

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



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**Children and Adults Health Programs Group**

NOV 15 2013

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

Dear Mr. Milligan:

The Centers for Medicare and Medicaid Services (CMS) is issuing technical corrections to Maryland's Medicaid section 1115 demonstration, entitled "HealthChoice" (waiver number 11-W-00099/3) under authority of section 1115(a) of the Social Security Act (the Act), to ensure that the Special Terms and Conditions (STCs) reflect how the state is currently operating its demonstration.

Specifically, we are revising the STCs approved on October 18, 2013, to reflect the following:

- Revised eligibility language to reflect changes to the eligibility criteria for the Increased Community Services (ICS) program;
- Added language to STC 63 to clarify that there are three different composite federal share ratios for this demonstration; and
- Removed Not Applicable authority to limit amount, duration and scope for individuals in the ICS program because participants receive full Medicaid State plan benefits.

These approvals are conditioned upon written acceptance from the state that it agrees with the amendments, expenditure authorities, and STCs. This written acceptance is needed for our records within 30 days of the date of this letter.

Your project officer is Ms. Elizabeth Matthews. She is available to answer any questions concerning your section 1115 demonstration. Ms. Matthews' contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid & CHIP Services  
Mail Stop: S2-01-16  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Telephone: (410) 786-5433

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Email: Elizabeth.matthews@cms.hhs.gov

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

Francis McCullough  
The Public Ledger Building  
150 South Independence Mall West, Suite 226  
Philadelphia, PA 19106  
Email: francis.mccullough@cms.hhs.gov

If you have any questions regarding this correspondence, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at 410-786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

A black rectangular redaction box covers the signature of Diane T. Gerrits. To the right of the box, there are handwritten initials, possibly 'L' and 'D'.

Diane T. Gerrits  
Director

Enclosures

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cc: Eliot Fishman, CMCS  
Francis McCullough, ARA, Region III  
Elizabeth Matthews, CMCS  
Andrea Cunningham, 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 November 1, 2013 through December 31, 2016. 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.

**Presumptive Eligibility Option**

**Section 1902(a)(47) insofar as it incorporates sections 1920 and 1920A**

To permit Maryland to provide presumptive eligibility for pregnant women and children using a method for determining presumptive eligibility that is not in accordance with sections 1920 and 1920A. And allow the state to continue the use of the Accelerated Certification of Eligibility (ACE) process to determine eligibility for pregnant women and children.

**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 mental health services from providers with 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 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 authority shall enable Maryland to operate its section 1115 Medicaid HealthChoice demonstration.

1. **Demonstration Population 11 [Primary Adult Care (PAC)].** Expenditures on behalf of childless and non-custodial adults ages 19 and above, not otherwise eligible for Medicaid, Medicare or the Children's Health Insurance Program (CHIP), with incomes at or below 116 percent of the Federal poverty level (FPL). This expenditure authority expires on December 31, 2013.
2. **Demonstration Population 12 [Family Planning].** Expenditures for family planning and family planning related services for women, of childbearing age, who are not otherwise eligible for Medicaid, the PAC program, CHIP or Medicare, and who have income at or below 200 percent of the FPL.
3. **Demonstration Population 13 [Increasing 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:
  1. Individuals must meet one of the following criteria:
    - a. Is residing (and has resided for at least 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 90-day nursing facility stay requirement; or

- b. Is currently receiving services through the Living at Home or Older Adults 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 90-day consecutive nursing facility stay requirement does not apply to these individuals.
- 2. Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act.
- 3. 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.
- 4. Pursuant to STC 23, the state may not enroll more than 30 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.

- 4. **Demonstration Population 15 [Women with Breast and Cervical Cancer]** Effective January 1, 2014, 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.
- 5. **Medicaid Eligibility Quality Control.** Expenditures that would have been disallowed as erroneous excess payments under section 1903(u) of the Act.
- 6. **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.
- 7. **Full Medicaid Benefits for Presumptively Eligible Pregnant Women.** Effective 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.
- 8. **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, when the enrollee is automatically re-enrolled into the enrollee's prior MCO after an eligibility lapse of no more than 120 days.
  - 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).

- 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).

