CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W -00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health and Mental Hygiene

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Maryland's HealthChoice section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the Maryland Department of Health and Mental Hygiene (State) to operate this Demonstration and the Centers for Medicare & Medicaid Services (CMS) has granted waivers of statutory Medicaid requirements permitting deviation from the approved State Medicaid plan and expenditure authorities authorizing expenditures for cost not otherwise matchable. The waivers and expenditure authorities are separately enumerated. These STCs set forth conditions and limitations on those waiver and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration.

The STCs related to the program for those State Plan and Demonstration Populations affected by the Demonstration are effective from the date identified in the CMS Demonstration approval letter through December 31, 2013.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Historical Context
III. General Program Requirements
IV. General Reporting Requirements
V. General Financial Requirements Under Title XIX
VI. General Financial Requirements Under Title XXI
VII. Monitoring Budget Neutrality
VIII. Evaluation ofthe Demonstration
IX. Additional attachments have been included to provide supplementary information and guidance for specific STCs.

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 recipients 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 ofhealth 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 Demonstration eligibles into a managed care organization for comprehensive primary and acute care, and/or one of the Demonstration's authorized health care programs. The targeted programs authorized solely by the Demonstration include the Rare and Expensive Case Management (REM) program, the Primary Adult Care (PAC) program, the Family Planning program, and the Increasing Community Services (lCS) program. Mental health services are provided under the Demonstration in a separate fee-for-service delivery system managed by an Administrative Services Organization (ASO), and dental services are managed by a dental ASO.

As of March 31, 2011, approximately 725,000 individuals are enrolled in the HealthChoice Demonstration. This total includes 659,974 beneficiaries eligible under the Medicaid and CHIP, 54,440 PAC program participants, and approximately 10,586 Family Planning program participants.

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. This population will be eligible for full benefits in 2014 when the Medicaid expansion occurs under the Affordable Care Act.

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. Within this Demonstration extension period, the State is expanding eligibility to include all women who have a family income at or below 200 percent of the FPL, rather than the previous eligibility that included only women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum. The State is also electing to

remove the 5 year eligibility limit that was previously in place for this Demonstration population. In addition to these expansions, the State moved its Employed Individuals with Disabilities (EID) program under the Medicaid State plan, rather than under the Demonstration, effective October 1, 2008.

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

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.** To the extent that a change in Federal law, regulation, final court order, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.

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

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

6. **Changes Subject to the Amendment Process.** Demonstration provisions related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below. The State will notify CMS of proposed Demonstration changes at the monthly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

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

    a. An explanation of the public process used by the State to reach a decision regarding the requested amendment;
    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment 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 though the 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 amendment which isolates (by Eligibility Group) the impact of the amendment;
    c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
    d. If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

8. **Demonstration Phase Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein should be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval prior to implementation of phase out. 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.

9. **Enrollment Limitation During Demonstration Phase Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 8, during the last 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.

10. **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.

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

12. **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 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.

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

14. **Public Notice 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, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 7, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, amendment and/or renewal of this Demonstration.

15. **Compliance with Managed Care Regulations.** The State shall comply with all of the managed care regulations published at 42 CFR section 438 et. seq., except as expressly identified as not applicable in the STCs. The per member, per month fixed amount pursuant to paragraph 58 must be developed and certified as actuarially sound in accordance with 42

CFR 438.6. Procurement and the subsequent final contracts developed to implement selective contracting by the State with an MCO shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers (FQHC) shall continue in force.

Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall 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).

16. **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.

17. **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 individuals otherwise ineligible for Medicaid may be determined eligible for the PAC, Family Planning, or ICS programs.

18. **Specific Eligibility Criteria.** The mandatory and optional Medicaid State plan populations listed below 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 the State's application and these STCs. State plan eligibles are included in the Demonstration to generate savings through mandatory enrollment in managed care waiver of other specific programmatic requirements. Groups which are made Demonstration-eligible by virtue of the expenditure authorities expressly granted in this Demonstration are subject to all applicable Medicaid laws or regulations in accordance with the Medicaid State plan, except as specified as not applicable in the expenditure authorities for this Demonstration.

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

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

Medicaid State Plan Mandatory Groups	**Federal Poverty Level (FPL) and/or Other Qua1ifying Criteria**	**Expenditure and CMS 64 Eligibility Group Reporting**
TANF children, pregnant women, parents and caretaker adults, and foster care	Families with dependent children and foster children with incomes less than 116 percent of the FPL, including individuals with incomes below the pre-July 1, 2008 TANF income thresholds.	TANF Adults Thru 29, TANF Children Thru 29 or TANF Adults 30-116, TANF Children 30-116

children		
SOBRA women and children	Children with incomes above the pre-July 1, 2008 TANF income threshold who are not enrolled in the TANF group: Under age 1: Up to and including 185 percent of the FPL; Ages 1 to 6: Up to and including 133 percent of the FPL; and Ages 6 to 19: Up to and including 100 percent of the FPL; 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 T ANF group.	SOBRA Adults or SOBRA Children
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 FBR: $674 for individuals and $1,011 for couples.	SSI/BD Adults or SSI/BD Children
Medicaid State Plan Optional Groups	**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)

b. Health Choice Benefits. The HealthChoice program provides comprehensive Medicaid State plan benefits to Demonstration participants.

