DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

April 1, 2021

Dennis R. Schrader
Chief Operating Officer & Medicaid Director
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Mr. Schrader:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Maryland HealthChoice Evaluation Design, which is required by the Special Terms and Conditions (STC) of Maryland's section 1115 demonstration, "Maryland HealthChoice" (Project No: 11-W-00099/3), effective through December 31, 2021. CMS determined that the evaluation design, which was submitted on July 9, 2019 and revised on January 15, 2021, meets the requirements set forth in the STCs and therefore, approves the state's HealthChoice evaluation design. We sincerely appreciate the state's commitment and its collaboration with CMS in finalizing the evaluation design.

CMS has added the approved HealthChoice evaluation design to the demonstration's STCs as Attachment C. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved evaluation design may now be posted to the state's Medicaid website within thirty days. CMS will also post the approved evaluation design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an interim evaluation report, consistent with the approved evaluation design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a summative evaluation report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

If the demonstration were to be extended beyond the current period of approval, CMS would expect Maryland to develop a comprehensive and rigorous evaluation design for all demonstration components, inclusive of a robust cost analysis, in alignment with CMS's pertinent evaluation design guidance, including that for the Substance Use Disorder section 1115 demonstrations.

We appreciate our continued partnership with Maryland on the Maryland HealthChoice section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S
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Date: 2021.04.01 11:11:58 -04'00'

Angela D. Garner -S
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Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Angela D. Garner
Director
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cc: Talbatha Myatt, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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 from January 1, 2017 through December 31, 2021, unless otherwise stated.

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

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

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

1. **Demonstration Population 11 [Family Planning].** Expenditures for family planning and family planning related services for women, of childbearing age, who are not otherwise eligible for Medicaid, CHIP, or Medicare, and have income at or below 200 percent of the federal poverty level (FPL), effective until the approval date of MD SPA 18-0005 as set forth in STC 23. Effective upon the approval date of MD SPA 18-0005, expenditures for family planning and family planning related services for women, of childbearing age, who are not otherwise eligible for Medicaid, CHIP, or Medicare, and have income at or below 200 percent of the FPL, but had Medicaid pregnancy coverage, for 12 months immediately following the 2-month post-partum period as set forth in STC 23.

2. **Demonstration Population 12 [Increased Community Services].** Expenditures for home and community-based services provided to individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the State plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, subject to the following conditions:

a. Individuals must have resided in a nursing facility for at least six months, and been eligible for Medicaid for at least 30 consecutive days immediately prior to being enrolled in this program; and
b. Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act.
c. The cost to Medicaid for the individual in the community must be less than the cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.
d. Pursuant to STC 24, the state may not enroll more than 100 participants into the ICS program at any one time.

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

3. Demonstration Population 13 [Women with Breast and Cervical Cancer]. Expenditures for women with breast and cervical cancer, with incomes above 133 percent and up to 250 percent of the FPL who were enrolled in the Breast and Cervical Cancer Treatment Act Program as of December 31, 2013.

4. **Demonstration Benefits.** Expenditures for benefits specified in the STCs provided to enrollees participating in the Rare and Expensive Case Management program which are not available to individuals under the Medicaid State plan. This includes the services provided to REM enrollees who remain in the REM program after becoming eligible for Medicare in order to allow them to continue to receive private duty nursing and shift home health aide services until age 65.

5. **Full Medicaid Benefits for Presumptively Eligible Pregnant Women.** As of January 1, 2014, expenditures to provide full Medicaid State plan benefits to presumptively eligible pregnant women with incomes up to 250 percent of the FPL.

6. **Demonstration Operations for Automatic Reenrollment into the MCO.** Expenditures for capitation payments made to managed care organizations (MCOs) under a contract that does not require the MCO to:

    a. Provide an enrollee with the disenrollment rights required by sections 1903(m)(2)(A)(vi) and 1932(a)(4) of the Act, along with 42 CFR 438.56(g),when the enrollee is automatically re-enrolled into the enrollee's prior MCO after an eligibility lapse of no more than 120 days. This expenditure authority does not impact the requirements under 42 CFR 438.56(c)(2)(iii). Section 438.56(c)(2)(iii) allows a beneficiary to request disenrollment if a temporary loss of eligibility caused the beneficiary to miss the annual disenrollment opportunity.

    b. Enforce the requirement that an enrollee's verbal appeal be confirmed in writing as specified in sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 42 CFR 438.402(b)(3)(ii) and 42 CFR 438.406(b)(1). As of July 1, 2017, the regulations cite changes to 42 CFR 438.402(c)(3)(ii) and 42 CFR 438.406(b)(3).

When a beneficiary's oral request for an appeal is not followed up in writing, the plan will send written confirmation of the appeal request to the beneficiary or the beneficiary's authorized representative.

c. Send a written notice of action for a denial of payment [as specified in 42 CFR 438.400(b)(3)] when the beneficiary has no liability, as required by sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 438.404(c)(2). The expenditure authority expires on December 31, 2017.

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

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

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

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

11. **HealthChoice Diabetes Prevention Program (DPP).** Expenditures for a diabetes prevention program for Medicaid eligible individuals 18-64 who have pre-diabetes or who are at high risk for developing type 2-diabetes as set forth in STC 31, effective July1, 2019.

12. **Medically Managed Intensive Inpatient Services (ASAM Level 4.0).** Expenditures to extend coverage of medically managed intensive inpatient services for up to 15 days in a month for individuals 21 through 64 years of age who are residing in institutions for mental diseases (IMDs) and have a primary SUD diagnosis and a secondary mental health diagnosis as set forth in STC 32, effective July 1, 2019.

13. **Adult Dental Pilot Program.** Expenditures to offer dental services to dually eligible adults 21 through 64 years as set forth in STC 33, effective April 1, 2019.

14. **Collaborative Care Model Pilot Program.** Expenditures to implement a Collaborative Care Model (CoCM) pilot program as set forth in STC 34, no earlier than July 1, 2020.

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

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

Amount, Duration, and Scope — **Section 1902(a)(10)(B)**

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

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

Methods of Administration: Transportation — **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

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

Eligibility Procedures — **Section 1902(a)(17)**

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

Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics — **Section 1902(a)(15)**

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

Retroactive Eligibility — **Section 1902(a)(34)**

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) — **Section 1902(a)(43)**

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

Title XIX Requirements Not Applicable to the Population in the REM Program or CoCM Pilot Program

Any Willing Provider **Section 1902(a)(23)(A) insofar as it incorporates 42 CFR 431.55(f)**

To the extent necessary, to permit the state to selectively contract with a single entity for the provision of the Rare and Expensive Case Management (REM) benefit as authorized under this demonstration through Expenditure Authority 4 and the CoCM pilot authorized under this demonstration through Expenditure Authority 14. 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 for the REM benefit.

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

To the extent necessary, to allow the state to offer the CoCM pilot program on less than a statewide basis.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **11-W-00099/3**

TITLE: **HealthChoice Medicaid Section 1115 Demonstration**

AWARDEE: **Maryland Department of Health and Mental Hygiene**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project January 1, 2017, through December 31, 2021. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

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

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

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

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

a. To enable the state to restrict freedom of choice of provider, other than for family planning services, for children with special needs, as identified in section 1932(a)(2)(A)(i-v) of the Act, who are participants in the demonstration.

b. To enable the state to require that all populations participating in the demonstration receive outpatient behavioral health services from providers within the public mental health system.

Retroactive Eligibility **Section 1902(a)(34)**

To exempt the state from extending eligibility prior to the date of application to optional targeted low-income children, except for infants under age 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
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00099/3**

TITLE: **HealthChoice Medicaid Section 1115 Demonstration**

AWARDEE: **Maryland Department of Health (MDH)**

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 (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 related to this demonstration.

These STCs are effective January 1, 2017 through December 31, 2021, unless otherwise specified.

The STCs have been arranged into the following subject areas:

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

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

Attachment A: Rare and Expensive Case Management (REM) Program and Increased Community Services (ICS) Benefits
Attachment B: Quarterly Report Template
Attachment C: Evaluation Design [Reserved]

Attachment D: Evidence-Based Home Visiting Services (HVS) Pilot Program Protocol
Attachment E: Assistance in Community Integration Services (ACIS) Pilot Program Protocol
Attachment F: Family Planning Monitoring Template
Attachment G: SUD Monitoring Protocol *(reserved pending CMS approval)*

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

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

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

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

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

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

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

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

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

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

The 2017 extension made the following changes to the demonstration:

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

On June 29, 2018, the Maryland Department of Health submitted an amendment to the HealthChoice section 1115 demonstration. The state requested authority to provide National

Diabetes Prevention Program (National DPP) services , expand and extend medically managed intensive inpatient hospital services (ASAM 4.0) for Medicaid eligible individuals who reside in an in-state IMD and have a primary SUD diagnosis and a secondary mental health diagnosis for up to 15 days in a month, offer a limited adult dental pilot program for dually eligible adults 21-64, expand the annual enrollment cap of the Assistance in Community Integration Services (ACIS) pilot program, and modify the family planning program so that effective upon the approval date of MD SPA 18-0005 women of childbearing age who have a family income at or below 250 percent of the FPL and who are not otherwise eligible for Medicaid, CHIP, or Medicare, but had Medicaid pregnancy coverage, will be eligible for the HealthChoice family planning program for 12 months immediately following the 2-month post-partum period. .

On June 24, 2019, the Maryland Department of Health (MDH) submitted an amendment to the HealthChoice section 1115 demonstration to establish a Collaborative Care Model (CoCM) pilot program. This amendment allows the state to implement a CoCM pilot program that delivers a patient-centered, evidence-based approach for integrating physical and behavioral health services to a limited number of HealthChoice beneficiaries who screen positive for a behavioral health condition, including depression, substance use disorder, or a mental health condition. Pilot participants will work with a team of three providers—a primary care provider, a behavioral health care manager, and a psychiatric consultant—who will help them achieve concrete treatment goals. The HealthChoice CoCM benefit is effective no earlier than July 1, 2020.

The state will test whether the HealthChoice section 1115 demonstration amendment programs described in these special terms and conditions (STCs) are likely to assist in promoting the objectives of the Medicaid by achieving the following results:

1. Improving access to health care for the affected Medicaid populations;
2. Improving the quality of health services delivered;
3. Expanding coverage to additional low income beneficiaries;
4. Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs; and
5. Promoting health, wellness, and disease prevention.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes**. The state agrees that it must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

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

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy**. The state must, within the timeframes specified in law, regulation, court order, or policy directive, come into compliance with any changes in federal law, regulation, court order, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is explicitly waived under the STCs herein governing the demonstration.

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

    a. To the extent that a change in federal law, regulation, final court order, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the day, such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments**. The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, sources of non-federal share of funding, and budget neutrality must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process**. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:

    a. Demonstration of Public Notice 42 CFR §431.408 and tribal consultation: The state must provide documentation of the state's compliance with public notice process as specified

in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in STC 15 have been met.

b. Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming title XIX and/or title XXI state plan amendment, if necessary.

c. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment.

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

e. An up-to-date CHIP allotment neutrality worksheet, if necessary; and

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

8. Extension of the Demonstration

a. Should the state intend to request an extension of the demonstration under section 1115(a) or 1115(f), the state must submit an extension request no later than six (6) months prior to the expiration date of the demonstration. A request to extend an existing demonstration under 1115(e) must be submitted at least twelve (12) months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase out plan consistent with the requirements of STC 9 of this section.

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

9. Demonstration Phase Out. The state may suspend or terminate this demonstration in whole or in part, consistent with the following requirements:

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the thirty (30) day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than fourteen (14) days after CMS approval of the phase-out plan.

c. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

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

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

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

10. Enrollment Limitation During Demonstration Phase Out. If the state elects to suspend, terminate, or not renew this demonstration as described in STC 9, during the last six (6) months of the demonstration, the state may choose to not enroll individuals into the

demonstration who would not be eligible for Medicaid under the current Medicaid state plan. Enrollment may be suspended if CMS notifies the state in writing that the demonstration will not be renewed.

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

    a. Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

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

    c. Federal Public Notice: CMS will conduct a thirty (30) day federal public comment period consistent with the process outlined in 42 CFR §431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the thirty (30) day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) days after CMS approval of the plan.

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

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

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

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

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

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

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

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

19. **Deferral for Failure to Submit Timely Demonstration Deliverables.** The state agrees that CMS has the authority to issue deferrals in the amount of $5,000,000 (federal share) when

deliverables are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

c. CMS may agree to a corrective action as an interim step before applying the deferral, if requested by the state.

d. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

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

f. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required reports, evaluations, and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

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

IV. ELIGIBLE POPULATIONS AFFECTED AND ELIGIBILITY UNDER THE DEMONSTRATION

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

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

20. Eligibility Groups Affected by the Demonstration. Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan and are subject to all

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

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

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

Medicaid State Plan Mandatory Groups	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Expenditure and CMS–64 Eligibility Group Reporting**
New Adult Group	Childless adults and non-custodial parents ages 19-64 with 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 123 percent of the FPL, including individuals with incomes below the pre-July 1, 2008, TANF income thresholds.	TANF Adults 0-123
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 of the FPL who are not enrolled in the TANF group.	SOBRA Adults
Non-Dual Blind and Disabled	Individuals whose Medicaid eligibility derives from their status as blind or disabled and who are not entitled to Medicare.	SSI/BD Adults or SSI/BD Children
Medicaid State Plan Optional Group	**FPL and/or Other Qualifying Criteria**	**Expenditure and CMS–64 Eligibility Group Reporting**

Medically Needy Adults and Children	Families with dependent children, or foster children, whose gross income and resources exceed 116 percent of the FPL but who incur medical expenses such that their income is equal to or less than 116 percent FPL.	MN Adults or MN Children
Optional targeted low income children through age 18.	Up to first birthday: Between 185 and 200 percent of the FPL; On first birthday through age 5: between 133 and 200 percent of the FPL; and Upon sixth birthday through age 18: between 100 and 200 percent of the FPL.	MCHP (Only during periods when title XXI funding is exhausted)
Optional targeted low income children through age 18	Between 200 percent of the FPL and 300 percent of the FPL who pay a premium.	MCHP Premium (Only during periods when title XXI funding is exhausted)
Demonstration Eligible Groups	**FPL and/or Other Qualifying Criteria**	**Expenditures and CMS–64 Eligibility Group Reporting.**
Family Planning	Women of childbearing age who are not otherwise eligible for Medicaid, CHIP, or Medicare, and who have a family income at or below 250 percent of the FPL, effective until the approval date of MD SPA 18-0005, as described in STC 23. Effective upon the approval date of MD SPA 18-0005, women, of childbearing age, who are not otherwise eligible for Medicaid, CHIP, or Medicare, and have income at or below 250 percent of the FPL, but had Medicaid pregnancy coverage, for 12 months immediately following the 2-month post-partum period, as described in STC 23.	Family Planning
Increased Community Services (ICS)	Medicaid eligible individuals over the age of 18 residing in a nursing home at the time initially determined eligible for ICS, with an income level at or below 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR).	ICS
Women with Breast and Cervical Cancer	Women diagnosed with breast or cervical cancer with incomes between 133-250 percent of the FPL and who were in active treatment under the Breast & Cervical Cancer Treatment program as of December 31, 2013.	WBCCHP
Presumptively Eligible Pregnant	Presumptively eligible pregnant women with	PEPW