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, 12, and 13:**

**Amount, Duration, and Scope**

**Section 1902(a)(10)(B)**

Effective through December 31, 2013, to enable the state to provide a limited benefit package to demonstration participants in the PAC program.

Effective through December 31, 2016, to enable the state to provide a limited benefit package to demonstration participants in the limited benefit family planning program.

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

**Section 1902(a)(15)**

To enable the state to establish reimbursement levels to these clinics for a limited benefit package provided to PAC program participants, which is different from reimbursement levels established by the prospective payment system. This not applicable authority expires on December 31, 2013.

To enable the state to establish reimbursement levels to these clinics that would compensate them solely for family planning and family planning-related services rendered only to women enrolled in Demonstration Population 12 (Family Planning).

**Retroactive Eligibility**

**Section 1902(a)(34)**

Effective through December 31, 2013, to exempt the state from extending eligibility prior to the date of application for the PAC population.

Effective through December 31, 2016, to exempt the state from extending eligibility prior to the date of application for Demonstration Population 12 (Family Planning).

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

**Section 1902(a)(43)**

Effective through December 31, 2013, to exempt the state from furnishing or arranging for EPSDT services for the PAC population who are ages 19 or 20.



Effective through December 31, 2016, to exempt the state from furnishing or arranging for EPSDT services for Demonstration Population 12 (Family Planning).

**Title XIX Requirements Not Applicable to Demonstration Population 11 Effective through December 31, 2013 only:**

**Cost Sharing and Denial of Service**

**Section 1902(a)(14) as it would otherwise enforce 1916(e)**

To enable the state to allow pharmacy providers to deny service to enrollees for failure to pay the required cost sharing for pharmacy services. This not applicable authority expires on December 31, 2013.

**Reasonable Promptness**

**Section 1902(a)(8)**

To enable the state to implement an enrollment target for the PAC Demonstration Population. This not applicable authority expires on December 31, 2013.

**Title XIX Requirements Not Applicable to Demonstration Population 12 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.

**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)**

Effective January 1, 2014, 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 6. 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

**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 November 1, 2013 through December 31, 2016, 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. Eligibility
- V. General 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. Attachments.

**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 currently authorized by the demonstration will expire on December 31, 2013. Mental health services are provided under the demonstration in a separate fee-for-service 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 60 days postpartum. The state also elected to remove the 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 Living at Home 1915(c) waiver in all aspects except eligibility, and three additional 1915(c) waiver services. 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.

For the 2013-2016 renewal period, Maryland will expand Medicaid State plan coverage to individuals with incomes up to 133 percent of the FPL effective January 1, 2014 through the Medicaid State plan. As of January 1, 2014 the state will no longer operate the PAC program. This population will instead be covered under the Medicaid state plan, but will continue to receive services through the HealthChoice demonstration managed care delivery system.

Also, effective January 1, 2014, the state will no longer provide Medicaid State plan coverage for new Breast and Cervical Cancer Treatment Act Program applicants with incomes between 133-250 percent of the FPL.

Other changes to the demonstration that will be implemented during this renewal include the state providing full Medicaid State plan benefits to pregnant women during the presumptive eligibility period; and the state claiming REM case management services as medical expenses.

### **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.** 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.

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.
6. **Changes Subject to the Amendment Process.** Changes of demonstration provisions related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements in these STCs 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. 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 paragraph 7 below. The state will notify CMS of proposed demonstration changes at the monthly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.
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 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

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

**8. Extension of the Demonstration.**

- a. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 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.
- b. Compliance with Transparency Requirements at 42 CFR §431.412:  
As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 16.

**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 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 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 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. 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 paragraph 9, during the last six 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 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 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 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 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 paragraph 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 pursuant to paragraph 0 must be developed and certified as actuarially sound in accordance with 42 C.F.R. § 438.6. 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. Existing contracts with Federally Qualified Health Centers (FQHC) must continue in force.

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).

**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.

#### **IV. ELIGIBILITY**

Under the Maryland Health Choice demonstration, state plan beneficiaries are enrolled in a Managed Care Organization (MCO) or in the case management program. Participation in HealthChoice is mandatory for the majority of Maryland's Medicaid eligible population. HealthChoice participants are enrolled in MCOs or in the REM Program. 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, under the Primary Adult Care (until December 31, 2013), Family Planning, or ICS programs.