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 5% aggregate cost sharing limit per family. Cost sharing shall be equal to or less than:
   1) Copayments of $3.00 per prescription and refill for brand name drugs; and
   2) Copayments of $1.00 per prescription and refill for generic drugs.
   3) Copayments of $1.00 per prescription and refill for preferred drugs provided on a fee-for-service basis (outside of the MCO prescription drug benefit).
   4) Premiums for children through age 18 with incomes between 200 percent up to and including 250 percent of the FPL -is calculated at 2 percent of a family household income of two at 200 percent of the FPL per family per month.
   5) Premiums for children through age 18 with incomes between 251 percent up to and including 300 percent -is calculated at 2 percent of a family household income of two at 250 percent of the FPL per family per month.

d. Redetermination and Disenrollment: Made in accordance with the Medicaid State plan.
e. Delivery System. Physical health, vision and substance abuse benefits are rendered through one of seven Medicaid MCOs; rehabilitation services are rendered on a fee for service basis; dental services are rendered through a dental Administrative Services Organization (ASO); and mental health benefits are rendered through an ASO.

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

a. Maryland Health Choice participants 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. The State may also enroll in the REM program individuals who are not otherwise participating in the Demonstration, who are under age 65 and receiving Medicare benefits, if the individual was previously enrolled in the REM program and receiving private duty nursing services or home health aide services.
b. Benefits. Specific benefits provided to beneficiaries enrolled in the REM program are found 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. As described in the Medicaid State plan.
e. Delivery System. An individual choosing to enroll in the REM program is prohibited from enrolling in an MCO. Services are delivered on a FFS basis.

21. **Family Planning** Program for Demonstration Population 14

a. Participation. Family planning and family planning-related services are available to all women of childbearing age who are not otherwise eligible for Medicaid, the PAC program, CHIP, or Medicare, and are:
   i. Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum (e.g. SOBRA women) and who have income at or below 200 percent of the FPL at the time of annual redetermination; or
   ii. Beginning January 1, 2012, women who have a family income at or below 200 percent of the FPL.

b. Family Planning Benefits.
   1) Family planning services and supplies described in section 1905(a)(4)(c) and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:
      a) Approved methods of contraception;
      b) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams;
         i. Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the

clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

c) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and

d) Contraceptive management, patient education, and counseling.

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

a) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.

b) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STIISTD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.

c) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.

d) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

e) Treatment of major complications arising from a family planning procedure such as:

i. Treatment of a perforated uterus due to an intrauterine device insertion;

ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or

iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

3) Primary Care Referrals. Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this Demonstration. The State must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to Demonstration participants. The written materials must explain to the participants how they can access primary care services.

c. Cost Sharing. There is no cost sharing requirement for this population.

d. Redetermination. The State must ensure that redeterminations of eligibility for the Family Planning Program are conducted at least every 12 months. Redeterminations may be administrative in nature.
e. Disenrollment. If a woman becomes pregnant while enrolled in the Demonstration, 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 Demonstration.
f. Delivery System. Services provided for this Demonstration population are paid fee for service (FFS).

22. Primary Adult Care (PAC) Basic Program for Demonstration Population 13

a. Participation. Childless and non-custodial adults age 19 and older with incomes up to and including 116 percent of the FPL who are not otherwise eligible for Medicaid.
b. Benefits. PAC provides a limited benefit package encompassing outpatient-type services. Specific benefits and the incremental increase in benefits planned during the extension period are found in Attachment A.
c. Cost Sharing. $7.50 per prescription and refill for brand name drugs; and $2.50 per prescription and refill for generic drugs.
d. Redetermination. Annual active redetermination processes similar to the Medicaid State plan.
e. Disenrollment: PAC participants may be disenrolled if they become eligible for other Medicaid or Medicare; income exceeds 116 percent of the FPL; or move out of the State.
f. Delivery System. Physical health and substance abuse benefits are furnished through one of the Medicaid MCOs and mental health services, mental health drugs and HIV/AIDS related drugs are provided on a FFS basis.
g. Enrollment Cap. In cases where the State determines, based on advance budget projections that it cannot continue to enroll PAC applicants without exceeding the funding available for the program the State can establish an enrollment cap for the PAC program.
    i. *Notice* - before affirmatively implementing the caps authorized in subparagraph (g), the State must notify CMS at least 60 days in advance. This notice must also include the impact on budget neutrality.
    ii. *Implementing the Limit* - if the State imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the Demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant
    iii. *Outreach/or those on the Wait Lists* - the State will conduct outreach for those individuals who are on the PAC wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid or the MHIP programs at any time.
    iv. *Removing the Limit* - the State must notify CMS in writing at least 30 days in advance when removing the limit.