Women	incomes up to 250 percent of the FPL who receive full Medicaid state plan benefits through this demonstration.	
Demonstration Programs	**FPL and/or Other Qualifying Criteria**	**Expenditures and CMS–64 Eligibility Group Reporting.**
Residential Treatment for Individuals with Substance Use Disorder *Effective July 1, 2017	Effective July 1, 2017, expenditures for SUD treatment in IMDs.	SUD
Assistance in Community Integration Services (ACIS) Pilot *Effective July 1, 2017	Effective July 1, 2017, expenditures for the ACIS Pilot as described in STC 28.	ACIS
Evidence-Based Home Visiting Services (HVS) Pilot *Effective July 1, 2017	Effective July 1, 2017, expenditures for evidence-based home visiting services to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children up to 2 years old.	HVS
Enhanced Dental Services for Former Foster Youth *January 1, 2017	Effective January 1, 2017, expenditures for enhanced dental services for former foster care youth up to 26 years old.	Former Foster Dental
HealthChoice National Diabetes Prevention Program *Effective July 1, 2019	Effective July 1, 2019, expenditures for a National Diabetes Prevention Program for individuals 18-64 who have prediabetes or are at high risk of developing type 2 diabetes as described in STC 31.	National Diabetes Prevention Program (National DPP)
Medically Managed Intensive Inpatient Hospital Services (ASAM 4.0) *Effective July 1, 2019	Effective July 1, 2019, expenditures for extended medically managed intensive inpatient hospital services (ASAM 4.0) for Medicaid eligible individuals 21-64 who reside in an in-state IMD and have a primary SUD diagnosis and a secondary mental health diagnosis as described in STC 32.	Medically Managed Inpatient Hospital Services (ASAM 4.0)
Adult Dental Pilot Program *Effective April 1, 2019	Effective April 1, 2019, expenditures for a limited dental benefit for full dually eligible adults (21-64) as described in STC 33.	Adult Dental Pilot
Collaborative Care Model (CoCM) Pilot Program	Effective no earlier than July 1, 2020., expenditures to establish and implement a Collaborative Care Model (CoCM) pilot program that integrates primary and behavioral health services for a limited number of HealthChoice beneficiaries as describe in STC 34.	Collaborative Care Model (CoCM)

b. HealthChoice Benefits. The HealthChoice program provides comprehensive Medicaid state plan benefits to demonstration participants. The new adult group receives benefits provided through the state's approved alternative benefit plan (ABP) state plan.

c. Health Choice Cost Sharing. All cost-sharing must be in compliance with Medicaid requirements for state plan populations that are set forth in statute, regulation and policies and all demonstration participants must be limited to a five percent aggregate cost sharing limit per family. Cost sharing must be equal to or less than:

i. Copayments of $3.00 per prescription and refill for brand name drugs.
ii. Copayments of $1.00 per prescription and refill for generic drugs.

iii. Copayments of $1.00 per prescription and refill for preferred drugs provided on a fee-for-service basis (outside of the MCO prescription drug benefit).

iv. Premiums for children through age 18 with incomes between 200 percent up to and including 250 percent of the FPL – is calculated at two percent of a family household income of two at 200 percent of the FPL per family per month.

v. Premiums for children through age 18 with incomes between 251 percent up to and including 300 percent – is calculated at two percent of a family household income of two at 250 percent of the FPL per family per month.

d. Redetermination and Disenrollment. Redeterminations and disenrollment are made in accordance with the Medicaid state plan.

e. Delivery System. Physical health and vision benefits are rendered through one of nine Medicaid MCOs; rehabilitation services (occupational therapy, physical therapy, and speech) are rendered on a fee for service basis for children (20 years old and under); dental services are rendered through a dental Administrative Services Organization (ASO); and specialty behavioral health benefits (mental health and substance use disorder benefits) are rendered through an ASO, other than those provided through the CoCM pilot. The managed care authority applies to all populations except for those listed in STC 23.

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

a. Maryland HealthChoice participants including the New Adult Group, who have specified conditions that are expensive and require complex medical treatment may be enrolled in a special case management program operated by the state. The REM case management program includes certain optional services, not otherwise provided under the Medicaid program, to assist with the special needs of this population. To qualify, individuals must continue to meet eligibility diagnosis criteria for REM services. Should an individual no longer meet the diagnostic criteria for REM, that individual will be disenrolled from the REM program. The state may also enroll individuals who are not otherwise participating in the demonstration, who are under age 65 and receiving Medicare benefits in the REM program, if the individual was previously enrolled in the REM program and receiving private duty nursing services or home health aide services. REM services are reimbursed at the medical assistance

rate. The state is allowed to contract with a single agency for the provision of the REM benefit as authorized under this demonstration through Expenditure Authority 4. The operation of this selective contracting authority does not affect a beneficiary's ability to select between two or more qualified case managers.

b. Benefits. Specific benefits provided to beneficiaries enrolled in the REM program are described in Attachment A. Benefits for Medicare beneficiaries will be limited to services not available under Medicare.

c. Cost Sharing. Applicable state plan cost sharing requirements apply.

d. Redetermination and Disenrollment. Redetermination and disenrollment decisions must be made in accordance with the Medicaid State plan.

e. Delivery System. An individual choosing to enroll in the REM program is prohibited from enrolling in an MCO. Services are delivered on a FFS basis.

23. Family Planning Program

Women of childbearing age who have a family income at or below 250 percent of the FPL and who are not otherwise eligible for Medicaid, CHIP, or Medicare, but had Medicaid pregnancy coverage, will be eligible for the HealthChoice family planning program for 12 months immediately following the 2-month post-partum period. The services available under the HealthChoice family planning program are the family planning state plan services set forth in SPA 18-0005.

Primary care referrals to other social services and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for women who are eligible for this family planning program. 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. Maryland will not require enrollees to pay any cost sharing to receive family planning services under this program.

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

24. Increased Community Services (ICS) Program

a. Participation. Expenditures for home and community-based and state plan services provided to individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the state plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, subject to the following conditions:

   i. Individuals must meet one of the following criteria:

      a. Is residing (and has resided for at least ninety (90) consecutive days) in a nursing facility and is receiving Medicaid benefits for nursing home services furnished by such nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the ninety (90) day nursing home stay requirement; or

      b. Is currently receiving services through the Home and Community-Based Options waiver, and whose income exceeds the income eligibility threshold by no more than 5 percent. These individuals would be permitted to transition directly into the ICS program as long as they continued to meet the nursing facility level-of-care standard. The ninety (90) day nursing home stay requirement does not apply to these individuals.

   ii. Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act; and,

   iii. The cost to Medicaid for the individual in the community must be less than the cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.

b. Benefits. This program provides Medicaid state plan benefits and home and community-based services identical to those provided under the Community Options 1915(c) waiver. These services enable the participant to live at home with appropriate supports rather than in a nursing facility.

c. Enrollment Cap. The number of participants that may be enrolled in the ICS program at any one time is limited to 100. The state will create a registry that identifies all individuals eligible for the program who have indicated interest in receiving home and community-based services. The registry will be sorted based on date and time of interest. As slots become available, the state shall will notify individuals on the registry in numerical order of the opportunity to participate in the ICS program. Interested individuals will have fifteen (15) days to indicate whether or not they are still interested

in participating. If after fifteen (15) days an individual fails to respond, a second letter will be mailed to the individual. If state receives no response in seven (7) days after the second letter is mailed, the state will remove the individual's name from the registry, and offer that slot to the next person on the registry.

d. Assurances. For the ICS population the state will comply with the HCBS assurances contained in 42 C.F.R. §441.302.

e. Cost Sharing. All cost-sharing must be in compliance with Medicaid requirements for state plan populations that are set forth in statute, regulation and policies and all demonstration enrollees must be limited to a five percent aggregate cost sharing limit per family. Cost sharing must be equal to or less than:

i. $3.00 per prescription and refill for brand name drugs;

ii. $1.00 per prescription and refill for generic and HIV drugs; and,

iii. $1.00 per prescription and refill for preferred drugs provided on a fee-for-service basis (outside of the MCO prescription drug benefit).

f. Delivery System. The state will operate the ICS program in a manner consistent with its approved Community Options 1915(c) waiver program and must meet all quality, administrative, operational, and reporting requirements contained therein.

g. Redetermination and Disenrollment. Redetermination and disenrollment decisions will be made in accordance with the Medicaid State plan.

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

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

26. Eligibility Exclusions. The following persons shall not be eligible to participate in the managed care component of the HealthChoice demonstration, and will receive benefits unaffected by the state demonstration unless otherwise indicated.

a. Individuals with dual Medicare/Medicaid coverage with exception of those individuals who participate in the REM Program pursuant to STC 22.

b. Individuals over 65 years old.
c. Individuals determined Medically Needy under a spend-down.

d. Individuals expected to be continuously institutionalized for more than ninety (90) successive days in a long-term care or skilled nursing facility except individuals transitioning to community placement under the ICS program.

e. Beneficiaries enrolled in the Home Care for Disabled Children under a Model Waiver.

f. Individuals expected to be continuously institutionalized for more than thirty (30) successive days in an Institution for Mental Diseases (IMD) (this includes only psychiatric IMDs, not SUD residential services that would be eligible under the SUD component of the demonstration).

g. Beneficiaries enrolled in the Breast and Cervical Cancer Treatment Program (BCCTP) until December 31, 2013. Beginning January 1, 2014 this population will be covered through the demonstration as described in STC 25.

h. Employed Individuals with Disabilities (EID) participants as of October 1, 2008.

i. Certain foster care groups:

    i. A child receiving an adoption subsidy who is covered under the parent's private insurance;
    ii. A child under State supervision receiving an adoption subsidy who lives outside the state; and
    iii. A child under State supervision who is in an out-of-state placement.

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

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

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

Table One: Maryland SUD Benefits (with Expenditure Authority)

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

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

	Management		aged 21 to 64)

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

a. Residential services are provided in a MDH licensed residential facility that has been enrolled by MDH as a Medicaid provider and issued a certification by MDH as capable of delivering care consistent with the ASAM Criteria as a Level 3.1, 3.3, 3.5 and/or 3.7 program.
b. Residential services can be provided in settings of any size.

c. Only two (2) - 30-day residential stays will be covered in a one (1) year period. Extended lengths of stay can be provided if medically necessary using other identified funds.

d. Effective July 1, 2017, services will be covered for ASAM Levels of Care 3.3, 3.5, 3.7 and 3.7 WM. Effective January 1, 2019, services will be covered for ASAM Level of Care 3.1.

e. Through revisions to the state's program standards for SUD, including but not limited to the Administrative Service Organization (ASO) provider handbook, MDH will update its standards of care for residential treatment programs to further incorporate industry standard benchmarks from the ASAM Criteria for defining provider and service specifications. These revisions are expected to be completed prior to July 1, 2017.

f. Each residential treatment provider will be assessed to meet the provider and service specifications described in the ASO provider handbook consistent with the ASAM Criteria for the requisite level or sublevel of care prior to participating in the Maryland Medicaid program under this section 1115 demonstration. Prior to enrolling a residential treatment provider in Medicaid and prior to service provision under this demonstration, MDH will conduct site visits and certify residential treatment providers as ASAM Level 3.1, 3.3, 3.5 and/or 3.7 programs. The ASO will provide preliminary credentialing for ASAM Levels 3.1, 3.3, 3.5 and/or 3.7 contingent on the providers receiving certification from the state. The ASO will finalize its credentialing after the providers submit their site visit reports verifying they are ASAM Level 3.1, 3.3, 3.5 and/or 3.7 programs.

g. Prior authorization is required for residential services. For ASAM Levels 3.1 to 4.0, providers will complete a preadmission assessment of the member's clinical needs and submit the clinical information to the ASO for prior authorization. Utilization management staff or a licensed physician employed by the ASO will document the use of the ASAM multidimensional assessment and matrices for matching severity with type and intensity of services. Each prior authorization review will assess service needs, coordination needs and ensure appropriate placement in the appropriate level of care based on the member's needs as demonstrated in the ASAM Criteria multidimensional assessment. The ASO must provide prior authorization for residential services within twenty-four (24) hours of the prior authorization request being submitted by the provider.

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

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

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

Source	Measure	Collection Mechanism
NQF #0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims/encounter data
NQF #2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Claims/encounter data

28. Community Health Pilot Program: Assistance in Community Integration Services (ACIS) Pilot Program. Under this program, the state will provide a set of HCBS services under a pilot that is capped at 600 individuals annually.

Under this pilot program, the state will provide a set of Home and Community Based Services (HCBS) to a population that meets the eligibility criteria in Attachment E, capped at 600 individuals annually. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA). The protocol outlines the content that would otherwise be documented in a 1915(i) SPA, and includes service definitions and payment methodologies (See Attachment E).

29. Community Health Pilot Program: Evidence-Based Home Visiting Services Pilot Program. Under this program, the state will provide evidence-based home visiting services by licensed practitioners to promote enhanced health outcomes, whole person

care, and community-integration for high-risk pregnant women and children up to two (2) years old. The program is aligned with two evidence-based models focused on the health of pregnant women. Additional information regarding this pilot program can be found in Attachment D.

a. Nurse Family Partnership (NFP): The NFP is designed for reinforces maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The HealthChoice section 1115 demonstration NFP pilot program will adhere to the NFP national program standards and service will be suspended once the child reaches two (2) years old.

b. The Healthy Families America (HFA). The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, SUD, mental health issues, and domestic violence.

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

31. HealthChoice Diabetes Prevention Program (DPP). Effective July 1, 2019, the HealthChoice section 1115 demonstration benefit package will include National Diabetes Prevention Program (National DPP) services. The specific program requirements are set forth in in the National Diabetes Prevention Program (National DPP) administered by the Centers for Disease Control, including "Centers for Disease Control and Prevention Diabetes Prevention Recognition Program Standards and Operating Procedures (OMB No. 0920-0909)."

Eligibility Requirements:
Under the HealthChoice DPP, Medicaid eligible beneficiaries who receive services through HealthChoice managed care organizations (MCOs) and meet the Centers for Disease Control and Prevention (CDC) eligibility criteria are eligible for HealthChoice DPP services.

HealthChoice DPP Eligibility Criteria (Per currently-effective CDC Diabetes Prevention Recognition Program (DPRP) standards):

1. Receive services through a HealthChoice MCO;
2. Between 18-64 years old;
3. Overweight or obese (Body Mass Index (BMI) of ≥ 25 kg/m$^{2;}$ ≥ 23 kg/m^{2,} if Asian); AND
4. Elevated blood glucose level OR History of gestational diabetes mellitus (GDM)[1]

[1] This refers to a 1)Fasting glucose of 100 to 125 mg/dl ; 2) Plasma glucose measured 2 hours after a 75 gm glucose load of 140 to 199 mg/dl; 3) A1c of 5.7 to 6.4; or 4) Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy.