**18. 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.

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

- a. 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.

<b>Medicaid State Plan Mandatory Groups</b>	<b>Federal Poverty Level (FPL) and/or Other Qualifying Criteria</b>	<b>Expenditure and CMS 64 Eligibility Group Reporting</b>
New Adult Group  *Effective January 1, 2014	Beginning January 1, 2014 childless adults and non-custodial parents ages 19-64 with 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.	New Adult Group
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 percent	SOBRA Adults

	of the FPL who are not enrolled in the TANF group.	
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
<b>Medicaid State Plan Optional Groups</b>	<b>FPL and/or Other Qualifying Criteria</b>	<b>Expenditure and CMS 64 Eligibility Group Reporting</b>
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)
<b>Demonstration Eligible Groups</b>	<b>FPL and/or Other Qualifying Criteria</b>	<b>Expenditures and CMS 64 Eligibility Group Reporting</b>
Primary Adult Care (PAC)  *Expires on December 31, 2013	Childless and non-custodial adults age 19 and older with incomes up to and including 116 percent of the FPL who are not otherwise eligible for Medicaid. Effective January 1, 2014 these individuals will become eligible for the New Adult Group.	PAC
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  *Effective January 1, 2014	Effective January 1, 2014, 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 Treatment program as of December 31, 2013.	WBCCTP
Presumptively Eligible	Effective January 1, 2014, presumptively eligible	PEPW

Pregnant Women *Effective January 1, 2014	pregnant women with incomes up to 250 percent of the FPL who receive full Medicaid State plan benefits through this demonstration.	
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- b. Health Choice Benefits. The HealthChoice program provides comprehensive Medicaid state plan benefits to demonstration participants. Effective January 1, 2014, the New Adult Group will receive benefits provided through the state’s approved alternative benefit plan (ABP) state plan amendment (SPA), which is effective as of the effective date in the approved ABP SPA.
- 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:
  - 1) Copayments of \$3.00 per prescription and refill for brand name drugs; and
  - 2) Copayments of \$1.00 per prescription and refill for generic drugs.
  - 3) 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).
  - 4) 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.
  - 5) 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: Made in accordance with the Medicaid State plan.
- e. Delivery System. Physical health, vision and substance abuse benefits are rendered through one of seven Medicaid MCOs; rehabilitation services are rendered on a fee for service basis; dental services are rendered through a dental Administrative Services Organization (ASO); and mental health benefits are rendered through an ASO.

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

- a. Maryland Health Choice 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 will be reimbursed at the medical assistance rate beginning January 1, 2014. 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 6. 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.

## **21. Primary Adult Care (PAC) Basic Program Expires on December 31, 2013**

This program will end on December 31, 2013.

- a. Participation. Childless and non-custodial adults age 19 and older with incomes up to and including 116 percent of the FPL who are not otherwise eligible for Medicaid.
- b. Benefits. PAC provides a limited benefit package encompassing outpatient-type services. Specific benefits and the incremental increase in benefits planned during the extension period are found in Attachment A.
- c. Cost Sharing. \$7.50 per prescription and refill for brand name drugs; and \$2.50 per prescription and refill for generic drugs.
- d. Redetermination. Annual active redetermination processes similar to the Medicaid State plan.
- e. Disenrollment: PAC participants may be disenrolled if they become eligible for other Medicaid or Medicare; income exceeds 116 percent of the FPL; or move out of the State.
- f. Delivery System. Physical health and substance abuse benefits are furnished through one of the Medicaid MCOs and mental health services, mental health drugs and HIV/AIDS related drugs are provided on a FFS basis.
- g. Enrollment Cap. In cases where the state determines, based on advance budget projections that it cannot continue to enroll PAC applicants without exceeding the funding available for the program the State can establish an enrollment cap for the PAC program.
  - i. *Notice* - before affirmatively implementing the caps authorized in subparagraph (g), the State must notify CMS at least 60 days in advance. This notice must also include the impact on budget neutrality.
  - ii. *Implementing the Limit* - if the State imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the Demonstration based on date of application starting with the oldest date.

- Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant
- iii. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the PAC wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid or the MHIP programs at any time.
  - iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.

