following the end of the approval period represented by these STCs. The

Summative Evaluation Report must include the information in the approved evaluation design.

- a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within thirty (30) days of receiving comments from CMS.

82. State Presentations for CMS. The state will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 75. The state shall present on its interim evaluation in conjunction with STC 80. The state shall present on its summative evaluation in conjunction with STC 81.

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

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

84. Interim Evaluation Reports. In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the state’s request for each subsequent renewal.

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date - Specific	Deliverable	Reference
120 days following award of the extension	Submit Draft Evaluation Design	STC 75
60 days after receiving CMS comments	Revised Draft Evaluation Design	STC 75
June 30, 2023	Summative Evaluation Report	STC 81

Annual		
	By October 1 st - Draft Annual Report	STC 42
Each Quarter		
	Quarterly Reports	STC 37
	Quarterly Enrollment Reports	STC 37
	CMS-64 Reports	STC 47
	Eligible Member Months	STC 51

ATTACHMENT A

Rare and Expensive Case Management (REM) Program and Increased Community Services (ICS) Program Benefits

REM Program Benefits

The REM Program provides all medically necessary services to individuals with specific qualifying conditions. In addition to State plan benefits, REM provides:

- Chiropractic services for over 21*
- Dental coverage for over 21*
- Nutritional counseling for over 21*
- Nutritional supplements (Nutritional supplements are dietary supplements prescribed when medically necessary. These include medical foods for participants with inborn errors of metabolism, and enteral feedings for participants not receiving the feedings by tube (g-tube etc.). Nutritional supplements can also include prescribed vitamins and minerals.)
- Physician participation in development of a treatment plan
- Occupational therapy for over 21*
- Speech, Hearing and Language services for over 21*
- Shift nursing services for over 21*
- Certified nursing assistant for over 21*
- Home health aide for over 21* (Home health aide services in excess of the home health aide services available under the state plan.)
- Private duty nursing for dually eligible Medicaid and Medicare services

*These services are covered under the EPSDT benefit for children.

ICS Program Benefits

The ICS Program provides Medicaid state plan benefits and the home and community-based services described in the state's Community Options 1915(c) waiver.

ATTACHMENT B
Quarterly Report Template

Under Section V, STC 37, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration.

The reports are due to CMS sixty (60) days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Maryland HealthChoice Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 20 (January 1, 2017, through December 31, 2017)

Federal Fiscal Quarter: 2/2017 (1/1/2017 -3/31/2017)

Introduction

Provide information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0.”

Enrollment Counts

Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the CMS-64)	Previous Quarter (last day of previous quarter)	Current Enrollees (to date)
TANF Adults 0-116		
New Adult Group		
Medicaid Children		
SSI/BD Adults		
SSI/BD Children		

ATTACHMENT B
Quarterly Report Template

Medically Needy Adults		
Medically Needy Children		
SOBRA Adults		
MCHP		
MCHP Premium		
Family Planning		
ICS		
WBCCTP		
PEPW		

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Family Planning Program

Identify all significant program developments/issues/problems that have occurred in the current quarter, including the required data and information under Section VII, including enrollment data requested that is not represented in the formatted tables.

REM Program

- Beneficiaries Enrolled
- Programmatic Update
- Reasons for disenrollment/discharge from program

ICS Program

- Status of Registry
- For the quarter ending March 30 each year, attach a copy of the annual report completed in accordance with Appendix A of the approved ICS waiver.

MCHP and MCHP Premium Status/Update/Projections

Expenditure Containment Initiatives

Identify all current activities, by program and or demonstration population. Include items such as status, and impact to date as well as short and long-term challenges, successes and goals.