Eligibility Exclusion:
Consistent with the CDC National DPP eligibility criteria, participants cannot have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment. Individuals who are currently pregnant are not eligible for National DPP services.

HealthChoice DPP Services:
The HealthChoice DPP will provide services through any or all of the delivery modes outlined in the currently-effective CDC DPRP standards.

This expenditure authority for the HealthChoice DPP is conditioned on it not seeking funds for the HealthChoice DPP from a different funding source.]

32. Medically Managed Intensive Inpatient Hospital Services (ASAM Level 4.0). Effective July 1, 2019, the HealthChoice benefit package will include coverage of medically managed intensive inpatient hospital services (ASAM Level 4.0) for up to 15 days per month for individuals 21-64 years of age who are residing in Institutions for Mental Diseases (IMD) and have a primary substance use disorder (SUD) diagnosis and a secondary mental health diagnosis.

Any stay over the 15-day threshold will be paid for with state only dollars.
The medically managed intensive inpatient hospital services providers will be limited to in-state IMDs.

33. Adult Dental Pilot Program: Effective April 1, 2019, the HealthChoice benefit package will include coverage of a dental benefits for full dually eligible individuals as set forth below.

Enrollment and Service Cap Limit:
The adult dental pilot program will be capped at $800 per person per calendar year. There is no enrollment cap for this pilot program.

Eligibility Requirements:
Under the adult dental pilot program, individuals who are eligible for both Medicaid and Medicare services and between 21 through 64 years of age are eligible for the adult dental pilot program. "Partial duals," *i.e.*, those who are only eligible for Medicaid assistance with their Medicare cost-sharing requirements are not eligible to receive services under the adult dental pilot program.

Adult Dental Pilot Program Services:
Below is a list of dental benefits covered under the adult dental pilot program:

Code	Description
	Diagnostic codes
D0120	Periodic oral evaluation - established patient
D0140	Limited oral evaluation

Code	Description
D0150	Comprehensive oral evaluation - new or established patient
	Note: Limit one (1) D0120 or D0150 per patient per 6 month period.
	Note: Limit one (1) D0140 per patient per 12 month period.
	Note: Limit one (1) D0150 per patient per 36 month period.
	Diagnostic Imaging
D0270	Bitewing- Single Radiographic Image
D0272	Bitewings- Two Radiographic Images
D0273	Bitewings- Three Radiographic Images
D0274	Bitewings- Four Radiographic Images
	Note: Limit one (1) per patient per 12 months period for D0270, D0272, D0273, and D0724.
D0210	Intraoral - Complete Series of Radiographic Images
D0220	Intraoral – Periapical First Radiographic Image
D0230	Intraoral – Periapical Each Additional Radiographic Image
D0330	Panoramic Radiographic Image
	Note: Limit six (6) per patient per 12 month period for D0230.
	Note: Limit one (1) per patient per 36 month period for D0210 and D0330.
	Preventive Care
D1110	Prophylaxis – Adult (Permanent Dentition)
	Note: Limit one (1) D1110 per Patient per 6 month period.
	Restorative Care
D2140	Amalgam – One Surface, Permanent
D2150	Amalgam – Two Surfaces, Permanent
D2160	Amalgam – Three Surfaces, Permanent
D2161	Amalgam – Four or More Surfaces, Permanent
D2330	Resin-Based Composite - One Surface, Anterior
D2331	Resin-Based Composite – Two Surfaces, Anterior
D2332	Resin-Based Composite – Three Surfaces, Anterior
D2335	Resin-Based Composite – Four or More Surfaces or Involving Incisal Angle (Anterior)
D2391	Resin-Based Composite – One Surface, Posterior
D2392	Resin-Based Composite – Two Surfaces, Posterior
D2393	Resin-Based Composite – Three Surfaces, Posterior
D2394	Resin-Based Composite – Four Or More Surfaces, Posterior
	Note: Limit one (1) restoration per patient per tooth per surface per 36 months.
	Non-Surgical Periodontal Service
D4355	Full Mouth Debridement to Enable a Comprehensive Evaluation and Diagnosis On a Subsequent Visit
	Note: Limit one (1) full mouth dedbridement per patient per twenty four (24) month period
	Oral Surgery
D7140	Extraction, Erupted Tooth Or Exposed Root
D7210	Surgical Removal – Erupted Tooth, Removal of Bone/Sectioning of Tooth
D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis

Reimbursement Methodology:
The adult dental pilot program will be reimbursed fee-for-service (FFS).

34. Collaborative Care Model (CoCM) Pilot Program. Effective no earlier than July 1, 2020, the state must implement a Collaborative Care Model (CoCM) pilot program for a limited number of HealthChoice beneficiaries. The state must provide CoCM pilot program services to HealthChoice beneficiaries through a FFS delivery system. The state will select up to three sites at which the CoCM Pilot Program will be established over a 4-year period. To the extent practical, one of the sites selected will be located in a rural area of the state.

CoCM Pilot Program Eligibility Requirement:

Services shall be provided by a team of three providers: a primary care provider (PCP), a behavioral health care manager, and a psychiatric consultant. A PCP must assess participants' behavioral health needs through a clinical screening tool, such as the Patient Health Questionnaire (PHQ-9). Participants who are diagnosed with mild to moderate depression or another behavioral health condition and have expressed interest and given verbal consent to their PCP may enroll in the CoCM pilot program. HealthChoice beneficiaries who actively receive specialty behavioral health care services through a HealthChoice Administrative Services Organization (ASO) are not eligible for the CoCM pilot program.

CoCM Pilot Program Services:

The CoCM pilot program must provide evidence-based therapeutic intervention services and case management services.

1) Evidence Based Therapeutic Intervention Services:
   i. **Behavioral activation**: A therapeutic intervention that is often used to treat depression, which includes scheduled activities to change the environment of the beneficiary and improve the mood of the beneficiary.
   ii. **Motivational interviewing and problem solving therapy**: A therapeutic intervention that helps beneficiaries establish and embrace behavioral changes that support better health outcomes.
2) Targeted Case Management Services:
   i. Care coordination;
   ii. Monitoring and treatment services using a validated clinical rating scale;
   iii. Caseload review and consultation for patients who do not show clinical improvement; and
   iv. Referrals
      a) In the case that a beneficiary requires additional psychiatric services outside the collaborative care intervention, the behavioral

health care manager, under the direction of the psychiatric consultant, will schedule psychiatric or crisis services.

V. MONITORING AND REPORTING REQUIREMENTS

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

Operations and performance:

a. Transition and implementation activities;

b. Stakeholder concerns;

c. Enrollment;

d. Cost sharing;

e. Quality of care;

f. Beneficiary access;

g. Benefit package and wrap around benefits;

h. Audits;

i. Lawsuits;

j. Financial reporting and budget neutrality issues;

k. Progress on evaluation activities and contracts;

l. Related legislative developments in the state; and,

m. Any demonstration changes or amendments the state is considering

36. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state

must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments and how they have been addressed in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

37. Submission of Post-Approval Deliverables. The state shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs ("deliverables"). The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.

38. Compliance with Federal Systems Innovation. As federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state will work with CMS to:

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

b. Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to are provided; and,

c. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.

39. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully and timely with CMS and its contractors' evaluation activities. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required by the state under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in Section III, STC 19.

40. Cooperation with Federal Learning Collaboration Efforts. The state will cooperate with improvement and learning collaboration efforts by CMS.

41. Quarterly and Annual Progress Reports.

a. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The Quarterly Reports are due no later than sixty (60) days following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90) days following the end of the DY.

b. The Quarterly and Annual Reports shall provide sufficient information for CMS to understand implementation progress of the demonstration including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The reports will include all required elements and should not direct readers to links outside the report. (Additional links not referenced in the document may be listed in a Reference/Bibliography section).

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

    i. Operational Updates. The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.

    ii. Performance Metrics. Progress on any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.

    iii. Budget Neutrality and Financial Reporting Requirements. The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

    iv. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycles assessment in trends for monitoring and evaluation of the demonstration.

v. The Annual Report must include all items outlined in STC 40. In addition, the Annual Report must at a minimum include the requirements outlined below:

a) All items included in the Quarterly Reports must be summarized to reflect the operation/activities throughout the DY;

b) Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

c) Yearly unduplicated enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

d) Annual Report Template for the family planning component of the demonstration that will enable CMS to obtain common program data across family planning demonstration programs for collective analysis of performance and trends. The Family Planning Annual Report Template is incorporated in these STCs as Attachment F.

42. 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.

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

a. Encounter Data (Health Plan Responsibilities) – The health plan must collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.

b. Encounter Data (State Responsibilities) – The state must, in addition, develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and to correct deficiencies identified in the collection of encounter data. The state must have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state must contract with its EQRO to validate encounter data through medical record review.

c. Encounter Data Validation Study for New Capitated Managed Care Plans – If the state contracts with new managed care organizations, the state must conduct a validation study eighteen (18) months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study must include validation through a sample of medical records of demonstration enrollees.

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

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

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

46. SUD Monitoring Protocol. The state must submit a SUD Monitoring Protocol. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol must be incorporated in STCs as Attachment H. At a minimum, the SUD Monitoring Plan Protocol must include reporting relevant to each of the program implementation areas listed in STC 27. The SUD Monitoring Protocol must also describe the data collection, reporting analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section V of the demonstration. In addition, the SUD Monitoring Protocol must identify a baseline, a target to be achieved by the end of the demonstration.

Where possible, baseline will be informed by state data, and targets will be benchmarked against performance in best practice setting. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the SUD Monitoring Protocol will be reported via the quarterly and annual monitoring reports.

VI. GENERAL FINANCIAL REQUIREMENTS

47. Reporting Expenditures under the Demonstration. In order to track expenditures under this demonstration, Maryland must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in section 2500 and section 2115 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver, identified by the demonstration project number assigned by

CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Expenditures for optional targeted low income children (MCHP and MCHP Premium children) claimed under the authority of title XXI must be reported each quarter on forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver. For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or l0C. 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

48. 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.

49. 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.

50. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form CMS-64.9 or CMS-64.9P Waiver.

51. Use of Waiver Forms for Medicaid. For each demonstration year, separate Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver shall be completed to report expenditures for the following demonstration populations and demonstration services. The waiver names to be used to identify these separate forms CMS-64.9 Waiver and/or CMS-64.9P Waiver appear in quotation marks following the colon. Expenditures should be allocated to these forms based on the guidance found below.

a. Demonstration Population 1: "New Adult Group" – EG consists of childless adults, ages 19-64, with income up to 133 percent of the FPL, as defined in section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, pursuant to the approved state plan.

b. Demonstration Population 2: "TANF Adults 0-123" – EG consists of families with dependent children and foster children with incomes less than 123 percent of the FPL, including individuals with incomes below the pre-July 2008, TANF income thresholds.

c. Demonstration Population 3: "Medicaid Children" – EG consists of children whose Medicaid eligibility derives from their status as a minor child up to 21 years of age.

d. Demonstration Population 4: "SOBRA Adults" – EG consists of income eligible pregnant women.

e. Demonstration Population 5: "SSI/BD Adults" – EG consists of adults whose Medicaid eligibility derives from their status as blind or disabled.

f. Demonstration Population 6: "SSI/BD Children" – EG consists of children whose Medicaid eligibility derives from their status as blind or disabled.

g. Demonstration Population 7: "MN Adults" – EG consists of adults whose income and resources exceed the categorically needy limits but are within Medicaid State plan limits.

h. Demonstration Population 8: "MN Children" – EG consists of children whose income and resources exceed the categorically needy limits but are within Medicaid State plan limits.

i. Demonstration Population 9: "MCHP" – EG consists of optional targeted low income children with incomes up to and including 200 percent of the FPL who do not pay premiums and who are eligible to claim title XIX funds under the state's approved title XIX State plan only when the state has exhausted its title XXI allotment and only until the next title XXI allotment becomes available to the state.

j. Demonstration Population 10: "MCHP" Premium – EG consists of optional targeted low income children with incomes above 200 percent up to and including 300 percent of the FPL who pay premiums and who are eligible to claim title XIX funds under the state's approved title XIX State plan only when the State has exhausted its title XXI allotment and only until the next title XXI allotment becomes available to the state.

k. Demonstration Population 11: "Family Planning" – The EG is eligible for only family planning and family planning related services and the EG consists all women, of childbearing age, who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP) or Medicare, with income at or below 250 percent of the FPL.

l. Demonstration Population 12: "Increased Community Services (ICS) program" – The EG consists of individuals over the age of eighteen (18) who were determined

Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the state plan resources limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, subject to the following conditions:

i. Individuals must have resided in a nursing facility for at least six (6) months, and been eligible for Medicaid for at least thirty (30) consecutive days immediately prior to being enrolled in this program;
ii. Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act; and
iii. The cost to Medicaid for the individual in the community must be less than cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.

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

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

o. Demonstration Population 15: "Residential Treatment for Individuals with Substance Use Disorder (SUD) program" – The EG consists of expenditures for individuals 21 through 64 who are receiving residential treatment SUD services as outlined in these STCs.

p. Demonstration Population 16: "Dental Expansion for Former Foster Youth (Former Foster Dental)" – The EG consists of additional expenditures for dental services for the former foster youth ages 21 up to (but not including) age 26.

q. Demonstration Population: 17: "Home Visiting Services (HVS) Pilot" – The EG consists of expenditures for evidence-based home visiting services to high risk pregnant women and children up to two (2) years of age.

r. Demonstration Population 18: "Assistance in Community Integration Services (ACIS) Pilot" – The EG consists of expenditures for the ACIS Pilot Program.

s. Demonstration Population 19: "HealthChoice Diabetes Prevention Program (DPP)" – The EG consists of expenditures for the HealthChoice DPP program.

t. Demonstration Population 20: "Medically Managed Intensive Inpatient Hospital Services (ASAM Level 4.0)" – The EG consists of expenditures for the expansion of

SUD services to include Medically Managed Intensive Inpatient Hospital Services (ASAM 4.0) in psychiatric IMDs who have a dual SUD diagnosis.

u. Demonstration Population 21: "Adult Dental Pilot Program" – The EG consists of expenditures for the adult dental pilot program.

v. Demonstration Population 22: "Collaborative Care Model Pilot Program" – The EG consists of expenditures for the HealthChoice Collaborative Care Model (CoCM) pilot program.

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

a. The state is eligible to receive title XXI funds for expenditures for these children, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver in accordance with the instructions in section 2115 of the State Medicaid Manual.

b. Title XIX funds are available under this demonstration if the state exhausts its title XXI allotment once timely notification as described in subparagraph (c) has been provided.

c. If the state exhausts its title XXI allotment prior to the end of a federal fiscal year, title XIX federal matching funds are available for MCHP and MCHP Premium children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver. To initiate this:

i. The state must provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for this demonstration population; and,

ii. The state must submit:

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

b) An up-to-date Children's Health Insurance Program (CHIP) allotment neutrality worksheet.

c) Expenditures subject to the budget agreement. For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all title XIX expenditures provided to individuals who are enrolled in this

demonstration as described in STC 52(c)(i-xv). All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or CMS-64.9P Waiver.