## 22. 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 Benefits.

- 1) 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;
    - 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 the state’s provider enrollment requirements (subject to the national drug rebate program requirements); and
  - d) Contraceptive management, patient education, and counseling.
- 2) Family Planning-Related Benefits. 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.
- 3) Primary Care Referrals. Primary care referrals to other social service 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 can access primary care services.
- 4) Cost Sharing. There is no cost sharing requirement for this population.
- 5) Redetermination. The state must ensure that redeterminations of eligibility for the Family Planning Program are conducted at least every 12 months. Redeterminations may be administrative in nature.
- 6) Disenrollment. 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.
- 7) Delivery System. Services provided for this demonstration population are paid fee for service (FFS).

23. **Increasing 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:
- 1) Individuals must meet one of the following criteria:
    - a. Is residing (and has resided for at least 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 90-day nursing facility stay requirement; or
    - b. Is currently receiving services through the Living at Home or Older Adults 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 90-day consecutive nursing facility stay requirement does not apply to these individuals.
  - 2) Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act.
  - 3) 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 home and community-based services identical to those provided under the state's Living At Home (LAH) 1915(c) waiver with three additions – assisted living, behavior consultation services, and senior center plus services. These services enable the participant to live at home with appropriate supports rather than in a nursing facility. The specific benefits provided to participants in this program are described in Attachment A.
- c. **Enrollment Cap.** The number of participants that may be enrolled in the ICS program at any one time is limited to 30. 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 will notify individuals on the registry in numerical order of the opportunity to participate in the ICS program. Interested individuals will have 15 days to indicate whether or not they are still interested in participating. If after 15 days an individual fails to respond, a second letter will be mailed to the individual. If state receives no response in 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. Except where prohibited by federal law:
  - 1) \$3.00 per prescription and refill for brand name drugs;
  - 2) \$1.00 per prescription and refill for generic and HIV drugs; and
  - 3) \$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 LAH 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.

**24. Breast and Cervical Cancer Treatment Act Program**

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

- 25. Eligibility Exclusions.** The following persons shall not be eligible to participate in the HealthChoice demonstration, and will receive benefits unaffected by the state demonstration.
- a. Beneficiaries with dual Medicare/Medicaid coverage except those participating in the REM Program pursuant to STC 20.
  - b. Short term eligible beneficiaries -in a spend-down status.
  - c. Beneficiaries residing in long term care facilities or skilled nursing facilities for more than 30 days, except individuals transitioning to community placement under the ICS program.
  - d. 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.
  - e. Employed Individuals with Disabilities (EID) participants as of October 1, 2008

**V. GENERAL REPORTING REQUIREMENTS**

- 26. General Financial Requirements.** The state must comply with all general financial requirements under title XIX set forth in section IX.

27. **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.
28. **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. 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 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 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 (Transformed 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.
29. **Reporting Requirements Relating to Budget Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality as set forth in section XI.
30. **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 30 days after the end of each quarter.
31. **Bi-monthly Calls.** CMS must schedule bi-monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery,

enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or State plan amendments the State is considering submitting. The state and CMS must discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS must update the state 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 must jointly develop the agenda for the calls.

32. **Quarterly Operational Reports.** The state shall submit progress reports in the format specified in Attachment C no later than 60 days following the end of each quarter. The intent of these reports is to present the state's data along with an analysis of the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:
- a. Updated budget neutrality and allotment neutrality monitoring spreadsheets;
  - b. Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, including approval and contracting with new plans; benefits changes; enrollment counts with description of variances upward or downward; grievances by type and count; complaints by type and count; quality initiatives and plans; access; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; and other operational issues;
  - c. Action plans for addressing any policy and administrative issues identified; and
  - d. Evaluation activities and interim findings.
  - e. Reporting Requirements Related to the ICS Program:
    - 1) The state will include data on the Program and its enrollees in the LAH waiver annual report it will be completing each March, as specified in Appendix A of the state's approved LAH waiver.
  - f. Reporting Requirements Related to the Family Planning Program:
    - 1) Quarterly enrollment reports for Demonstration eligibles (eligibles include all individuals enrolled in the demonstration);
    - 2) Total number participants served during the quarter (participants include all individuals who obtain one or more covered family planning services through the demonstration);
    - 3) Notification of any changes in enrollment and/or participation that fluctuate ten percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY;
33. **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 paragraph 32. The state must submit the draft annual report no later than October 1 of each year. Within 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 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

34. **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 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

35. 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.