**ATTACHMENT B
Quarterly Report Template**

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the State’s actions to address these issues.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Total for Previous Quarter Ending XX/XX	Current Qtr. Month 1	Current Qtr. Month 2	Current Qtr. Month 3	Total for Quarter Ending XX/XX
TANF Adults 0-116					
New Adult Group					
Medicaid Children					
SSI/BD Adults					
SSI/BD Children					
Medically Needy Adults					
Medically Needy Children					
SOBRA Adults					
MCHP					
MCHP Premium					
Family Planning					
WBCCTP					

B. For Informational Purposes Only

ATTACHMENT B
Quarterly Report Template

Eligibility Group	Total Previous Quarter Ending XX/XX	Current Qtr. Month1	Current Qtr. Month2	Current Qtr. Month 3	Total for Quarter Ending XX/XX
ICS					
Home Visiting Pilot					
ACIS Pilot					

Consumer Issues

A list of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, complaints by type, complaints by health plan, the resolution of complaints, any actions taken or to be taken to prevent other occurrences, and corrective action plans for health plans.

Legislative Update

Discussion of health care initiatives or other pertinent pending legislation.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT D
Evidence-Based Home Visiting Services Pilot Protocol
Approved: April 27, 2017

Per STC 29, the following protocol includes additional information about the evidence-based home visiting services (HVS) pilot program.

As described in STC 29, the pilot program provides evidence-based home visiting services by licensed practitioners or certified home visitors to promote health outcomes, whole person care, and community-integration for high-risk pregnant women and children up to two (2) years old. The services are described in Table One: Description of Services below which are based on evidence-based program requirements. The provider qualifications are described in Table Two: Provider Requirements below which include provider titles, licensure certification, education, training, and experience requirements. The HVS pilot program is aligned with two evidence-based models focused on the health of pregnant women.

- a. Nurse Family Partnership (NFP): The NFP is designed to reinforce maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The HealthChoice section 1115 demonstration NFP pilot program will adhere to the NFP national program standards and service will be suspended once the child reaches two (2) years old.
- b. The Healthy Families America (HFA). The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, substance use disorder (SUD), mental health issues, or domestic violence.

The services are described in Table One: Description of Services below.

Table One: Description of Services

Service	Description of Service
Prenatal Home Visit	<p>The HVS Pilot Project will provide home visit services to expectant mothers during their pregnancy. The prenatal home visit services will provide:</p> <ul style="list-style-type: none"> • Monitoring for high blood pressure or other complications of pregnancy (NFP only); • Diet and nutritional education; • Stress management; • Sexually Transmitted Diseases (STD) prevention education; • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; and • Domestic and intimate partner violence screening and education.
Postpartum Home Visits	<p>The HVS Pilot Project will provide home visit services to Medicaid eligible mothers during their sixty (60) day postpartum period.</p> <ul style="list-style-type: none"> • Diet and nutritional education; • Stress management; • STD prevention education;

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	<ul style="list-style-type: none"> • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; • Domestic and intimate partner violence screening and education; • Breastfeeding support and education (NFP may refer beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service); • Guidance and education with regard to well woman visits to obtain recommended preventive services; • Medical assessment of the postpartum mother and infant (NFP only); • Maternal-infant safety assessment and education e.g. safe sleep education for Sudden Infant Death Syndrome (SIDS) prevention • Counseling regarding postpartum recovery, family planning, needs of a newborn; • Assistance for the family in establishing a primary source of care and a primary care provider (i.e. ensure that the mother/ infant has a postpartum/newborn visit scheduled); • Parenting skills and confidence building (HFA emphasis).
Infant Home Visits	<p>The HVS Pilot Project will provide home visit services to newborn infants born to HVS Pilot Project beneficiaries until the child reaches two (2) years of age.</p> <ul style="list-style-type: none"> • Breastfeeding support and education (NFP may refer beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service)); and • Child developmental screening at major developmental milestones from birth to age two (2); • Parenting skills and confidence building (the HFA program emphasizes these skills).

Both HFA and NFP evidence-based practice models specify an array of services that may be provided to meet the needs of the family.

The HFA program model meets the criteria established by the U.S. Department of Health and Human Services (HHS) for an “evidence-based early childhood home visiting service delivery model.” Goals include reducing child maltreatment, improving parent-child interactions and children’s social-emotional well-being, and promoting children’s school readiness. HFA Model program components include 1) screenings and assessments to determine families at risk for child maltreatment or other adverse childhood experiences; 2) parent education and support services; and 3) routine screening for child development and maternal depression as well as screening for domestic violence and substance abuse. In the case of a positive screen, the individual is referred for appropriate treatment services. In such cases, care coordination may also occur if consent is provided by the parent. If consent is provided, home visitors may refer participants out to external resources and providers. The type of referral may vary depending upon the type of service required. With additional consent, home visitors will liaise with the provider to ensure coordination of care.