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

54. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two (2) years after the conclusion or termination of the demonstration. During the latter two (2) year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

55. Reporting Member Months. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 37, the actual number of eligible member months for the demonstration populations defined in STC 47. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

a. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three (3) months contributes three (3) eligible member months to the total. Two individuals who are eligible for two (2) months each contribute two (2) eligible member months to the total, for a total of four (4) eligible member months.

56. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS must make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS must reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

57. Extent of (Federal Financial Participation) FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in STC 61:

a. Administrative costs, including those associated with the administration of the demonstration;
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and

c. Net medical assistance expenditures authorized under section 1115 demonstration for the HealthChoice program.

d. CMS must provide FFP for family planning and family planning-related services and supplies at the applicable federal matching rates described in STC 23, subject to the limits and processes described below:

i. For family planning services, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in STC 23, should be entered in Column (D) on the Forms CMS-64.9 Waiver.

iii. Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in STC 23, should be entered in Column (B) on the Forms CMS-64.9 Waiver.

iv. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them.

58. 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.

59. 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.

60. 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

61. **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.

62. **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.

63. **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).

64. **Claiming Period**. All claims for expenditures related to the demonstration (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two (2) year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

65. **Standard Medicaid Funding Process.** The standard CHIP funding process will be used during the demonstration. The state must estimate matchable Medicaid expansion CHIP (MCHP) expenditures on the quarterly Form CMS-37.12 (Narrative) for both Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). On the form CMS-37.12, the state must separately identify estimates of expenditures for the demonstration population. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 waiver forms with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

66. **Administrative Costs**. Administrative costs under title XXI may be claimed on the CMS-21 for the enhanced match or the CMS-64.21 at the regular FMAP if the state has met the title XXI ten percent cap or if the state is concerned about having sufficient title XXI funds for services. If title XXI funding is ever exhausted, administrative costs will be claimed on the CMS-64 at the regular FMAP.

67. 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.

68. 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.

69. Exhaustion of Title XXI Funds. After the state has exhausted Title XXI funds, expenditures for optional targeted low income children within CHIP state plan-approved income levels, may be claimed as Title XIX expenditures as approved in the Medicaid state plan. The state must report expenditures for these children, identified as MCHP and MCHP Premium, as waiver expenditures on the Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver in accordance with STC 48.

70. 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

71. 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.

72. 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.

73. 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 STC 50 for each EG, times the appropriate estimated "per member per month" (PMPM) costs from the table in subparagraph (iii) below.

i. The PMPM costs in this subparagraph reflect the agreed-upon case-mix adjustment that was applied for each year of the budget neutrality agreement.

ii. In addition, the Family Planning population is structured as a "pass-through" or a "hypothetical state plan population." Therefore, the state may not derive savings from this component.

iii. The annual budget neutrality expenditure cap for the demonstration is the sum of the annual EG estimate for each EG calculated in subparagraph i above as well as, the *actual* expenditures for the MCHP and MCHP Premium EGs claimed as title XIX expenditures as approved in the Medicaid State plan when the state has exhausted title XXI funding.

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

Demonstration Eligibility Groups (PMPM costs)	Trend Rate	DY20 01/01/17 – 06/30/17 6 Months	DY21 07/01/17 – 06/30/18 12 Months	DY22 07/01/18 – 06/30/19 12 Months	DY23 07/01/19 – 06/30/20 12 Months	DY24 07/01/20 – 06/30/21 12 Months	DY25 07/01/21 – 12/31/21 6 Months
Medically Needy Children	4.0%	$2,562.44	$2,664.93	$2,771.53	$2,882.39	$2,997.69	$3,117.59
SOBRA Adults	5.1%	$4,456.21	$4,683.47	$4,922.33	$5,173.37	$5,437.21	$5,714.51
SSI/BD Adults	4.0%	$2,305.65	$2,397.87	$2,493.79	$2,593.54	$2,697.28	$2,805.17
SSI/BD Children	4.0%	$2,089.58	$2,173.16	$2,260.09	$2,350.49	$2,444.51	$2,542.29
ACIS Pilot Program	0.0%	$0.00	$666.67	$666.67	$666.67	$666.67	$666.67
Evidence-Based HVS Pilot Program	0.0%	$0.00	$300.00	$300.00	$300.00	$300.00	$300.00
National Diabetes Prevention Program	0.00%	$0.00	$0.00	$0.00	$41.67	$41.67	$41.67
Adult Dental Program	0.00%	$0.00	$0.00	$10.82	$10.82	$10.82	$10.82
Collaborative Care Model	0.00%	$0.00	$0.00	$0.00		$190.00	$190.00

The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality cap calculated in subparagraph iii, that includes the *actual* expenditures for the MCHP and MCHP Premium EGs claimed as title XIX expenditures as approved in the Medicaid State plan when the state has exhausted title XXI funding. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations reported under the following Waiver Names (TANF Adults 0-116, Medicaid Children, SSI/BD Adults, SSI/BD Children, MN Adults, MN Children, SOBRA Adults, PAC, MCHP and MCHP Premium, ICS, PEPW and WBCCTP), plus

any excess from the Supplemental Tests described below. Each DY, the net variance between the without-waiver cost and actual with-waiver cost will be reduced. The Each DY, the net variance between the without-waiver cost and actual with-waiver cost will be reduced. The reduced variance, to be calculated as a percentage of the total variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) The formula for calculating the reduced variance is, reduced variance equals total variance times applicable percentage.

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

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

b. **Supplemental Budget Neutrality Tests: Hypothetical Groups.** The budget neutrality test for this demonstration includes an allowance for hypothetical populations, which are optional populations that could have been added to the Medicaid program through the state plan, but instead will be covered in the demonstration only. The expected costs of hypothetical populations are reflected in the "without-waiver" budget neutrality expenditure limit. The state must not accrue budget neutrality "savings" from hypothetical populations. To accomplish these goals, a separate expenditure cap is established for the hypothetical groups, to be known as Supplemental Budget Neutrality Tests.

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

MEG	Trend Rate	DY20 – PMPM	DY21 – PMPM	DY22 – PMPM	DY23– PMPM	DY24 - PMPM	DY25 - PMPM
Family Planning	5.2%	$54.69	$57.54	$60.53	$63.68	$65.73	$0.00

i. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for each group in the above table in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of Supplemental Cap 1 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 1.

ii. Supplemental Budget Neutrality Test 1 is a comparison between the federal share of Supplemental Cap 1 and total FFP reported by the state for hypothetical groups

under the following Waiver Name (Family Planning).

iii. If total FFP for hypothetical groups should exceed the federal share of Supplemental Cap 1, the difference must be reported as a cost against the budget neutrality limit described in STC 67.

c. **Supplemental Budget Neutrality Test 2: New Adult Group**. Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in the budget neutrality.

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

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

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

i. If the state's experience of the take up rate for the New Adult Group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the New Adult group, the state may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

ii. The Supplemental Cap 2 is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The Federal share of the Supplemental Cap 2 is obtained by multiplying total computable Supplemental Cap 2 by the Composite Federal Share 3.

iii. Supplemental Budget Neutrality Test 2 is a comparison between the Federal share of the Supplemental Cap 2 and total FFP reported by the state for New Adult Group.

iv. If total FFP for New Adult Group should exceed the Federal share of Supplemental Cap 2 after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit described in these STCs.

d. **Supplemental Budget Neutrality Test 3: SUD Component**

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

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

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

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

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

f. The MEG Listed in the table below is included in Supplemental Budget Neutrality Test 5.

MEG	Trend Rate	DY22 PMPM	DY23 PMPM	DY24 PMPM	DY25 PMPM
Medically Managed Intensive Inpatient Hospital Services (ASAM Level 4.0)	1.0	$1,435.00	$1,449.00	$1,464.00	$1,478.00

74. **Composite Federal Share Ratio**. The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed-upon method.

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

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

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

76. 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

77. Independent Evaluator. At the beginning of the demonstration period, the state must acquire an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft evaluation plan. For scientific integrity, every effort should be made to follow the approved methodology, but requests for changes may be made in advance of running any data or due to mid-course changes in the operation of the demonstration.

78. Evaluation Design Approval and Updates. The state must submit its draft evaluation design to CMS no later than 120 days after the award of the demonstration extension. The state's Draft Evaluation Design may be subject to multiple revisions until a format is agreed upon by CMS. The state must submit a revised Draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the Draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation research and submit their evaluation implementation progress in each of the Quarterly Reports and Annual Reports (per STC 37), including any required Rapid Cycle Assessments (per

as outlined in STC 37(c)).

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

80. Evaluation Requirements.

a. The demonstration evaluation will meet the prevailing standards of scientific evaluation and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings.

   i. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

   ii. The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

b. The state shall also conduct an evaluation pursuant to STC 27 which shall include an investigation of the impact of providing Medicaid reimbursement for IMD services on the following outcomes among beneficiaries in need of acute mental health or substance use disorder treatment:

   i. Emergency room utilization for consequences of substance use disorders including opioid overdoses;

   ii. Access to acute inpatient treatment and residential treatment for substance use disorders;

   iii. Lengths of stay in acute inpatient and residential settings for treatment for treatment of substance use disorder;

   iv. Access to acute inpatient and residential treatment for substance use disorders;

   v. Quality of substance use disorder treatment including medication assisted treatment;

vi. Quality of discharge planning in making effective linkages to community-based care;

vii. Readmissions to the same level of care or higher;

viii. Cost of treatment for substance use disorder conditions;

ix. Overall cost of care for individuals with substance use disorders including co-morbid physical and mental health conditions;

x. Opioid prescribing patterns; and,

xi. Drug overdose deaths.

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

a. At a minimum, the Draft Evaluation Plan must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those outlined in the goals of the demonstration outlined in Section II. The draft design shall discuss:

i. The outcome measures that must be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population;

ii. It shall discuss the data sources and sampling methodology for assessing these outcomes; and,

iii. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration are isolated from other initiatives occurring in the state.

b. The evaluation must outline and address evaluation questions for all of the following components:

i. Substance use disorder demonstration component;

ii. Expanded dental for former foster care youth;

iii. Increased Community Services;

iv. Home Visiting Services (HVS) Pilot

v. Assistance in Community Integration (ACIS) Pilot; and

vi. Family planning component

vii. National Diabetes Prevention Program (National DPP)

viii. Adult Dental Pilot

ix. Collaborative Care Model (CoCM) Pilot Program

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

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

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state requests changes to the demonstration, it must identify research questions and hypotheses related to the changes requested and an evaluation design for addressing the proposed revisions.

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

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

85. State Presentations for CMS. The state will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 78. The state shall present on its interim evaluation in conjunction with STC 83. The state shall present

on its summative evaluation in conjunction with STC 84.

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

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

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

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date - Specific	Deliverable	Reference
120 days following award of the extension	Submit Draft Evaluation Design	STC 78
60 days after receiving CMS comments	Revised Draft Evaluation Design	STC 78
June 30, 2023	Summative Evaluation Report	STC 84
Annual		
	By October 1st - Draft Annual Report	STC 42
Each Quarter		
	Quarterly Reports	STC 40
	Quarterly Enrollment Reports	STC 40
	CMS-64 Reports	STC 46
	Eligible Member Months	STC 54

REM Program Benefits

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

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

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

ICS Program Benefits

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

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

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

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

NARRATIVE REPORT FORMAT:

Title Line One – Maryland HealthChoice Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 20 (January 1, 2017, through December 31, 2017)
Federal Fiscal Quarter: 2/2017 (1/1/2017 -3/31/2017)

Introduction

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

Enrollment Information

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

Enrollment Counts

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

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

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

Outreach/Innovative Activities

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

Operational/Policy Developments/Issues

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

Family Planning Program

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

REM Program

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

ICS Program

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

MCHP and MCHP Premium Status/Update/Projections

Expenditure Containment Initiatives

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

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting

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

A. For Use in Budget Neutrality Calculations

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

B. For Informational Purposes Only

Eligibility Group	Total Previous	Current Qtr.	Current Qtr.	Current Qtr.	Total for Quarter

	Quarter Ending XX/XX	Month1	Month2	Month 3	Ending XX/XX
ICS					
HVS Pilot					
ACIS Pilot					

Consumer Issues

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

Legislative Update

Discussion of health care initiatives or other pertinent pending legislation.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

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

State Contact(s)

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

Date Submitted to CMS

Maryland Department of Health

§1115 HealthChoice Demonstration Evaluation Design

January 15, 2021

Table of Contents

Acronyms

ACA	Patient Protection and Affordable Care Act
ACIS	Assistance in Community Integration Services
AIDS	Acquired immunodeficiency syndrome
ASO	Administrative services organization
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CLR	Childhood Lead Registry
CMS	Centers for Medicare and Medicaid Services
CoCM	Collaborative Care Model
CRISP	Chesapeake Regional Information System for our Patients
CY	Calendar year
ED	Emergency department
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External quality review organization
FFS	Fee-for-service
HEDIS®	Healthcare Effectiveness Data and Information Set
HMO	Health maintenance organization
HIE	Health information exchange
HIV	Human immunodeficiency virus
HSI	Health Services Initiative
HVS	Home Visiting Services
ICS	Increased Community Services
IMD	Institutions for mental disease
IT	Information technology
LARC	Long-acting reversible contraceptive
MCO	Managed care organization
NCQA	National Committee for Quality Assurance
OUD	Opioid use disorder
REM	Rare and Expensive Case Management
SBIRT	Screening, Brief Intervention and Referral to Treatment
SUD	Substance use disorder

Background and History of Maryland's §1115 Demonstration

Following approval of the §1115 waiver by the Centers for Medicare and Medicaid Services (CMS) in October 1996, Maryland implemented the HealthChoice program and moved its fee-for-service (FFS) and health maintenance organization (HMO) enrollees into a managed care payment system in July 1997.[1] HealthChoice managed care organizations (MCOs) receive a predetermined monthly capitated payment in exchange for providing covered services to participants. Since the program's inception, HealthChoice has provided oversight to the continuing standards of high-quality coordination of care and controlling Medicaid costs by providing a patient-focused system with a medical home for all beneficiaries; building on the strengths of the established Maryland health care system; providing comprehensive, prevention-oriented systems of care; holding MCOs accountable for high-quality care; and achieving better value and predictable expenses.

Subsequent to the initial grant, the Maryland Department of Health[2] (the Department) requested and received several program renewals—in 2002, 2005, 2008, 2011, 2013 and 2016. In June 2016, Maryland applied for its sixth extension of the HealthChoice demonstration, which CMS approved for the period of calendar years (CYs) 2017 to 2021. Approved effective January 1, 2017 through December 31, 2021, the current waiver period builds on the innovations of the previous extensions by focusing on developing cost-effective services that target the significant and complex health care needs of individuals enrolled in Maryland Medicaid. Specifically, the demonstration will implement initiatives to address the social determinants of health, such as those encountered by individuals with substance use disorders (SUD), high-risk pregnant women and former foster care participants, among others.