36. 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.

37. Pharmacy Rebates. Maryland and CMS agree that expenditures subject to budget neutrality include pharmacy rebates associated with utilization by the demonstration populations. Because Maryland has reported pharmacy rebate expenditures on the CMS.64.9 Base, however, not the 64.9 Waiver form, total expenditures subject to budget neutrality are overstated, as reflected in the C Report. Maryland will continue its historical practice and report all pharmacy rebates on Form CMS-64.9 Base. To create a more complete record of budget neutrality expenditures, effective January 1, 2014, the state will include a supplemental report on the 64.9 narrative that shows the portion of pharmacy rebates attributable to the 1115 by MEG.

38. Use of Waiver Forms for Medicaid. For each demonstration year, separate Forms CMS-64.9 Waiver and/or 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 64.9P Waiver appear in quotation marks following the colon. Expenditures should be allocated to these forms based on the guidance found below.

1. 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.
2. 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.
3. 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.
4. Demonstration Population 4: “SSI/BD Adults” - EG consists of adults whose Medicaid eligibility derives from their status as blind or disabled.
5. Demonstration Population 5: “SSI/BD Children” - EG consists of children whose Medicaid eligibility derives from their status as blind or disabled.
6. Demonstration Population 6: “MN Adults”—EG consists of adults whose income and resources exceed the categorically needy limits but are within Medicaid State plan limits.

7. Demonstration Population 7: “MN Chldrn”—EG consists of children whose income and resources exceed the categorically needy limits but are within Medicaid State plan limits.
8. Demonstration Population 8: “SOBRA Adults”—EG consists of income eligible pregnant women.
9. 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.
10. 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.
11. Demonstration Population 11: “PAC”—EG consists of childless and non-custodial adults up to and including 116 percent of the FPL. This eligibility group expires on December 31, 2013.
12. Demonstration Population 12: “Family Planning”—This 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.
13. Demonstration Population 13: “ICS”—EG consists 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:
  - 1) Individuals must meet one of the following criteria:
    - a. Is residing (and has resided for at least 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 90-day nursing facility stay requirement; or

- b. Is currently receiving services through the Living at Home or Older Adults 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 90-day consecutive nursing facility stay requirement does not apply to these individuals.
  - 2) Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act.
  - 3) 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.
14. Demonstration Population 14: “PEPW”- EG consists of presumptively eligible pregnant women who receive full Medicaid State plan benefits through demonstration. This eligibility group will be effective January 1, 2014.
15. Demonstration Population 15: “WBCCTP”- EG consists of women who were enrolled in the Breast & Cervical Cancer Treatment program when coverage was provided by the State Medicaid plan as of December 31, 2013. This population will receive coverage under the demonstration beginning January 1, 2014.

### **39. 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:
  - 1) 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
  - 2) 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 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 paragraph 39 (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 64.9P Waiver.

39. **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 64.10P Waiver.
40. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 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 2 years after the conclusion or termination of the demonstration. During the latter 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.
41. **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 paragraph 32, the actual number of eligible member months for the demonstration populations defined in paragraph 38. 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 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.
42. **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 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.

**43. 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 paragraph 62:

- 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 paragraph 22, subject to the limits and processes described below:
  - 1) 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.
  - 2) Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in paragraph 22, should be entered in Column (D) on the Forms CMS-64.9 Waiver.
  - 3) Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in paragraph 22, should be entered in Column (B) on the Forms CMS-64.9 Waiver.
  - 4) 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. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

**44. 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.

**45. 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.

**46. Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

**47. MSIS Data Submission..** On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data", was released. It

states that all states are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Maryland. Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the State Medicaid Manual Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

48. **“Mandated Increase in Physician Payment Rates in 2013 and 2014.** Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a Federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state must exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. Should the state elect this, these amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their “P” counterparts), and not on any waiver form.”
49. **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

50. **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.
51. **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.
52. **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).
53. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within 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-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.