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In addition, many sites offer services such as parent support groups and father involvement programs. Home visitors complete training modules that include such topics such as keeping babies healthy and safe, fostering infant and child development, and promoting mental health. Thus, HFA model services offered to mothers may include both teaching basic parenting skills, and training parents on how to manage a child’s medical, behavioral, and/or developmental treatment needs.

The NFP program model also meets the criteria established by DHHS for an “evidence-based early childhood home visiting service delivery model.” The program model is designed for first-time, low-income mothers and their children, and is designed to improve 1) prenatal health and outcomes; 2) child health and development; and 3) families’ economic self-sufficiency and/or maternal life course development. NFP home visitors use input from parents, nursing experience, nursing practice, and a variety of model-specific resources coupled with the principles of motivational interviewing to promote low-income, first-time mothers’ health during pregnancy, care of their child, and own personal growth and development. NFP program model, therefore, may also address both teaching basic parenting skills, as well as training parents on how to manage a child’s medical, behavioral, and/or developmental treatment needs.

The provider qualifications for the services provided are described in Table Two: Provider Qualifications below.

Table Two: Provider Qualifications

<i>Home Visitor Provider Qualifications</i>				
Home Visitors	Education (typical)	Experience (typical)	Skills (preferred)	Training
Healthy Families America Home Visitors – Must be hired by an HFA affiliated or accredited agency	Bachelor’s Degree in Behavioral Sciences (Social Work, Psychology, Sociology, Mental Health, Nursing and Education) preferred; Associate’s Degree in Human Services or related field. May have high school diploma or GED.	3-5 years’ experience working in Human or Social Services; 1 year working with or providing services to children and families; Case management or service coordination experience preferred; Experience and willingness to work with a culturally diverse population.	Oral and written communication skills. Ability to develop trusting relationships. Ability to maintain professional boundaries. Acceptance of individual differences. Knowledge of infant and child development.	Must meet HFA program training requirements, including: Core Training; Curriculum training; Wraparound training; customized advanced training; any additional program based continuing education training requirements.

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		A Master’s Degree in nursing or public health may be substituted for one year of the required experience.	Openness to reflective practice.	
Nurse Family Partnership (NFP) Nurse Home Visitors – Hired by approved Nurse Family Partnership implementing agency	Registered nurse (RN) with Baccalaureate degree in nursing; may have additional degrees beyond BSN such as MSN or, other related/advanced practitioner designations e.g. nurse practitioner, nurse midwife; current licensure.	At least 5 years’ experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. May have American Heart Association HealthCare provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification. A Master’s Degree in nursing or public health may be substituted for one year of the required experience.	Technical skills: Providing care mgmt. and care coordination to high-risk pops; understanding and applying federal, state, local, and grant program regulations and policies in a public health environment; Leadership skills, interpersonal and relationship building; communication and quality improvement analysis skills.	Comprehensive training and preparation as required by NFP model.
Nurse Home Visitor Supervisor – Hired by approved Nurse Family Partnership implementing agency	Registered nurse (RN) with Baccalaureate degree in nursing. Preferred that nurse supervisors have additional degrees beyond BSN such as MSN or, other related/advanced	At least 5 years’ experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. May have American Heart Association HealthCare	Nurses must receive reflective supervision weekly to meet requirements of the evidence based program. This nurse supervision is part of the direct services provided.	Comprehensive training and preparation as required by NFP model.

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Evidence-Based Home Visiting Services Pilot Protocol
Approved: April 27, 2017

	<p>practitioner designations e.g. nurse practitioner, nurse midwife.</p>	<p>provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification.</p> <p>A Master’s Degree in nursing or public health may be substituted for one year of the required experience.</p>	<p>Nurse supervisors may conduct home visits as required to support nurses and/or beneficiaries level of care needs. For example, if a child or caregiver is ill for a month, a Nurse Home Visitor Supervisor may visit the home to re-assess the caregiver and child and offer an appropriate level of care.</p>	
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Description of Payment Methodologies

The Lead Entity (LE) will supply IGTs solely for the payment of services authorized under the demonstration. The services are defined in Table One: Description of Services above.