As of December 2020, HealthChoice served over 1.33 million participants, constituting nearly 87 percent of Medicaid recipients in Maryland, over 367,000 of which receive coverage under the ACA's Medicaid expansion.

In June 2018, Maryland applied for an amendment to the HealthChoice demonstration, which CMS approved effective March 18, 2019 through December 31, 2021. This amendment approval authorizes the state to carry out the HealthChoice Diabetes Prevention Program (DPP); expand medical managed intensive inpatient services (ASAM 4.0); develop an adult dental pilot program; increase the Assistance in Community Integration Services (ACIS) pilot program annual enrollment cap; and modify the family planning program effective upon approval of MD SPA 18-0005 so that women of childbearing age who have a family income at or below 250 percent of the FPL and who are not otherwise eligible for Medicaid, CHIP or Medicare, but had Medicaid pregnancy coverage will be eligible for the HealthChoice family planning program for 12 months immediately following the two-month post-partum period.

In June 2019, Maryland applied for another amendment to the HealthChoice demonstration to establish the limited Collaborative Care Model (CoCM) Pilot Program. CMS approved the amendment in April 2020.

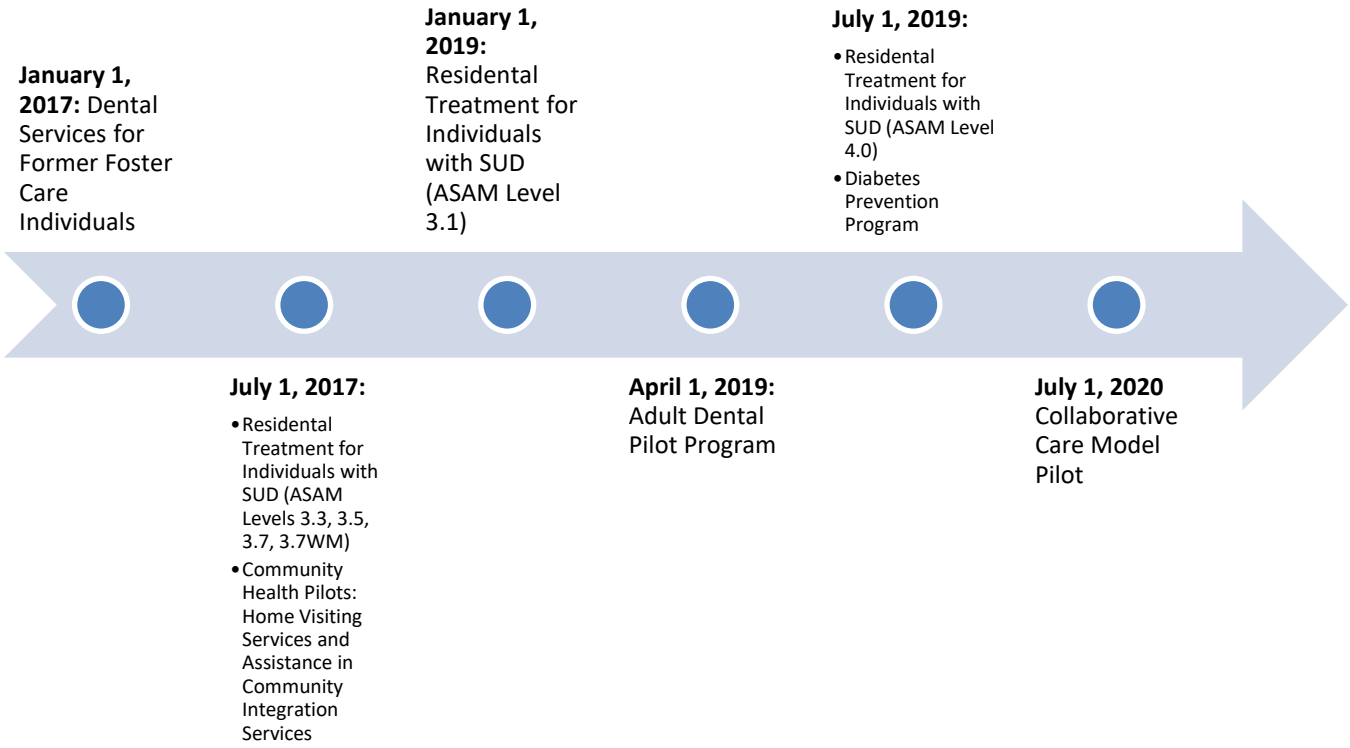
[1] CMS was then known as the Health Care Financing Administration.
[2] Formerly known as the Maryland Department of Health and Mental Hygiene.

Initial evaluation of new participants in HealthChoice due to the ACA expansion have suggested that not only does this population have significant, complex health needs, but they may also have limited health literacy or struggle with homelessness, leading to challenges in the appropriate use of care. Therefore, in addition to assuring that efforts to improve the quality of care throughout the HealthChoice demonstration continue during the current waiver period, the Department requested—and CMS approved—to implement or continue the following program expansions:

1) Increased Community Services (ICS) for 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;
2) Family Planning for women of childbearing age with a family income at or below 250 percent of the Federal Poverty Limit (FPL), who are not otherwise eligible for Medicaid, CHIP or Medicare but had Medicaid pregnancy coverage (per the 2018 amendment);
3) Dental Services for Former Foster Care Individuals up to 26 years old;
4) Residential Treatment for Individuals (21-64) with SUDs;
5) Community Health Pilots: Home-Visiting Services (HVS) for high-risk pregnant women and children up to age two;
6) Community Health Pilots: Assistance in Community Integration Services (ACIS) for individuals residing in institutions or at imminent risk of institutional placement;
7) Adult Dental Pilot Program for full dually-eligible adults (21-64);
8) Diabetes Prevention Program (DPP) for individuals (18-64) who have prediabetes or are at high risk of developing type 2 diabetes; and
9) Collaborative Care Model Pilot Program which integrates primary care and behavioral health services for HealthChoice participants who have experienced a behavioral health need (either a mental health condition or SUD) but have not received effective treatment.

Figure 1 provides a timeline for the implementation of the components associated with the sixth waiver extension and amendments.

Figure 1. Implementation Timeline for HealthChoice Demonstration Components



CMS requires evaluations of all §1115 waiver demonstrations. The Department and its Independent Evaluator (the Hilltop Institute at the University of Maryland, Baltimore County) will prepare a summative evaluation comparing HealthChoice's performance results with the research hypotheses.

Through the implementation and continuation of the HealthChoice demonstration, the Department aims to improve the health status of low-income Marylanders by meeting the following goals:

1) Improve access to health care for the Medicaid population;
2) Improve the quality of health services delivered;
3) Provide patient-focused, comprehensive and coordinated care by providing Medicaid participants with a single medical home;
4) Emphasize health promotion and disease prevention; and
5) Expand coverage to additional low-income Marylanders with resources generated through managed care efficiencies.

Evaluation Questions and Hypotheses

As discussed above, the Maryland §1115 HealthChoice demonstration is a mature program, providing services to over one million participants annually. Evaluation questions will therefore focus on changes implemented during the waiver renewal period. The following three major questions, stated as hypotheses, will be addressed:

1. Eligibility and enrollment changes implemented during the current HealthChoice waiver period will increase coverage and access to care for HealthChoice participants;
2. Payment approaches implemented during the current HealthChoice waiver period will improve quality of care for HealthChoice participants; and
3. Innovative programs address the social determinants of health and will improve the health and wellbeing of the Maryland population.

Hypothesis 1 represents the continuing need for HealthChoice to assure and improve coverage and access to eligible populations. Because Maryland Medicaid participants, with a few excepted groups, are nearly completely covered by MCOs, improvements to access must now address more subtle and difficult barriers to enrollment and obtaining access to services. The evaluation study will ask whether the following two policy changes made an impact in improving access:

- Did the initiation of automated renewals of coverage—based on data indicating no substantial changes in participants' financial position—reduce the amount of time Medicaid-eligible individuals were without Medicaid coverage? The policy change commenced in CY 2016.
- Does automated selection of an MCO after one day for new participants, who in the past were permitted up to twenty-eight days to select an MCO, speed new participants' ability to access services? The policy change commenced in July 2018.

Hypothesis 2 concerns how incentivizing providers through larger and quicker payment would increase their provision of high-priority, high-quality care. This hypothesis will generate questions regarding these three policy initiatives:

- Do additions to value-based purchasing goals result in higher rates of achievement of those goals, without reducing the outcomes achieved by previously existing goals? Changes to the Value-Based Purchasing program went into effect starting in CY 2019.
- Do programs incentivizing greater attention to problems of particular concern among children (*e.g.*, asthma and lead exposure) help to reduce the incidence of those problems? Maryland's Health Services Initiative (HSI) went into effect on July 1, 2017.
- Do programs restricting access to prescription drugs that may be subject to misuse control the rates of such misuse? The policy change commenced on March 1, 2016.

Hypothesis 3 involves the largest number of policy initiatives, although many are currently being implemented as pilot programs and so will have relatively limited enrollment. Therefore, the research questions around pilot programs will benefit from the ability to compare participants' results with the results of a control group. This hypothesis will produce the following policy questions:

- Does the opportunity to treat acute cases of SUD in residential treatment in institutions for mental disease (IMDs) improve the control of SUDs? This benefit went into effect in July 2017, covering ASAM Levels 3.3, 3.5, 3.7 and 3.7WM.[3] ASAM Levels 3.1 and 4.0 were phased in in January and July 2019, respectively.

[3] 3.7WM licensed as 3.7D in Maryland.

- Can home visiting services for new and expectant mothers improve outcomes for both children and their mothers? This program went into effect in July 2017, with awards to local Lead Entities first granted in November 2017.
- Does the ACIS pilot help the outcomes and living situations of persons at risk of institutionalization? This program went into effect in July 2017, with awards to local Lead Entities first granted in November 2017.
- If dental benefits are extended to currently non-covered populations—young adults aged out of foster care and dual eligibles—would these benefits also result in reduced incidence and costs of conditions related to dental disease? These programs went into effect in January 2017 and April 2019, respectively.
- Does ICS reduce the lengths of nursing facility stays for program participants? This program is a continuation from previous waiver periods; the current waiver increase the program's cap to 100 slots.
- Does coverage of contraception under family planning services result in increases in the use of contraceptive drugs and devices to help families plan their families? This program is a continuation from previous waiver periods; the amendment approved during the current waiver period modified program eligibility to women leaving Medicaid pregnancy coverage—but not otherwise eligible for Medicaid, CHIP or Medicare—for 12 months following the two-month postpartum period.
- Does implementation of the National Diabetes Prevention Program (National DPP), proven to be sufficiently-effective to become a covered service under Medicare, work equally well with preventing diabetes diagnoses for a Medicaid population? The HealthChoice DPP was approved effective April 2019.
- Does a service model that integrates primary and behavioral health care and provides evidence-based therapeutic intervention and case management services for individuals with behavioral health conditions through the Collaborative Care Model result in improved outcomes for the target population? This pilot program went into effect on July 1, 2020.

All of these hypotheses and the research questions they generate are consistent with the goals of Title XIX and XXI in improving the health and wellbeing of low-income and chronically-ill populations.

Driver Diagram

Table 1 provides a driver diagram, offering a visual representation of the aims of the 2017-2021 waiver period, along with a closer look at the measures that the Department intends to employ to assess HealthChoice's performance against the stated hypotheses. In addition to the proposed measures, the Department will continue to monitor the development and release of new sources of information—such as upcoming surveys or HEDIS® measures—that may serve to evaluate the demonstration.

Table 1. Driver Diagram for Maryland §1115 Waiver Evaluation

Aims	Primary Drivers	Secondary Drivers
Eligibility and enrollment changes implemented during the current HealthChoice waiver period increase coverage and access to care for HealthChoice participants.	Auto-renewal process	Periods of continuous enrollment without interruption
		Decreases in the frequency of disenrollment and reenrollment (churn)
	MCO auto-assignment after one day policy	Improved service utilization of new participants (>120 day six-month enrollment gap)
Payment approaches implemented during the current HealthChoice waiver period improve quality of care for HealthChoice participants	Value-Based Purchasing (VBP) Program	Better rates of HbA1c control
		Increased well-child visits for children under 15 months in age
	CHIP Health Services Initiative addressing lead and asthma	Healthy Homes for Healthy Kids (Program 1)
		Childhood Lead Poisoning Prevention and Environmental Case Management Program (Program 2)
	Statewide health IT solutions	Streamlined Corrective Managed Care targeting prescription drug abuse
Innovative programs address the social determinants of health and improve the health and wellbeing of the Maryland population	IMD Exclusion Waiver	Improving rates of initiation and engagement of alcohol and other drug dependence treatment among members with SUD
		Better follow-up care after ED visit for alcohol and other drug abuse or dependence
		Lower rates of acute inpatient stays that had any SUD/opioid use disorder (OUD) diagnosis
		Reduced lengths of stay in acute inpatient and residential settings for treatment for SUD
		Increased rates of medication-assisted treatment (MAT) among participants with OUD
		Decreased rates of readmission to the same level of care or higher among members discharged from residential treatment facilities.
		Improved rates of members receiving any addiction treatment for SUD

		Decreased cost of care for individuals with SUD including co-morbid physical and mental health conditions
		Reduction in opioid-related mortality
	Evidence-Based Home Visiting Services Pilot	Increased well-child visits for children under 15 months in age
		Improved attendance at post-partum visits
		Increased screening for depression
		Decreased ED visits
		Increased dental utilization
		Increased post-partum contraceptive uptake
	Assistance in Community Integration Services Pilot	Decreased ED visits (incl. Potentially Avoidable Utilization)
		Decreased inpatient admissions
		Better follow-up care after hospitalization
		Reduced admissions to CFR 578.3 facilities
	Dental benefits for former foster care children	Increased use of dental services, including preventive/diagnostic, and restorative visits
		Reduction in ED use for dental-related conditions
	Pilot for Adult Dental Benefits improves outcomes related to dental care	Reduction in utilization for other health conditions found to be highly related to oral health
		Reduction in ED use for dental-related conditions
	Increased Community Services Program	Reduction in nursing facility admissions and lengths of stay
	Family Planning Program	Increased uptake of contraceptive methods due to inclusion in Maryland Health Connection
	HealthChoice Diabetes Prevention Program	Improved medication utilization practices

		Appropriate reduction in total cost of care
		Decreased diabetes incidence
		Reduction in ED Services
		Reduction in hospital admissions where diabetes is the primary diagnosis
	Collaborative Care Model Pilot Program	Increased rate of depression screening
		Increased monthly contact with enrolled pilot participants
		Improvement in depression diagnostic scores
		Increased case and treatment plan review
		Increased proportion of enrolled pilot participants in remission
		Increased referral to and utilization of specialty behavioral health services by participants identified with high levels of acuity that cannot be appropriately addressed through the Collaborative Care Model

Methodology

Evaluation Design

Depending on the specific sub-population affected by policies and their related research questions, the evaluation will apply a mixed-method approach to create valid and rigorous tests of the programs in question. The Maryland Department of Health recognizes that implementing a policy in pursuit of the driver diagram's predicted results must test whether those results occurred because of the policy or as a result of other factors (changes in economic or social conditions that could change the mix of participants, externally-driven trends in disease incidence and prevalence, or policies implemented outside of the HealthChoice program that pursue the same goals, among other factors). An environmental survey could identify policy changes and other economic and technological trends of potential impact.