54. **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 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.
55. **Administrative Costs.** Administrative costs under Title XXI may be claimed on the CMS21 for the enhanced match or the CMS64.21 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.
56. **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.
57. **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.
58. **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 paragraph 39.

59. **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

60. **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.
61. **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.
62. **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:

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 paragraph 32 for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (2) below.
  - 1) The PMPM costs in this subparagraph reflect the agreed-upon case-mix adjustment that was applied for each year of the budget neutrality agreement.
  - 2) 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.

- 3) The annual budget neutrality expenditure cap for the demonstration is the sum of the annual EG estimate for each EG calculated in subparagraph 1) 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	DY 17 (01/01/14 – 06/30/14)	DY 18 (07/01/14 – 06/30/15)	DY 19 (07/01/15 – 06/30/16)	DY 20 (07/01/16 – 13/31/16)
TANF Adults 0-116	4.9%	\$809.25	\$848.90	\$890.50	\$934.13
Medicaid Children	4.5%	\$445.05	\$465.08	\$486.01	\$507.88
Medically Needy Adult	4.4%	\$4,734.49	\$4,942.81	\$5,160.29	\$5,387.34
Medically Needy Child	4.4%	\$2,165.30	\$2,260.57	\$2,360.04	\$2,463.88
Sobra Adults	5.1%	3,652.20	\$3,838.46	\$4,034.22	\$4,239.97
SSI/BD Adults	4.4%	1,948.31	\$2,034.04	\$2,123.53	\$2,216.97
SSI/BD Children	4.4%	\$1,765.73	\$1,843.42	\$1,924.53	\$2,009.21

- b. 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.
- c. **Supplemental Budget Neutrality Test 1: 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 Test 1.

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

MEG	TREND	DY 17 – PMPM	DY 18 – PMPM	DY19 – PMPM	DY20 – PMPM
Family Planning	5.0%	\$44.91	\$47.16	\$49.51	\$51.99

- 2) 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 2.
- 3) 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).
- 4) 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 paragraph 111.

d. **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.

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

MEG	TREND	DY 17 – PMPM	DY 18 – PMPM	DY19 – PMPM	DY20 – PMPM
New Adult Group	4.7%	\$790.85	\$828.02	\$866.94	\$907.68

- 2) 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 paragraph 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.

- 3) 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.
- 4) 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.
- 5) 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.

**63. 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. There are three Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under the Waiver Names listed in STC62 (b); Composite Federal Share 2, based on the expenditures reported under the Waiver Names listed in STC 62 (c); and Composite Federal Share 3, based on the expenditures reported under the Waiver Names listed in STC 62 (d). Should the demonstration be terminated prior to the end of the extension approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. 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.

**64. 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.

<b>Demonstration Year</b>	<b>Cumulative Expenditure Cap Definition</b>	<b>Percentage</b>
Year 18	Budget neutrality expenditure cap plus	1 percent
Years 18 and 19	Combined budget neutrality expenditure caps plus	0.5 percent
Years 18 through 20	Combined budget neutrality expenditure caps	0 percent



	plus	
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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.

65. **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

66. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraph (a), 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 programs in the demonstration. The state must submit to CMS for approval a draft evaluation design no later than 90 days of the approval date of the HealthChoice renewal.

- a. **HealthChoice.** At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

67. **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.

68. **Final Evaluation Plan and Implementation.** CMS must provide comments on the draft designs within 60 days of receipt, and the state must submit a final plan for the overall evaluation of the demonstration described in paragraph 68, within 60 days of receipt of CMS comments. The state must implement the evaluation designs and report its progress on each in the quarterly reports. The evaluation design must be modified to incorporate specific research questions assessing the impact of the ICS program on participants' quality of life as well as costs to the demonstration. The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments. The final report must

include the following:

- a) An executive summary;
- b) A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;
- c) A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;
- d) A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);
- e) Final evaluation findings, including a discussion of the findings (interpretation and policy context); and
- f) Successes, challenges, and lessons learned.