Department of Health and Mental Hygiene (DHMH) will pay LEs on a quarterly basis for home visiting services provided (per unit cost). The unit cost that will be based on such things as, estimated salary costs, travel cost, reporting costs, and other reasonable and necessary expenditures divided by the number of expected number of visits. The expected number of visits will be based on the model, the number of beneficiaries to be served, and the number of home visitors. DHMH will evaluate the reasonableness of the unit cost and total payment. DHMH anticipates that the initial quarterly payments will be prospective, and thereafter retrospective based on the LE’s actual HVS services rendered. In turn, DHMH anticipates that the HVS provider will invoice the LE monthly or quarterly for home visits provided to a specific Medicaid beneficiary based on the LE and HVS provider’s contractually agreed upon payment schedule. Lead Entities are expected to submit a budget proposal and narrative that reflects average expected evidence-based home visiting frequency and intensity, taking into account the potential for variations, that is, accommodating for those few cases that may require more intense visits.

Both the HFA and NFP evidence-based home visiting programs tailor home visiting services and the number of visits to the needs of each family.

Frequency of home visiting may vary from family to family, but must remain within the scope of the evidence-based programs. Below are the home visiting frequency and intensity protocols for HFA and NFP.

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Evidence-Based Home Visiting Services Pilot Protocol
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Healthy Families America: HFA sites offer at least one home visit per week for the first six (6) months after the child’s birth. After the first six (6) months, visits might be less frequent. Visit frequency is based on families’ needs and progress over time. Typically, home visits last one hour. HFA sites begin to provide services prenatally or at birth and continue for this Pilot demonstration up to age two (2).

Nurse Family Partnership: NFP nurses conduct weekly home visits for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first six (6) weeks after the baby is born, and then every other week until the baby is twenty (20) months. The last four (4) visits are monthly until the child is two (2) years old. Home visits typically last 60 to 75 minutes. The visit schedule may be adjusted to meet client needs.

NFP recommends that programs begin conducting visits early in the second trimester (14–16 weeks gestation) and requires programs to begin visits by the end of the 28th week of pregnancy. Clients graduate from the program when the child turns two (2) years old.

Payment will be withheld if Lead Entities do not report required data to DHMH in a timely and complete manner as outlined and agreed upon in applicable data use agreements.

Table Three: Healthy Families America (HFA) Agencies in Maryland with Accreditation Status

Jurisdiction	Agency	Current Status
Allegany	Health Department	Affiliated
Baltimore County	Health Department	Accredited
Baltimore City	Family League	Accredited
Calvert County	Public Schools	Accredited
Charles County	Center for Children	Accredited
Dorchester	Health Department	Accredited
Frederick	Mental Health Association	Accredited
Garrett	Health Department	Accredited
Harford	Health Department	Affiliated
Howard	Howard General Hospital	Accredited
Lower Shore (Somerset)	Eastern Psych Association	Accredited
Mid Shore	Health Department	Accredited
Montgomery	Family Services	Accredited
Prince George's	Dept. Family Services	2 Sites Accredited; 1 site Affiliated
Washington	Health Department	Accredited
Wicomico	Health Department	Accredited

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Per STC 29, the following protocol includes additional information about the evidence-based home visiting services (HVS) pilot program.

As described in STC 29, the pilot program provides evidence-based home visiting services by licensed practitioners or model trained home visitors to promote health outcomes, whole person care, and community-integration for high-risk pregnant women and children up to two (2) years old. The services are described in Table One: Description of Services below which are based on evidence-based program requirements. The provider qualifications are described in Table Two: Provider Requirements below which include provider titles, licensure (if applicable), certification, (if applicable), education, training, and experience requirements. The HVS pilot program is aligned with two evidence-based models focused on the health of pregnant women and infants.