Target and Comparison Populations

Because Medicaid is fluid in its enrollment of individuals, it is not always possible to maintain the programs' focus on particular participants or participant groups. Some of these programs evaluated

apply to the HealthChoice populations as a whole, or a subpopulation which intrinsically cannot be divided into intervention and comparison groups, such as new participants. In this case, the best way to measure effects is to compare trends before and after the implementation of the program, using statistical methodologies such as pooled cross-section time series that separate between fixed effects and time-varying effects to control for exogenous changes outside of the program implementation.

On the other hand, a number of the programs are pilot studies with limited enrollment or implementation in specific geographic areas, for example, the Residential Treatment for Adults with SUD and HealthChoice Diabetes Prevention Program components. Such programs can identify non-participants—who might be selected randomly or matched using propensity scoring techniques—to serve as a comparison group. Specific decisions about which approach might be used to create a comparison group may need to await the availability of sufficient data on the program participants, their number and their clinical, demographic, and geographic characteristics.

While mindful of these caveats, Table 2 (below) specifies how outcomes for each policy initiative will be measured, according to whether and how control groups will be specified, and which statistical techniques are best suited to measure outcomes validly and reliably.

Evaluation Period

The evaluation period covers outcomes measured during the renewal period of Maryland Medicaid's §1115 waiver. In some cases (*i.e.*, for certain measures), it may be necessary to look at data from before the renewal period in order to better identify trends in the measure in question. Because The Hilltop Institute at the University of Maryland, Baltimore County is the repository for Maryland Medicaid's MMIS, it would require little additional effort to incorporate these additional data to improve the validity of an analysis relying on trends over time, such as difference in difference methods or pooled cross-section time series.

Data Sources

In general, Maryland's evaluation of the HealthChoice demonstration includes the entire population of participants, which supports a more robust evaluation than does a sampling-based methodology. This approach is facilitated by Hilltop, the Independent Evaluator. Hilltop maintains managed care encounters and FFS claims for the entirety of the Maryland Medicaid program. An overview of these and other data sources the Department will utilize follows. As with past reports, the evaluation will disaggregate certain sub-populations—such as foster care participants and dual eligibles—to assess programs focusing on these particular populations. The evaluation will also identify measures for stratification across MCOs to determine differences in the provision and quality of care.

Due to the distinct attributes of the HealthChoice population, the evaluation will not take into consideration any additional populations for purposes of comparison. The Department believes that year-to-year trend comparisons of the enrolled population provide a more meaningful analysis. Over 86 percent of Maryland Medicaid participants are enrolled in managed care. The remaining 14 percent

consists largely of much smaller populations with greater health complexities: dual eligibles, spend-down recipients and participants in other partial benefit programs. Hence, the evaluation will not compare participants in the HealthChoice program with either the non-HealthChoice FFS population, Medicare beneficiaries or the commercially-insured.

Table 2 (Measurement Framework) identifies the anticipated source for each measure.

Fee-For-Service Claims and Managed Care Encounters (MMIS2)

The Department will leverage its existing relationship with Hilltop, which, in addition to conducting research, analysis and evaluation of publicly-funded health care, serves as the warehouse for Maryland Medicaid FFS claims and managed care encounters received via MMIS2 (and previously MMIS1). Claims and encounter data have been collected since Maryland began the HealthChoice demonstration in 1997, and are updated monthly and stored in analytic, SAS-ready data sets. Because these data are the basis for calculating payment rates under managed care, the data are validated through automated testing algorithms by the Department's information technology office on receipt from providers, by Hilltop on the receipt of data from the Department and by the consulting actuaries who assess the validity and actuarial soundness of managed care rate development.

Hilltop's data warehouse contains person-level demographic information, which allows for matching with other databases. In addition, this arrangement facilitates a variety of analyses, including cost, service utilization, provider network adequacy, enrollment trends and access to and quality of care.

Because 86 percent of Maryland Medicaid recipients participate in HealthChoice and are enrolled in an MCO, the majority of their somatic health services are covered through the managed care benefit and quantified via encounter submissions. Maryland's somatic MCO encounter reporting has been shown to be robust, correct and timely, with MCOs given six months to submit encounter data to the Department. Encounter data are used to determine medical loss ratios and, in rate-setting, give MCOs significant incentive to provide complete and accurate encounter data.

Several Medicaid benefits are carved out from the managed care package so that, even if enrolled with a HealthChoice MCO, a participant might receive some services outside of the MCO. Some of the key carved-out services include dental and behavioral health benefits, both of which are administered by administrative services organizations (ASOs), in addition to certain pharmacy benefits. Individuals participating in the Rare and Expensive Case Management (REM) program also receive their benefits on an FFS basis. FFS providers are allotted up to 12 months to submit claims, meaning that it is important to allow at least a year for claims run-out.

Cost data for FFS claims have been reliably captured since the beginning of Medicaid in Maryland. Since the beginning of the HealthChoice demonstration in 1997, encounter data have been continually improved and validated and are used for setting actuarially-sound capitation rates. Shadow-pricing for institutional claims relies on the all-payer payment rates set by the Maryland Health Services Cost Review Commission and are thus available to all MCOs. Physician and professional shadow prices are

based on the current FFS Medicaid professional fee schedule, which is the most reliable source for estimating MCO payment rates to health care professionals.

Notes on data: Within the HealthChoice evaluation, measures identified as part of an established domain—such as HEDIS®—will follow the specifications of those domains unless otherwise noted. Measures evaluating the emergent nature of ED visits will utilize the classification methodology identified by Billings et al from New York University.[4] Individuals with behavioral health diagnoses will be identified using the criteria outlined in Maryland regulation.[5]

Vital Statistics Administration

One of the key requirements of the HealthChoice demonstration's Residential Treatment for Individuals with SUD is to monitor the incidence of opioid-related mortality. Maryland's MMIS2 does not contain information regarding cause of death. The Department will collaborate with Maryland's Vital Statistics Administration to obtain the data necessary to populate this measure.

Department of Human Services

Hilltop, while able to identify foster care participants by their coverage group in MMIS2, does not maintain access to foster care participants in the subsidized adoption program. Subsidized adoption participants are excluded from the Department's analysis of foster care in the HealthChoice evaluation; therefore, the Department coordinates with the Maryland Department of Human Services to obtain updated foster care subsidized adoption lists on an annual basis.

Maryland Department of the Environment

While Medicaid claims and encounters contain information regarding blood lead testing, they do not include information on the results of those tests. To report on the number of HealthChoice children with elevated blood lead levels, the Department will utilize the statewide Childhood Lead Registry (CLR). Maintained by the Maryland Department of the Environment, the CLR performs childhood blood lead surveillance for Maryland and provides results to the Department, including to Medicaid and local health departments as needed for case management.

[4] Billings J, Parikh N, Mijanovich T. (2000). Emergency room use: The New York story. The Commonwealth Fund. Available https://wagner.nyu.edu/files/admissions/Billings%20-%20Emergency%20Room%20Use%20-%20The%20New%20York%20Story.pdf; accessed 5 April 2017.
[5] COMAR 10.09.70.02(L).

HealthCare Effectiveness Data and Information Set (HEDIS®)

The Department requires HealthChoice MCOs to report all Medicaid measures applicable to Medicaid, except measures exempted by the Department or if the services are carved out of the managed care benefit package (see Fee-for-Service Claims and Managed Care Encounters, above). HEDIS® requires input of high-quality encounter and enrollment data to construct comparison groups based on specific clinical criteria, as defined by diagnosis and procedure codes, and demographic characteristics such as age. MCOs follow the guidelines for HEDIS® data collection and specifications for measure calculations and receive an annual HEDIS® compliance audit by a competitively-procured organization licensed by the National Committee for Quality Assurance (NCQA). The Hilltop Institute uses a competitively-procured HEDIS® software (HEDIS Volume 2: Technical Specifications for Health Plans) to efficiently generate both HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS) sample survey data used for Medicaid program monitoring and evaluation.

Maryland Department of Health Sources

Several of the measures proposed for the HealthChoice evaluation will rely on systems and programs internal to the Department, including ICS program, *LTSSMaryland* system and internal program quality surveys. Certain measures under the HSI Program 2 are sources from Local Health Departments, based on self-report questionnaires completed by program participants during home visits. The questionnaires consist of standardized national asthma control and management metrics.

At present, the Department is actively investigating the possibility of obtaining and sharing with Hilltop quantitative data from other sources, such as state-only claims in support of evaluating the IMD exclusion waiver (residential SUD treatment). If this is not possible, the Department will make note in the Methodological Limitations section. Residential SUD treatment may also be covered in commercial behavioral health claims, but the Maryland All-Payer Claims Database relies on submissions from fully-insured carriers and voluntary submission from self-funded plans. In addition to potential bias from the data excluded, before submission to Maryland's APCD system there is a lag at least 18 months from dates of service delivery. These factors will result in challenges for comparing to Medicaid claims. Data to support the evaluation of the CoCM Pilot Program will be sourced from the contracted CoCM vendor.

Analytic Methods

Where there are pilot interventions or benefits limited to certain populations, a sample of participants and non-participants may be selected based on a propensity scoring model, matching participants on their predicted propensity to join the program. The propensity score would be based on a multivariate probit regression model, which would generate an estimated probability for each individual participant to become a participant if the program were offered them. Cases and controls would then be matched on their predicted probability scores, and further multivariate modeling would then test the effects of the interventions. Once such approach available when there are distinct participants and non-participant comparison groups is the difference-in-differences model. This multivariate technique takes account of trends in exogenous factors that jointly affect both the study and the comparison, and

measures whether the differences between the groups change over time after controlling for these factors.

To measure program effects for populations that cannot be separated into case and control groups, an interrupted time-series analysis is suitable for program measurements that are frequently repeated and can be measured prior to the initiation of the HealthChoice policy intervention.

Sole reliance on quantitative techniques risks missing some critical aspects of the projects undertaken. Data such as the reports of the qualitative impressions of key informants on implementation issues and program outcomes, program documents and literature or site visits by the evaluators, can be collected systematically and analyzed along with quantitative measures (although certain analyses are administrative and not suitable for qualitative approaches). The Department and its Independent Evaluator will use such mixed-methods as described in Table 2; additional detail will be submitted with upcoming HealthChoice Quarterly Reports.

Methodological Limitations

Within evaluation study designs, multiple potential limitations to data and analytic techniques threaten the validity of conclusions drawn from the measures that rely on them. Among these are limits on the data itself: transcription and input errors, variable definitions that are too broad or not well-specified and missing data that may be random or systematic and must be evaluated to determine how best to compensate for them. Some data may be missing because they represent populations or services not served through Medicaid. The target populations for a policy themselves may be difficult to identify and might be identified only when they come forth to receive waiver services, so that there is a threat to validity from biased selection. Although techniques such as matching controls to participants can help in part to hold measures affected by selection bias constant, there are not techniques that can completely control for all threats to validity.

As noted above, certain measures under HSI Program 2 are sourced from self-reported questionnaires administered during home visits for environmental case management. These measures are complemented in the methodology by quantitative measures regarding utilization-related outcomes.

One major concern is whether the effects of an intervention can be separated from other activities and external influences that may affect the measured outcomes of that intervention. External changes that may affect HealthChoice performance include the following:

- Economic trends, such as changes in employment or inflation;
- Introduction of new medical care standards or technology (*e.g.*, a new pharmaceutical protocol for behavioral health issues);
- Epidemiology of disease patterns, such as a flu epidemic or COVID-19;
- Simultaneous implementation of other physical health and behavioral health models, such as accountable health organizations and behavioral health homes;
- Changes in case-mix (*e.g.*, relative severity of illness); and

- State and federal policy changes.

Any external changes beyond the control of the HealthChoice program make isolating the effects of HealthChoice more difficult. The evaluation will conduct qualitative environmental surveys after the policy changes take effect to assess implementation progress and the perceived outcomes of the policy. The Department and the Independent Evaluator will consult with interest groups in communities of concern to define the counterfactual; *i.e.*, if measurable changes observed would have occurred without the HealthChoice program, and if those changes could be explained by the causes suggested in a systematic survey of alternatives. If not, then the analysis can conclude that the HealthChoice program had an impact.

Special Methodological Considerations

Certain pilot studies are small in scope, having relatively-low enrollment observable at this point in time. The analysis will likely need to pool the experience of pilot program participants over several years, along with that of any comparison group than can be constructed through propensity scoring or other techniques. Pooled cross-sectional time series may be used when the outcomes of interest—*e.g.*, a healthy birth weight or cumulative expenditures—can be measured on a yearly (or some other regular) basis.

Nevertheless, even pooled over the five-year time period, some of the pilots may not have attained enough participation to have sufficient statistical power in order to measure whether the outcomes observed are truly the effect of the intervention or simply occurred by chance. There may also be a lack of data necessary to build a truly "comparable" comparison group. This will limit the external validity of the evaluation and not allow for drawing conclusions about the policy's effectiveness or ineffectiveness. Although we cannot predict which policy evaluations will face this dilemma, should evaluators be unable to observe statistically-significant differences in a given pilot, we will report whether the policy results occurred in the expected direction and magnitude.

Table 2. Measurement Framework

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Hypothesis 1: Eligibility and enrollment changes implemented during the current HealthChoice waiver period increase coverage and access to care for HealthChoice participants.							
Implementation of auto-renewal improved continuity of enrollment and reduced enrollment churn.	Spans of coverage without interruptions	All HealthChoice participants are subject to autorenewal. Separate analysis will be performed for the ACA expansion coverage groups	Uninterrupted Coverage Spans	All coverage spans coming due during a specific measurement year	N/A	MMIS	Interrupted time-series analysis of trends pre-and post- policy implementation.
	Persons disenrolling and reenrolling within six months		Persons disenrolling and reenrolling within six months	All Persons disenrolling within a specific measurement year			Interrupted time-series analysis of trends pre-and post- policy implementation.
The auto-assignment to MCOs after one-day policy improved service utilization among new participants.	Mean duration until services first used by new participants	New participants (>120 day six-month enrollment gap)	Duration Data	N/A	N/A	MMIS	Interrupted time-series analysis of trends pre-and post- policy implementation.