23. Increasing Community Services (ICS) Program for Demonstration Population 15.

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 ofthe Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the State plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, , subject to the following conditions:
   1) Individuals must 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;
   2) Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act; and
   3) The cost to Medicaid for the individual in the community must be less than the cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.

b. Benefits. This program provides home and community-based services identical to those provided under the State's Living At Home (LAH) 1915(c) waiver with three additions - assisted living, behavior consultation services, and senior center plus services. These services enable the participant to live at home with appropriate supports rather than in a nursing facility. The specific benefits provided to participants in this program are listed in Attachment A.

c. Enrollment Cap. The number of participants that may be enrolled in the ICS program at any one time is limited to 30. The State will create a registry that identifies all individuals eligible for the program who have indicated interest in receiving home and community-based services. The registry will be sorted based on date and time of interest. As slots become available, the State will notify individuals on the registry in numerical order of the opportunity to participate in the ICS program. Interested individuals will have 15 days to indicate whether or not they are still interested in participating. If after 15 days an individual fails to respond, a second letter will be mailed. If there is no response in 7 more days, 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 CFR §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 5% aggregate cost sharing limit per family. Except where prohibited by Federal law:
   1) $3.00 per prescription and refill for brand name drugs;
   2) $1.00 per prescription and refill for generic and HIV drugs; and
   3) $1.00 per prescription and refill for preferred drugs provided on a fee-for-service basis (outside of the M CO prescription drug benefit.

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

g. Redetermination and Disenrollment. Made in accordance with the Medicaid State plan.

24. **Eligibility Exclusions.** The following persons will not participate in the HealthChoice Demonstration, and will receive benefits unaffected by the Demonstration.

a. Beneficiaries with dual Medicare/Medicaid coverage except those participating in the REM Program pursuant to STC 22.a..
b. Short term eligible beneficiaries in a spend-down status.
c. Beneficiaries residing in long term care facilities, except individuals transitioning to community placement under the ICS program.
d. Beneficiaries enrolled in a section 1915(c) Home and Community Based Waiver.
e. Beneficiaries enrolled in the Breast and Cervical Cancer Treatment Program (BCCTP).
f. Beneficiaries residing in skilled nursing facilities for more than 30 days, except participants in the ICS program.
g. Employed Individuals with Disabilities (EID) participants as of October 1, 2008
h. Beneficiaries enrolled in foster care

IV. GENERAL REPORTING REQUIREMENTS

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

26. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.

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

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

29. **Bi-monthly Calls.** CMS shall schedule bi-monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

30. **Quarterly Operational Reports.** The State must submit progress reports in the format specified in Attachment C no later than 60 days following the end of each quarter. The intent of these reports is to present the State's data along with an analysis of the status of the

various operational areas under the Demonstration. These quarterly reports must include, but are not limited to:

a. Updated budget neutrality and allotment neutrality monitoring spreadsheets;
b. Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, including approval and contracting with new plans; benefits changes; enrollment counts with description ofvariances upward or downward; grievances by type and count; complaints by type and count; quality initiatives and plans; access; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; and other operational issues;
c. Action plans for addressing any policy and administrative issues identified; and
d. Evaluation activities and interim findings.
e. Reporting Requirements Related to the ICS Program:
    1) The State will include data on the Program and its enrollees in the LAH waiver annual report it will be completing each March, as specified in Appendix A of the State's approved LAH waiver.
f. Reporting Requirements Related to the Family Planning Program:
    1) Quarterly enrollment reports for Demonstration eligible (eligibles include all individuals enrolled in the Demonstration);
    2) Total number participants served during the quarter (participants include all individuals who obtain one or more covered family planning services through the Demonstration);
    3) Notification of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY;

31. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under paragraph 30. The State shall submit the draft annual report no later than October 1 of each year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

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

32. **Transition Plan.** As this Demonstration will not be extended by CMS beyond December 31, 2013, the State is required to prepare, and incrementally revise a Transition Plan. By October 1, 2012, the State must submit to CMS for review and approval an initial Transition Plan, consistent with provisions of the Affordable Care act for all individuals enrolled in the demonstration. The plan must contain the required elements and milestones described in subsections a-f outlined below. In addition, the Plan will include a schedule of implementation activities that he State will use to operationlize the Transition Plan.