- a. Nurse Family Partnership (NFP): The NFP is designed to reinforce maternal behaviors that encourage positive parent child relationships and maternal, child, and family accomplishments. The HealthChoice section 1115 demonstration NFP pilot program will adhere to the NFP national program standards and service will be suspended once the child reaches two (2) years old.
- b. Healthy Families America (HFA). The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, substance use disorder (SUD), mental health issues, or domestic violence. The HealthChoice section 1115 demonstration HFA pilot program will adhere to the HFA national program standards and service will be suspended once the child reaches two (2) years old.

The services are described in Table One: Description of Services below.

Table One: Description of Services

Service	Description of Service
Prenatal Home Visit	<p>The HVS Pilot Project will provide home visit services to Medicaid eligible expectant mothers during their pregnancy. The prenatal home visit services will provide:</p> <ul style="list-style-type: none"> • Monitoring for high blood pressure or other complications of pregnancy (NFP only); • Diet and nutritional education; • Stress management; • Sexually Transmitted Diseases (STD) prevention education; • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; and • Domestic and intimate partner violence screening, education and safety planning.
Postpartum Home Visits	<p>The HVS Pilot Project will provide home visit services to Medicaid eligible mothers during their sixty (60) day postpartum period.</p>

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	<ul style="list-style-type: none"> • Diet and nutritional education; • Stress management; • STD prevention education; • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; • Domestic and intimate partner violence screening, education and safety planning; • Breastfeeding support and education (NFP may refer Medicaid beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service); • Guidance and education with regard to well woman visits to obtain recommended preventive services; • Medical assessment of the postpartum mother and infant (NFP only); • Maternal-infant safety assessment and education e.g. safe sleep education including Sudden Infant Death Syndrome (SIDS) prevention • Counseling regarding postpartum recovery, family planning, needs of a newborn; • Assistance for the family in establishing a primary source of care and a primary care provider (i.e. ensure that the mother/ infant has a postpartum/newborn visit scheduled); • Parenting skills and confidence building (HFA emphasis).
Infant Home Visits	<p>The HVS Pilot Project will provide home visit services to newborn infants born to HVS Pilot Project beneficiaries until the child reaches two (2) years of age.</p> <ul style="list-style-type: none"> • Breastfeeding support and education (NFP may refer Medicaid beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service); and • Child developmental screening at major developmental milestones from birth to age two (2); • Parenting skills and confidence building (the HFA program emphasizes these skills).

Both HFA and NFP evidence-based practice models specify an array of services that may be provided to meet the needs of the family.

The HFA program model meets the criteria established by the U.S. Department of Health and Human Services (HHS) for an “evidence-based early childhood home visiting service delivery model.” Goals include reducing child maltreatment, improving parent-child interactions and children’s social-emotional well-being, and promoting children’s school readiness. HFA Model program components include 1) screenings and assessments to determine families at risk for child maltreatment or other adverse childhood experiences; 2) parent education and support services; and 3) routine screening for child development and maternal depression as well as screening for domestic violence and substance abuse. In the case of a positive screen, the individual is referred for appropriate treatment services. In such cases,

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care coordination may also occur if consent is provided by the parent. If consent is provided, home visitors may refer participants out to external resources and providers. The type of referral may vary depending upon the type of service required. With additional consent, home visitors will liaise with the provider to ensure coordination of care. In addition, many sites offer services such as parent support groups and father involvement programs.

Home visitors complete training modules specific to each program model that include such topics such as keeping babies healthy and safe, fostering infant and child development, and promoting mental health. Thus, HFA model services offered to mothers may include both teaching basic parenting skills, and training parents on how to manage a child’s medical, behavioral, and/or developmental treatment needs.

The NFP program model also meets the criteria established by DHHS for an “evidence-based early childhood home visiting service delivery model.” The program model is designed for first-time, low-income mothers and their children, and is designed to improve 1) prenatal health and outcomes; 2) child health and development; and 3) families’ economic self-sufficiency and/or maternal life course development. NFP home visitors use input from parents, nursing experience, nursing practice, and a variety of model-specific resources coupled with the principles of motivational interviewing to promote low-income, first-time mothers’ health during pregnancy, care of their child, and own personal growth and development. NFP program model, therefore, may also address both teaching basic parenting skills, as well as training parents on how to manage a child’s medical, behavioral, and/or developmental treatment needs.