Hypothesis 2: Payment approaches implemented during the current HealthChoice waiver period improve quality of care for HealthChoice participants.							
Additions to Value Based Purchasing incentive payment program led to increases in utilization	HbA1c control (added in CY 2019)	Population diagnosed with diabetes, subanalysis by MCO	Persons in Denominator with HbA1c <=8.0	Persons identified with Diabetes (Patients ages 18 to 64 with diabetes who have at least two visits for this diagnosis in the last two years (established patient) with at least one visit in the last 12 months.	MN Community Measurement NQF ID: 0729	MMIS, HEDIS	Interrupted time-series analysis of trends pre-and post- policy implementation.
	Well-child visits for children under 15 months in age	Children < 15 months of age, subanalysis by MCO	The number of children who received 6 or more well-child visits (Well-Care Value Set), on different dates of service, with a PCP during their first 15 months of life. The well-child visit must	15 months old during the measurement year.	NCQA NQF ID: 1392	MMIS, HEDIS	Interrupted time-series analysis of trends pre-and post- policy implementation.

			occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.				
CHIP Health Services Initiative improved outcomes related to lead and asthma	Percentage of children with elevated blood lead levels (BLL) who have received services	Participants in Healthy Homes for Healthy Kids versus non-participants (Program 1)	Children receiving lead remediation	Children with elevated blood lead >=5µg/dL	N/A	MMIS using ICD-10 coding of BLL, Blood Lead matching, Local Health Departments, Childhood Lead Registry	Difference-in-differences analysis of trends between participants and non-participants.
	Among those will elevated BLL, the proportion whose follow up blood lead test was below 5µg/dL	Expansion of the Childhood Lead Poisoning Prevention and Environmental Case Management Program versus non-participants (Program 2). Non-participant comparison group will be selected from counties not participating in the program.	N/A	Children with elevated blood lead >=5µg/dL	N/A		
	Asthma: Fewer nights awakened; fewer days with shortness of breath; fewer days of rescue inhaler		N/A	N/A	N/A	Local Health Departments HEDIS MMIS	

	use; reduced asthma-related ED and inpatient use	Subgroup analysis can be performed by gender, age and geographic location.					
	Process Measures ***Program 1 (Lead Remediation)*** • IA and DUA signed between DHCD and MDH • DHCD procurement of abatement companies to work on program • DHCD procurement of lead inspector company to perform work for Program 1 • Successful completion of invoicing and billing payment • No. of lead remediation contractors procured for task order according to National HUD and local MDE guidelines • New provider type established in Maryland Medicaid's provider enrollment system: Lead Risk Assessor ***Program 2 (Environmental Case Management)*** • IA and DUA IRD to EHB • No. of IAs and DUAs established between IRD, EHB and LHDs • Successful completion of billing and payment mechanism, i.e. through IGT • No. of LHDs with MMIS and EVS access to screen for current Medicaid enrollment • No. of LHDs with staff onboarded based on quotas established by the Department • No. staff on-boarded at EHB for P1/P2 administration • No. of LHDs with staff that have been trained • No. Health Departments actively referring to P1 (DHCD) • No. LHDs conducting home visits						
Streamlined Corrective Managed Care	No. of persons on CMC	Persons using Rx identified for CMC, enrolled on	N/A	N/A	N/A	Point of Sale Pharmacy System	Difference-in-differences analysis of trends

decreases prescription drug abuse	No. of overdoses	CMC and not enrolled	N/A	N/A	N/A		between participants and non-participants.
Hypothesis 3: Innovative programs address the social determinants of health and improve the health and wellbeing of the Maryland population.							
IMD exclusion waiver results in improved outcomes for SUD	Probability of initiation and engagement of alcohol and other drug dependence treatment	Persons with SUD, users of IMD compared with non-users	Persons in denominator with claims for SUD treatment	All persons diagnosed with SUD	N/A	MMIS, HEDIS	Estimated odds ratio of IMD to Non-IMD users, controlling for level of care in IMD, using binary outcome regression.
	Follow-up after discharge from the ED for mental health or alcohol or other drug dependence		Persons in denominator with claims for SUD treatment after discharge	All persons diagnosed with SUD using ED services	N/A	MMIS	Odds ratio of follow up within seven and 30 days after discharge using binary outcome regression.
	ED utilization for consequences of SUD, including opioid overdoses		Frequency of SUD diagnoses in ED	N/A	N/A		Frequency of ED use with primary DX of SUD, controlling for IMD participation and level of care,

							using event-count regression models.
	Use of MAT services among persons with OUD and IMD placement		Persons in denominator receiving MAT	Persons with opioid SUD diagnoses	N/A		Frequency of ED use with primary DX of SUD, controlling for IMD participation and level of care, using event-count regression models.
	Presence of discharge planning in making effective linkages to community-based care[6]	IMD users		IMD users	N/A		Summary statistics of completed discharge planning, use of services post discharge, using Chi-square or t-tests.
	Readmission frequency to the same level		IMD users having readmissions		N/A		Pooled cross-sectional time-series counts of readmissions.

[6] The Department has limited resources to conduct record reviews, which may challenge the completion of this measure.

	of care or higher						Pooled cross-sectional time-series spending inclusive of IMD and outpatient treatment, controlling for persons with and without IMD use
	Overall cost of care for individuals with SUD including co-morbid physical and mental health conditions Tabulations of spending inclusive of IMD and outpatient treatment	Persons with SUD, users of IMD compared with non-users	N/A	N/A	N/A		
	Death by OUD	Deaths by OUD among Medicaid participants	Deaths of individuals in the denominator	All persons with SUD diagnoses		Vital Statistics	Incidence of OUD in binary regression model comparing IMD and non-IMD.

	Process Measures
	
	• Fee schedule created of Medicaid reimbursement rates
	• No. of IMDs billing Medicaid under the demonstration
	  ○ By region
	  ○ By ASAM level
	  ○ Compared with before demonstration implementation
	• No. of IMDs having participated in a Medicaid onboarding training (*e.g.*, how to bill):
	  ○ 3.3 - 3.7D						

	○ 3.1 ○ 4.0 ○ Duals expansion • No. of grievances, appeals and critical incidents related to SUD treatment services						
The HVS Pilot improves health outcomes for participating families and children	Length of time between initiation of well child visits	Comparing participants in HVS to non-participants, *i.e.,* in counties where HVS is not active, matching control cases to intervention group with propensity scoring for HVS enrollment.	N/A	N/A	N/A	MMIS	Hazard rate or time to event models
	Frequency of well-child visits around appropriate ages in months						Event count models (Poisson regression) for counts of visits.
	Length of time to mother's first post-partum visit						Hazard rate models
	Mother's screening for depression						Hazard rate models
	Mother and newborn use of ED for all causes					MMIS	Binary outcome regression controlling for participation in HVS, with All Cause ED use or ED use with

							injury, poisoning, trauma
	Mother's use of dental services						Binary outcome regression, controlling for participation in HVS
	Post-partum contraceptive uptake						Binary outcome regression, controlling for participation in HVS
	Mothers and infants admission rates, within one year of birth						Event count models, controlling for participation in HVS

	Process Measures
	• No. of Lead Entities participating
	  ○ Signed IA/DUA
	  ○ Successful completion of inter-governmental transfer (IGT) of funds for local match
	  ○ Completion rate of monthly implementation report
	• No. of Lead Entities with NFP or HFA accreditation
	Envisioned Qualitative Approach: Key informant interviews with Local Health Departments, home-visitors						

ACIS pilot improves health outcomes for participants	Pre- and post-living situation	ACIS participants vs Non-participants	N/A	N/A	N/A	Enrollment data on living arrangement	Interrupted time-series analysis.
	ED visits (incl. potentially-avoidable utilization)					MMIS, HEDIS	Event count models, controlling for participation.
	Inpatient admissions						Event count models, controlling for participation.
	HEDIS Follow Up after Hospitalization (FUH)		Submission Criteria 1: Patient Received Follow-Up within 30 Days after Discharge. A follow-up visit with a mental health practitioner within 30 days	Submission Criteria 1: Patients 6 years of age and older who were discharged from an acute inpatient setting (including acute care psychiatric	National Committee for Quality Assurance (HEDIS)		

			after acute inpatient discharge. Submission Criteria 2: Patient Received Follow-Up within 7 Days after Discharge: A follow-up visit with a mental health practitioner within 7 days after acute inpatient discharge.	facilities) with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement period Submission Criteria 2: Patients 6 years of age and older who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of			

				the measurement period			
	Frequency of admissions to NH, Behavioral Health, inpatient acute care from users of CFR 578.3 facilities	Users of CFR 578.3 facilities compared to non-users	N/A	N/A	N/A		Event count models, controlling for participation

	Process Measures
	• No. of Lead Entities participating
	  ○ Signed IA/DUA
	  ○ Successful completion of inter-governmental transfer (IGT) of funds for local match
	  ○ Completion rate of monthly implementation report
	• No. of Learning Collaboratives held and Lead Entity participation rate in each
	• No. of Lead Entities and Participating Entities with signed DUAs/contracts
	• No. of Lead Entities trained, licensed and using Homeless Management Information System
	Envisioned Qualitative Approach: Key informant interviews with lead entity and participating entity interviews, learning collaborative results						

Dental benefits for former foster care children reduced potentially-	Frequency of ED visits with dental diagnoses	Former foster care children	N/A	N/A	N/A	MMIS	Compare ED use for dental services, pre and post implementation.

avoidable utilization	Frequency of dental services, including preventive/diagnostic and restorative visits						Compare to similar age groups (REM and pregnant women), pre and post implementation in event count outcome regression
Pilot for Adult Dental Benefits improves outcomes related to dental care	Reduction in ED use for dental related conditions	Dual eligible pilot participant and non-participants	N/A	N/A	N/A	MMIS	Difference-in-differences for matched control group compared to pilot participants.
	Diagnoses of diabetes, MCH, inflammatory disease compared to similar age groups in multivariate regression						Participants compared to similar age groups in multivariate binary outcome regression

	Total Medicaid costs for dental benefit pilot participants vs non-participants						Pooled cross-section time series data of participants compared to matched control non-participants.
Increased Community Services increases transitions to the community	Transitions of long stay nursing facility residents to community settings	Nursing facility residents participating and not participating in the pilot	ICS participants	All nursing facility residents in pilot area	N/A	MMIS	Compare length of stay of ICS participants with similar nursing facility residents in a multivariate regression.
Family Planning increases utilization of family planning services	Effect of inclusion in Maryland Health Connection on enrollment and uptake of prescription contraceptives (daily and/or LARC)	Uptake of prescription contraceptives (daily and/or LARC)	Use of contraceptives by women of child-bearing age	All women of child-bearing age	N/A	MMIS	Multivariate difference in difference pre and post implementation, for binary outcome of daily prescription, LARC, and of any contraceptive

HealthChoice Diabetes Prevention Program improves health outcomes for participants	All-cause hospital admissions	Compare DPP participants to non-participants	All-cause hospital admissions for participants vs. eligible enrollees who did not participate in DPP	All eligible participants (comparing those that enrolled vs. those that did not enroll in DPP)	N/A	MMIS	Event count models
	Prescription adherence for participants who have progressed to type 2 diabetes		No. of participants who progressed to a type 2 diabetes diagnosis in adherence with medication regimen	All participants who progressed to a type 2 diabetes diagnosis	N/A		Frequency (count) of prescriptions
	Total cost of care		Total cost of care for participants vs. eligible enrollees who did not participate in DPP	All eligible participants (comparing those that enrolled vs. those that did not enroll in DPP)	N/A		Pooled cross-section time series analysis of costs
	Diabetes incidence		Diabetes incidence for participants vs. eligible enrollees who	All eligible participants (comparing those that enrolled vs.	N/A		Binary outcome regression

			did not participate in DPP	those that did not enroll in DPP)			
	ED visit rate		ED visits for participants vs. eligible enrollees who did not participate in DPP	All eligible participants (comparing those that enrolled vs. those that did not enroll in DPP)	N/A		Event count models
	Process Measures • New provider type established in Maryland Medicaid's provider enrollment system: DPP provider • No. of DPP providers enrolled in Maryland Medicaid, by delivery mode (in-person or virtual) • No. of MCOs with at least one DPP provider contracted in their network • No. of DPPs contracted with each MCO, disaggregated by in-person and virtual, and in each: o No. of individuals enrolled o No. of individuals retained at six months o No. of individuals achieving five-percent weight loss o No. of individuals achieving nine-percent weight loss **Envisioned Qualitative Approach**: Key informant interview with MCOs, DPP providers						
Integrated delivery of primary and behavioral health care through the Collaborative	Monthly contact: Proportion of participants receiving active	CoCM Pilot Program participants	No. of participants with at least one clinical contact per month[7]	Total no. of CoCM Pilot Program-enrolled participants in that month	N/A	CoCM provider	Event counts

[7] A "clinical contact" is defined as a contact in which monitoring may occur and treatment is delivered with corroborating documentation in the patient chart. This includes individual or group psychotherapy visits and telephonic engagement as long as treatment is delivered.

Care Model Pilot Program improves health outcomes for participants	treatment in CoCM						
	Depression screening rate: Proportion of participants receiving a depression screening		No. of participants who received a PHQ-2 or PHQ-9 screening in the past 12 months	No. of participants enrolled in CoCM Pilot Program	N/A		Event count models
	Depression diagnosis: Proportion of participants demonstrating clinically-significant improvement		No. of participants enrolled in CoCM Pilot Program for 70 days or greater with either: 1) a 50% reduction from baseline PHQ-9; or 2) a drop from baseline PHQ-9 to less than 10	No. of participants enrolled in CoCM Pilot Program for 70 days or more	N/A		Interrupted time-series analysis
	Case review: Proportion of participants without improvement whose case and/or		No. of participants enrolled in CoCM Pilot Program for 70 days or greater, who did not	No. of participants enrolled for 70 days or greater who did not meet clinical improvement	N/A		Interrupted time-series analysis

	treatment plan were reviewed		show improvement, whose case was reviewed by the Consulting Psychiatrist with treatment recommendations provided to the primary care provider or BH care manager OR had a documented change made to their treatment plan in the month of non-improved screening	criteria that month			
	Remission rate: Proportion of participants who achieved remission criteria		No. of participants whose last-recorded PHQ-9 score was below 5	No. of participants	N/A		Event count models
	Specialty behavioral health utilization rate		No. of participants 1) referred to the ASO for	No. of participants	N/A	MMIS	Event count models

			specialty behavioral health services and 2) of those referred, the number with a with a behavioral health claim paid by the ASO within 30 days				

	Process Measures
	
	• Signed contract with at least one entity to implement CoCM Pilot Program
	• No. of pilot sites established
	  o No. of rural sites
	  o No. of urban sites
	  o No. of Ob/Gyn provider sites
	• No. of participants enrolled per site						

Attachments

Independent Evaluator and Evaluation Budget

Selection of the Independent Evaluator

The Hilltop Institute is an independent non-partisan health research organization dedicated to advancing the health and wellbeing of people and communities. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, innovative and objective research analysis.

The Department chose Hilltop as the evaluator due to Hilltop's extensive experience and knowledge of Maryland Medicaid data and program policy. Hilltop has provided impartial consultation, technical support and program assistance to the Department since 1994 with the overarching goal of objectively evaluating and improving the Maryland Medicaid program without conflict of interest. The responsibilities of Hilltop are to: 1) assist the Department in managing the HealthChoice program, including conducting evaluations; 2) provide data analyses, rate-setting support and policy development of innovative proposals for the delivery of long-term services and supports; 3) provide administrative support activities; 4) facilitate database development; and 5) produce and disseminate studies, reports and analyses.