**69. Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the demonstration; the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

**X. ADDITIONAL ATTACHMENTS HAVE BEEN INCLUDED TO PROVIDE SUPPLEMENTARY INFORMATION AND GUIDANCE FOR SPECIFIC STCS**

<b>Date - Specific</b>	<b>Deliverable</b>	<b>Reference</b>
60 days following acceptance of the STCs	Submit Draft Evaluation Plan	STC 68
April 30, 2016	Submit Final Evaluation Report, if Not Requesting Extension	STC 69
<b>Annual</b>		
	By October 1 <sup>st</sup> - Draft Annual Report	STC 33
<b>Each Quarter</b>		
	Quarterly Operational Reports	STC 32
	Quarterly Enrollment Reports	STC 32
	CMS-64 Reports	STC 38
	Eligible Member Months	STC 32

## ATTACHMENT A

### Primary Adult Care (PAC), Rare and Expensive Case Management (REM) Program, and Increasing Community Services (ICS) Program Benefits

#### PAC Program Benefits\*

An MCO shall provide an enrollee the primary care services listed below:

- Primary and preventive services;
- Family planning services and supplies;
- Physician services (other than specialty services);
- Pharmacy (excluding specialty mental health drugs and HIV/AIDS drugs);
- Primary mental health services;
- The following laboratory services:
  - Complete blood count and chemistry panel including lipid profile
  - Urinalysis, urine dipstick, and urine culture and sensitivity studies
  - Family planning labs
  - PAP smear
  - PSA
  - STIs
  - Fecal occult blood
  - Blood glucose and glucose tolerance testing
  - Hemoglobin A<sub>1</sub>C
  - Therapeutic drug monitoring (excluding some HIV/AIDS related tests)
- Radiology services, including certain x-rays, EKGs and mammograms;
- Services for diabetics, including podiatry, vision care, nutrition education and the following DME:
  - Diabetic supplies;
  - Non custom Orthotics and footwear;
  - Glucose meters and related supplies; and
  - Insulin syringes.
- All medically necessary services performed in an Emergency Room setting.
- Community-based substance abuse treatment services, excluding those services provided in a hospital regulated setting
- All medically necessary specialty services performed in office based settings.
- All medically necessary outpatient hospital services, including surgeries.

PAC enrollees receive the following benefits through the fee-for-service system:

- Freestanding clinic and office-based limited specialty mental health services;
- Outpatient psychiatric rehabilitation services;
- Specialty mental health drugs;
- HIV/AIDS related drugs.

\*The PAC program and benefits listed in this table expire on December 31, 2013. As of January 1, 2014 these individuals will receive benefits provided through the state's approved alternative benefit plan (ABP) SPA.

## ATTACHMENT A

### Primary Adult Care (PAC), Rare and Expensive Case Management (REM) Program, and Increasing 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
- 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\*
- 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 home and community-based services in addition to those authorized under the State plan. These include:

Assisted Living  
Assistive Technology  
Attendant Care  
Behavior Consultation  
Case Management  
Dietitian / Nutritionist Services  
Environmental Accessibility Adaptations/Modifications  
Environmental Assessments  
Family and Consumer Training  
Fiscal Intermediary Services for individuals who self-direct attendant care services  
Home-Delivered Meals  
Medical Day Care  
Nurse Supervision  
Personal Emergency Response System  
Senior Center Plus

**ATTACHMENT B**  
**Quarterly Operational Report Format**

Under Section VIII, paragraph 33, 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 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: 18 (January 1, 2014, through December 31, 2015)

Federal Fiscal Quarter: 2/2014 (1/1/2014 -3/31/2014)

**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

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

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Medically Needy Adults		
Medically Needy Children		
SOBRA Adults		
MCHP		
MCHP Premium		
Family Planning		
PAC		
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

**PAC Program**

- Enrollment Activities and/or Backlog
- Benefit Expansion Status

**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 LAH waiver.

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**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.

**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	Previous Qtr Month 1	Previous Qtr Month 2	Previous Qtr Month 3	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								

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Family Plannin g								
WBCC TP								

**B. For Informational Purposes Only**

Eligibility Group	Previous Qtr Month 1	Previous Qtr Month 2	Previous Qtr Month 3	Total Previous Qtr Ending XX/XX	Current Qtr Month1	Current Qtr Month2	Current Qtr Month 3	Total for Quarter Ending XX/XX
PAC								
ICS								

**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**



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