The provider qualifications for the services provided are described in Table Two: Provider Qualifications below.

Table Two: Provider Qualifications

<i>Home Visitor Provider Qualifications</i>				
Home Visitors	Education (typical)	Experience (typical)	Skills (preferred)	Training
Healthy Families America Home Visitors – Must be hired by an HFA affiliated or accredited agency	Bachelor’s Degree in Behavioral Sciences (Social Work, Psychology, Sociology, Mental Health, Nursing and Education) preferred; Associate’s Degree in Human	3-5 years’ experience working in Human or Social Services; 1 year working with or providing services to children and families; Case management or service coordination experience preferred;	Oral and written communication skills; Ability to develop trusting relationships; Ability to maintain professional boundaries; Acceptance of individual	Must meet HFA program training requirements, including: Core Training; Curriculum training; Wraparound training; customized advanced training; any additional

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	Services or related field. May have high school diploma or GED.	Experience and willingness to work with a culturally diverse population. A Master's Degree in nursing, public health, social work or a relevant human services field may be substituted for one year of the required experience.	differences; Knowledge of infant and child development; Openness to reflective practice.	program based continuing education training requirements.
Nurse Family Partnership (NFP) Nurse Home Visitors – Hired by approved Nurse Family Partnership implementing agency	Registered nurse (RN) with Baccalaureate degree in nursing; may have additional degrees beyond BSN such as MSN or, other related/advanced practitioner designations e.g. nurse practitioner, nurse midwife; current licensure.	At least 5 years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. May have American Heart Association HealthCare provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	Technical skills: Providing care mgmt. and care coordination to high-risk populations; understanding and applying federal, state, local, and grant program regulations and policies in a public health environment; Leadership skills, interpersonal and relationship building; communication and quality improvement analysis skills	Comprehensive training and preparation as required by NFP model.
Nurse Home Visitor Supervisor – Hired by approved Nurse Family	Registered nurse (RN) with Baccalaureate degree in nursing. Preferred that nurse supervisors	At least 5 years' experience in public health nursing, maternal and child health, behavioral health nursing,	Nurses must receive reflective supervision weekly to meet requirements of the evidence	Comprehensive training and preparation as required by NFP model.

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Partnership implementing agency	have additional degrees beyond BSN such as MSN or, other related/advanced practitioner designations e.g. nurse practitioner, nurse midwife.	pediatrics, or other fields. May have American Heart Association HealthCare provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification. A Master’s Degree in nursing or public health may be substituted for one year of the required experience.	based program. This nurse supervision is part of the direct services provided. Nurse supervisors may conduct home visits as required to support nurses and/or beneficiaries level of care needs. For example, if a child or caregiver is ill for a month, a Nurse Home Visitor Supervisor may visit the home to re-assess the caregiver and child and offer an appropriate level of care.	
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Description of Payment Methodologies

The Department of Health and Mental Hygiene (DHMH) will pay Lead Entities (LE) (local health departments/ county governments) for home visiting services provided at a home visit rate. The home visit rate shall not exceed the amount expended by the Lead Entity for furnishing the direct service of the provider. The home visit rate will be developed based on a target cost per visit, adjusted for factors specific to the lead agency, such as the particular evidence-based practice, along with variables such as salary costs, type of visit, intensity of visit, and duration of visit or contracted evidence-based practice provider unit costs. Payment will be withheld if Lead Entities do not report required data to DHMH in a timely and complete manner as outlined and agreed upon in applicable data use agreements.

Both the HFA and NFP evidence-based home visiting programs tailor home visiting services and the number of visits to the needs of each family. Frequency of home visiting may vary from family to family, but must remain within the scope of the evidence-based programs. Below are the home visiting frequency and intensity protocols for HFA and NFP.

Healthy Families America: HFA sites offer at least one home visit per week for the first six (6) months after the child’s birth. After the first six (6) months, visits might be less frequent. Visit frequency is based on families’ needs and progresses over time. Typically, home visits last one hour. HFA sites

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begin to provide services prenatally or at birth and continue for this Pilot demonstration up to age two (2).