Evaluation Budget

The list of assigned personnel and their respective contributions and work effort is contained in Appendix A. The cost for the evaluation, inclusive of salary, fringe benefits and university overhead totals approximately $628,667.

The relationship between the Department and The Hilltop Institute is governed by a multi-year Master Agreement and Business Associate Agreement, with a scope of work and budget negotiated on an annual basis.

Timeline and Major Milestones

As described in the Data Sources section above, Medicaid claims and encounters for health care services are not immediately available for analysis. FFS providers are allowed 12 months to submit claims for payment, and MCOs are permitted six months to submit encounters. MMIS2 data are not considered completed until 12 months have passed for submission of FFS claims. Hilltop receives MMIS2 data on a monthly basis. For example, a claim or encounter paid on May 15, 2022 would be included in the data submission to Hilltop in early June 2022.

The evaluation period for participants will extend thru December 31, 2021. To accommodate the FFS claims run-out period, Hilltop will delay its analysis until 12 months have passed from the culmination of

the demonstration period, until after January 1, 2023. With the summative evaluation due to CMS in June 2023, this will allow approximately six months for data processing and analysis for those measures that rely on claims and encounters.

Maryland receives data from Local Health Departments—for the Community Health Pilots and HSI—on an ongoing, quarterly basis.

Table 3 provides a summary of the schedule of state deliverables for the demonstration period.

Table 3. Summary of Milestones for Completion of the Summative Evaluation Report

Milestone	Date
Draft evaluation design submitted	April 21, 2017
Draft evaluation design re-submitted	July 9, 2019
Draft evaluation design re-submitted	July 1, 2020
Draft evaluation design re-submitted	January 15, 2021
Last day of the HealthChoice demonstration period	December 31, 2021
Last day for MCO providers to submit encounters for inclusion in analysis	June 30, 2022
Last day for fee-for-service providers to submit claims for inclusion in analysis	December 31, 2022
Last day for Vital Statistics Administration data run-out	December 31, 2022
Last day for Maryland Department of the Environmental data run-out	December 31, 2022
Due data for draft of summative evaluation report	June 30, 2023
Due date for final summative evaluation report	*(Within 30 days of receipt of CMS comments)*
Final approved summative evaluation posted to the Department's website	*(Within 30 days of CMS approval)*

Appendix A. Budget Justification for The Hilltop Institute

Estimated Personnel Effort and Other Costs for Summative HealthChoice Evaluation
Period of Performance: 7/1/22 – 6/30/23
Budget Justification

This is the estimated budget for the final HealthChoice Summative evaluation due June 30, 2023. During years 1-4 of the waiver, data collection and analysis will be ongoing and will culminate in interim annual reports.

Personnel and Other Costs:

Executive Direction, .21 FTE ($44,342): The executive direction team will be responsible for overall supervision of the project and will provide assistance with project management and coordination with MDH. The team will provide management oversight of the evaluation team and final review and approval of the evaluation analysis.

Project Supervision and Direction, .32 FTE ($56,902): This team will be responsible for overall supervision of the project and will provide assistance with project management and expertise on the analysis of Medicaid utilization data and risk adjustment.

Methodology and Methods Team, .29 FTE ($42,214): The methodology and methods team will develop methodologies needed for the evaluation, and will work with the Maryland Department of Health to coordinate new data collection outside of encounter reporting. The team will advise on the application of appropriate statistical methods to the analysis of the evaluation data.

Programming Team, .7 FTE ($92,511): The programming team will have primary responsibility for SAS programming to calculate HealthChoice outcome measures, including HEDIS and other quality measures.

Policy Analysts, 1.42 FTE ($198,218): The policy analyst team will collaborate with MDH on stakeholder communication, analyze Medicaid utilization data, participate in the development of information needed for the evaluation, and will work with MDH to coordinate new data collection outside of encounter reporting. The team will provide technical support to SAS programmers on data analysis and risk adjustment and will contribute to data analysis, regression analysis, and interrupted time series analyses.

Editor, .03 FTE ($5,666): The editor will provide editorial services and graphics support for the evaluation report.

Fringe Benefits: Fringe benefit charges are estimated at 35%.

Travel and Conference Calls: Local travel and conference calls are estimated at $400 annually to meet with the Department.

Programming Subcontracts: Additional programming subcontracting costs are estimated at $20,000 annually.

Overhead: Facilities and Administrative (F&A) recovery rate applied to this project is 25%.

Annual Estimated Budget in FY 2023: $628,667

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

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

a. Nurse Family Partnership (NFP): The NFP is designed to reinforce maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The HealthChoice section 1115 demonstration NFP pilot program will adhere to the NFP national program standards and service will be suspended once the child reaches two (2) years old.

b. The Healthy Families America (HFA). The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, substance use disorder (SUD), mental health issues, or domestic violence.

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

Table One: Description of Services

Service	Description of Service
Prenatal Home Visit	The HVS Pilot Project will provide home visit services to expectant mothers during their pregnancy. The prenatal home visit services will provide: • Monitoring for high blood pressure or other complications of pregnancy (NFP only); • Diet and nutritional education; • Stress management; • Sexually Transmitted Diseases (STD) prevention education; • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; and • Domestic and intimate partner violence screening and education.
Postpartum Home Visits	The HVS Pilot Project will provide home visit services to Medicaid eligible mothers during their sixty (60) day postpartum period. • Diet and nutritional education; • Stress management; • STD prevention education; • Tobacco use screening and cessation education;

	• Alcohol and other substance misuse screening and counseling; • Depression screening; • Domestic and intimate partner violence screening and education; • Breastfeeding support and education (NFP may refer beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service); • Guidance and education with regard to well woman visits to obtain recommended preventive services; • Medical assessment of the postpartum mother and infant (NFP only); • Maternal-infant safety assessment and education e.g. safe sleep education for Sudden Infant Death Syndrome (SIDS) prevention • Counseling regarding postpartum recovery, family planning, needs of a newborn; • Assistance for the family in establishing a primary source of care and a primary care provider (i.e. ensure that the mother/ infant has a postpartum/ newborn visit scheduled); • Parenting skills and confidence building (HFA emphasis).
Infant Home Visits	The HVS Pilot Project will provide home visit services to newborn infants born to HVS Pilot Project beneficiaries until the child reaches two (2) years of age. • Breastfeeding support and education (NFP may refer beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service)); and • Child developmental screening at major developmental milestones from birth to age two (2); • Parenting skills and confidence building (the HFA program emphasizes these skills).

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

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

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

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

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

Table Two: Provider Qualifications

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

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

		(automated External Defibrillator) certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	support nurses and/or beneficiaries level of care needs. For example, if a child or caregiver is ill for a month, a Nurse Home Visitor Supervisor may visit the home to re-assess the caregiver and child and offer an appropriate level of care.	

Description of Payment Methodologies

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

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

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

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

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

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

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

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

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

Table Three: Healthy Families America (HFA) Agencies in Maryland with Accreditation Status (updated 2/20/19)

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

Per STC #28, the following protocol outlines the services and payment methodologies for the Assistance in Community Integration Services (ACIS) Pilot Program. Under this pilot program, the state will provide a set of Home and Community Based Services (HCBS) to a population that meets the needs-based criteria specified below, capped at 600 individuals annually. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA). The protocol outlines the content that would otherwise be documented in a 1915(i) SPA, and includes service definitions and payment methodologies.

Eligibility Criteria

The state's needs based criteria are specified below:

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

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

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

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

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

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

These services may include:

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

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

Housing Case Management Services – may include:

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

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

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

The state's needs based criteria are specified below:

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

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

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

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

Description of Payment Methodologies

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

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

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

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

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

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

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

Family Planning Section 1115 Demonstration
Template for Annual Monitoring Reports

Purpose and Scope:

In accordance with STC 40, the intent of this report is to present the state's analysis of collected data and assessment of performance of the family planning component of the [insert demo name]. The report should also include a discussion of trends and issues over the year, including progress on addressing any issues affecting access, quality, or costs.

Each annual report must include, at a minimum, the following program elements:

A. Executive Summary
B. Participation Monitoring
C. Utilization Monitoring
D. Program Outreach and Education
E. Program Integrity
F. Grievances and Appeals
G. Unduplicated Number of Beneficiaries Losing Coverage after 2-year Period of Enrollment by Demonstration Year
H. Unduplicated Number of Beneficiaries Re-enrolled in Demonstration Year for a Subsequent 2-year Period of Eligibility
I. Annual Post Award Public Forum
J. Budget neutrality
K. Demonstration evaluation activities and interim findings.

ANNUAL MONITORING REPORT
MARYLAND FAMILY PLANNING SECTION 1115 DEMONSTRATION

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

A. Executive Summary

1. Synopsis of the information contained in the report

2. Program Updates

a. Current Trends and Significant Program Activity

i. Narrative describing administrative and operational activities occurring in the last quarter including any changes to demonstration processes related, but not limited to, eligibility and enrollment, provider education, systems, health care delivery,

benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes.

ii. Narrative on any demonstration changes, such as notable changes in enrollment, service utilization, and provider participation (up or down 10 percent). Discussion of any action plan if applicable.

iii. Narrative on the existence of or results of any audits, investigations, or lawsuits that impact the demonstration.

3. Policy Issues and Challenges

a. Narrative of any operational challenges or issues the state has experienced.

b. Narrative of any policy issues the state is considering, including pertinent legislative/budget activity, and potential demonstration amendments.

c. Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable.

B. Participation Monitoring

The state will summarize activities and outcomes occurring in the last quarter to address improving demonstration participation and service utilization among demonstration enrollees.

C. Utilization Monitoring

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

Table 1. Utilization Monitoring Measures

Topic	Measure [reported for each month included in the report]
Utilization Monitoring	Unduplicated Number of Enrollees by Quarter
	Unduplicated Number of Beneficiaries with any Claim by Quarter (by key demographic characteristics such as age, gender, and income level)
	Utilization by Primary Method and Age Group
	Total number of beneficiaries tested for any sexually transmitted disease
	Total number of female beneficiaries who obtained a cervical cancer screening
	Total number of female beneficiaries who received a clinical breast exam

Table 2: Unduplicated Number of Enrollees by Quarter

	Number of Female Enrollees by Quarter				
	14 years old and under	15-20 years old	21-44 years old	45 years old and older	Total Unduplicated Female Enrollment*
Quarter 1					
Quarter 2					
Quarter 3					
Quarter 4					

*Total column is calculated by summing columns 2-5.

Table 3: Unduplicated Number of Beneficiaries with any Claim by Age Group per Quarter in the Demonstration Year (to date)

	Number of Females Who Utilize Services by Age and Quarter					
	14 years old and under	15-20 years old	21-44 years old	45 years old and older	Total Female Users *	Percentage of Total Unduplicated Female Enrollment
Quarter 1						
Quarter 2						
Quarter 3						
Quarter 4						

*Total column is calculated by summing columns 2-5.

Table 4: Contraception Utilization by Age Group per Demonstration Year (to date)

Effectiveness		Users of Contraceptives				
		14 years old and under	15 – 20 years old	21 – 44 years old	45 years old and older	Total
Most and Moderately Effective*	Numerator					
	Denominator					
Long-acting reversible contraceptive (LARC)*	Numerator					
	Denominator					
Total	Numerator					
	Denominator					

*This measure is calculated as per the Medicaid and CHIP Child and Adult Core Set measure for contraceptive care for all women.

Table 5: Number Beneficiaries Tested for any STD by Demonstration Year

Test	**Total Tests**	
	Number	Percent of Total Enrolled Females
Unduplicated number of beneficiaries who obtained an STD test		

Table 6: Total Number of Female Beneficiaries who obtained a Cervical Cancer Screening

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who obtained a cervical cancer screening		

Table 7: Breast Cancer Screening

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who received a Breast Cancer Screening		

Table 8: Post-Partum Contraceptive Care

Screening Activity	Number	Percent of Total Enrolled Females
Among female beneficiaries between the ages of 15 to 20 who had a live birth, the percentage that was provided within 3 and 60 days of delivery, a most effective or moderately effective method of contraception:		
Among female beneficiaries between the ages of 15 to 20 who had a live birth, the percentage that was provided within 3 and 60 days of delivery, a long-acting reversible method of contraception (LARC).		
Among female beneficiaries between the ages of 21 to 44 who had a live birth, the percentage that was provided within 3 and 60 days of delivery, a most effective or moderately effective method of contraception:		
Among female beneficiaries between the ages of 21 to 44 who had a live birth, the percentage that was provided within 3 and 60 days of delivery, a long-acting reversible method of contraception (LARC).		

D. Program Outreach and Education

1. General Outreach and Awareness
   - **a.** Provide information on the public outreach and education activities conducted this demonstration quarter; and,
   - **b.** Provide a brief assessment on the effectiveness of these outreach and education activities.

2. Target Outreach Campaign(s) (if applicable)
   - **a.** Provide a narrative on the populations targeted for outreach and education campaigns and reasons for targeting; and,
   - **b.** Provide a brief assessment on the effectiveness of these targeted outreach and education activities.

E. Program Integrity

Provide a summary of program integrity and related audit activities for the demonstration; including an analysis of point-of-service eligibility procedures.

F. Grievances and Appeals

Provide a narrative of grievances and appeals made by beneficiaries, providers, or the public, by type and highlighting any patterns. Describe actions being taken to address any significant issues evidenced by patterns of appeals.

G. Table 9: Unduplicated Number of Beneficiaries Losing Coverage after 2-year Period of Enrollment by Demonstration Year

Number of Female Enrollees Losing Coverage in Demonstration Year					
14 years old and under	15-20 years old	21-44 years old	45 years old and older	Total Females Lost Enrollment*	Percent of Total Enrolled Females

*Total column is calculated by summing columns 1-4.

H. Table 10: Unduplicated Number of Beneficiaries Re-enrolled in Demonstration Year for a Subsequent 2-year Period of Eligibility

Number of Female Enrollees Re-enrolled for a Subsequent 2-year Period of Eligibility					
14 years old and under	15-20 years old	21-44 years old	45 years old and older	Total Females Re-enrolled*	Percent of Total Enrolled Females

*Total column is calculated by summing columns 1-4.

I. Annual Post Award Public Forum

Provide a summary of the annual post award public forum conducted by the state as required by 42 CFR §431.420(c) that includes a report of any issues raised by the public and how the state is considering such comments in its continued operation of the demonstration.

J. Budget Neutrality

1. Please complete the budget neutrality workbook.
2. Discuss any variance noted to the estimated budget, including reasons for variance in enrollment and/or in total costs, and/or in per enrollee costs. Describe any plans to mitigate any overages in budget neutrality by the end of the demonstration period.

K. Demonstration Evaluation Activities and Interim Findings

1. Please provide a summary of the progress of evaluation activities, including key milestones accomplished. Include:
   - **a.** Status of progress against timelines outlined in the approved Evaluation Design.
   - **b.** Any challenges encountered and how they are being addressed.
   - **c.** Status of any evaluation staff recruitment or any RFPs or contracts for evaluation contractual services (if applicable).
2. Description of any interim findings or reports, as they become available