Nurse Family Partnership: NFP nurses conduct weekly home visits for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first six (6) weeks after the baby is born, and then every other week until the baby is twenty (20) months. The last four (4) visits are monthly until the child is two (2) years old. Home visits typically last 60 to 75 minutes. The visit schedule may be adjusted to meet client needs.

NFP recommends that programs begin conducting visits early in the second trimester (14–16 weeks gestation) and requires programs to begin visits by the end of the 28th week of pregnancy. Clients graduate from the program when the child turns two (2) years old.

Table Three: Healthy Families America (HFA) Agencies in Maryland with Accreditation Status

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Garrett	Health Department	Accredited
Harford	Health Department	Affiliated
Howard	Howard General Hospital	Accredited
Lower Shore (Somerset)	Eastern Psych Association	Accredited
Mid Shore	Health Department	Accredited
Montgomery	Family Services	Accredited
Prince George's	Dept. Family Services	2 Sites Accredited; 1 site Affiliated
Washington	Health Department	Accredited
Wicomico	Health Department	Accredited

ATTACHMENT E
Assistance in Community Integration Services Pilot Protocol
Approved: June 16, 2017

Per STC #28, the following protocol outlines the services and payment methodologies for the Assistance in Community Integration Services (ACIS) Pilot Program. Under this pilot program, the state will provide a set of Home and Community Based Services (HCBS) to a population that meets the needs-based criteria specified below, capped at 300 individuals annually. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA). The protocol outlines the content that would otherwise be documented in a 1915(i) SPA, and includes service definitions and payment methodologies.

Eligibility Criteria

The state's needs based criteria are specified below:

- 1) Health criteria (at least one)
 - a. Repeated incidents of emergency department (ED) use (defined as more than 4 visits per year) or hospital admissions; or
 - b. Two or more chronic conditions as defined in Section 1945(h)(2) of the Social Security Act.

- 2) Housing Criteria (at least one)
 - a. Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; or
 - b. Those at imminent risk of institutional placement.

Service Definitions for HCBS That Could Be Provided under a 1915(i) SPA

ACIS providers are required to provide a minimum of three services per month to each member to receive reimbursement in a given month.

Any of the following services may be used to satisfy the minimum payment requirements:

Tenancy-Based Case Management Services/Tenancy Support Services: Assist the target population in obtaining the services of state and local housing programs to locate and support the individual's medical needs in the home.

These services may include:

- Conducting a community integration assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual), assistance in budgeting for housing/living expenses, assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.

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- Assisting individuals to connect with social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs. This may include arranging for or providing transportation for services provided in the plan of care. Developing an individualized community integration plan based upon the assessment as part of the overall person centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
- Participating in person-centered plan meetings at redetermination and/or revision plan meetings as needed.
- Providing supports and interventions per the person-centered plan (individualized community integration portion).
- Providing supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
- Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
- Connecting the individual to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management.

Housing Case Management Services – may include:

- Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings as needed;
- Coordinating and linking the recipient to services including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports;
- Entitlement assistance including assisting individuals in obtaining documentation, navigating and monitoring application process and coordinating with the entitlement agency; and
- Assistance in accessing supports to preserve the most independent living, including skills coaching, financing counseling, anger management, individual and family counseling, support groups and natural supports.

Federal financial assistance from the Medicaid program cannot be used for room and board in home and community-based services.

The state must comply with all HCBS requirements as outlined in Subpart M ((42 CFR 441.700 through 441.745 including needs-based criteria (42 CFR 441.715), provision of services in home and community-based settings (42 CFR 441.710(a)(1) and (2)), adherence to conflict of interest provisions (42 CFR 441.730(b)), individualized service plans (42 CFR 441.725(a) and (b)) and Quality Improvement Strategy (42 CFR 441.745(b).

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The state's needs based criteria are specified below:

- 1) Health criteria (at least one)
 - a. Repeated incidents of emergency department (ED) use (defined as more than 4 visits per year) and hospital admissions; or
 - b. Two or more chronic conditions as defined in Section 1945(h)(2) of the Social Security Act.

- 2) Housing Criteria (at least one)
 - a. Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; or
 - b. Those at imminent risk of institutional placement.

ACIS Provider Qualifications for Tenancy-based Case Management Services or Housing Case Management Services:

Provider	Education (typical)	Experience (typical)	Skills (preferred)	Services
Case Manager	Bachelor's degree in a human/social services field; may also be an Associate's degree in a relevant field, with field experience.	1 year case management experience, or Bachelor's degree in a related field and field experience.	Knowledge of principles, methods, and procedures of case management. May also need knowledge of harm-reduction and trauma informed care, principles, methods, and procedures in handling addiction and dual diagnosis populations. Ability to negotiate and maintain positive relationships with co-workers and clients.	Tenancy-based case management or Tenancy Support; housing case management (as outlined above)
Supervisory Case Manager or Team Lead	Master's degree, with licensing, in human services-related field.	Minimum of 2 years experience in social and human services or related field, with hands-on experience working with diverse populations. Previous supervisory experience.	Knowledge of principles, methods, and procedures of case management. May also need knowledge of harm-reduction and trauma informed care, principles, methods, and procedures in handling addiction and dual diagnosis populations. Ability to negotiate and maintain positive relationships with co-workers and clients.	Tenancy-based case management; housing case management (as outlined above); supervise an individual case manager in providing these services, or leads a team in providing these services.

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Description of Payment Methodologies

The Department of Mental Health and Hygiene (DHMH) will pay the Lead Entities (LE) (local health departments/county governments) for the ACIS services provided at the ACIS rate. The ACIS rate shall not exceed the amount expended by the LE for furnishing for the direct service costs incurred by the provider. The monthly ACIS cost-based rate shall be the average cost of the total of a minimum of three ACIS tenancy-based care management/tenancy support services, and housing case management direct services (defined above) and provided per month as described in a Memorandum of Understanding to be executed between the LE and DHMH. The ACIS rate may vary by LE and will be developed based on a target cost per ACIS service, along with variables such as geographic location, salary costs, ACIS-related travel costs, intensity of services, and duration of services or contracted provider per unit costs.

Start-up costs, if approved by DHMH, will be paid directly to the LE. Start-up costs are available only in the first year of the pilot, and must be limited to no more than 10 percent of the award (i.e., 10 percent of the amount determined as follows: anticipated number of members served by the LE * per member, per month payment to the LE * 12 months). To receive start-up funding, the LE must:

- Conduct a community-based vulnerability assessment that is approved by DHMH in advance. The assessment must evaluate the relevant population for its needs with respect to the criteria identified above;
- Implement a process for verifying members' Medicaid eligibility with DHMH; and
- Implement a process for successfully enrolling members into the ACIS pilot program.

LEs must project an expected average number of individuals who will receive ACIS services on a monthly basis. Payment will be withheld if the LEs do not report required data to DHMH in a timely and complete manner as outlined and agreed upon in applicable data use agreements between DHMH and LE. ACIS providers must provide documentation and participate in the demonstration evaluation activities. As a precondition of payment, LEs must comply with all applicable DHMH audit and review policies, as well as the stated requirements in the HealthChoice 1115 Demonstration Special Terms and Conditions (STCs), ACIS Pilot Post-Approval Protocol, and the Request for Application.

ACIS Pilot LEs are required to submit quarterly reports and an annual report to DHMH. The quarterly and annual reports will be used to determine whether progress toward the Pilot requirements has been made. The purpose of the reports is to demonstrate that the Pilot is conducted in compliance with the requirements set forth in the STCs and post-approval protocols, attachments, the approved application, and any agreement between DHMH and the LE and/or policy letters and guidance from DHMH.

The LE will invoice DHMH for ACIS services provided to a specific Medicaid beneficiary. As part of this invoicing process, the LE must submit documentation to DHMH of the Medicaid beneficiary's eligibility status, the dates of service, and the types of service that were provided.

LEs are required to ensure ACIS providers meet minimum documentation standards and cooperate in any evaluation activities by DHMH, CMS, or their contractors. The state assures that there is no duplication of federal funding and the state has processes in place to ensure there is no duplication of federal funding.