    a. Seamless Transitions. Consistent with the provisions of the Affordable Care Act, the Transition plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL or newly apply for Medicaid) to coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:
        1) Determine eligibility for all January 1,2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(1 O)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
        2) Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
        3) Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014, eligibility groups for new applicants for Medicaid.
        4) Develop a modified adjusted gross income (MAGI) calculation for program eligibility. The State may implement prior to January 1, 2014.

    b. Access to Care and Provider Payments.
        1) Provider Participation. The State must identify the criteria that will be used for reviewing provider participation in (e.g. demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.
        2) Adequate Provider Supply. The State must provide the process that will be used to assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of the of service delivery. The report must separately address each of the following provider types:
            a) Primary care providers,
            b) Mental health services,
            c) Substance use services, and
            d) Dental.
        3) Provider Payments. The State will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective

payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all inclusive rate (e.g., certain Indian Health providers).

c. System Development or Remediation. The Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation. System milestones that must be tested for implementation on or before January 1,2014 include:
   1) Tracking out-of-pocket charges in order to implement a 5 percent aggregate family cost sharing cap for low income population coverage options;
   2) Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.

d. Pilot Programs. Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act-defined “medical homes,” ”accountable care organizations," and/or "person-centered health homes" to allow for more efficient and effective management of the highest risk individuals.

e. Progress Updates. After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

f. Implementation.
   1) By July 1, 2013, the State must begin implementation of a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning, these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.
   2) On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination.

g. Penalty. CMS reserves the right to impose a 2 percent FFP withhold for the Demonstration should the State fail to implement or operationlize milestones listed in paragraph 32. The penalty amount will result in loss of some percentage of expenditures attributable to the Demonstration. If the State continues to fail to meet the Transition Plan requirements or milestones, CMS may impose incrementally larger percentages by which the annually expenditure authority cap will be reduced. The reduction in expenditure authority will be applied to the claims for Federal match of each Federal quarter. Once the requirement or milestone has been met, no further associated penalties will be imposed.

V. GENERAL FINANCIAL REQUIREMENTS

33. **Reporting Expenditures under the Demonstration.** In order to track expenditures under this Demonstration, Maryland must report Demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine CMS-64

reporting instructions outlined in section 2500 and section 2115 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made). Expenditures for optional targeted low income children (MCHP and MCHP Premium children) claimed under the authority of title XXI shall be reported each quarter on forms CMS-64.21U Waiver and/or CMS 64.21UP Waiver.

34. Premiums and other applicable cost sharing contributions from enrollees that are collected by the State under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.

35. For each Demonstration year, 15 separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration populations and Demonstration services. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in bold following the colon. Expenditures should be allocated to these forms based on the guidance found below.

    a. Demonstration Population 1: TANF Adults Thru 29-Eligibility Group (EG) consists of adults whose Medicaid eligibility derives from their status as a relative caring for a child, or a pregnant woman through 30 percent FPL.

    b. Demonstration Population 2: TANF Children Thru 29-EG consists of children whose Medicaid eligibility derives from their status as a minor child through 30 percent FPL.

    c. Demonstration Population 3: TANF Adults 30-116-EG consists of adults whose Medicaid eligibility derives from their status as a relative caring for a child, or a pregnant woman whose income is 31 percent through 116 percent FPL.

    d. Demonstration Population 4: TANF Children 30-116-EG consists of children whose Medicaid eligibility derives from their status as child whose income is 31 percent through 116 percent FPL.

    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: SSIIBD-Children EG consists of children whose Medicaid eligibility derives from their status as blind or disabled.

    g. Demonstration Population 7: Medically Needy Adults (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: Medically Needy Children (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: SOBRA Adult-EG consists of income eligible pregnant women.

j. Demonstration Population 10: SOBRA Children-EG consists of income eligible children born after September 30, 1983.

k. Demonstration Population 11: 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.

l. Demonstration Population 12: 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.

m. Demonstration Population 13: PAC-EG consists of childless and non-custodial adults up to and including 116 percent of the FPL.

n. Demonstration Population 14: Family Planning - This EG is eligible for only family planning and family planning related services and the EG consists all women, of childbearing age, who are not otherwise eligible for Medicaid, the PAC program, the Children's Health Insurance Program (CHIP) or Medicare, and are:

    1) Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum (e.g. SOBRA women) and who have income at or below 200 percent of the FPL at the time of annual redetermination; or

    2) Beginning, January 1, 2012, women who have income at or below 200 percent of the FPL.

o. Demonstration Population 15: ICS-EG consists individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the State plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, , subject to the following conditions:
    1) Individuals must 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;

2) Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915 (c) of the Act; and.
3) The cost to Medicaid for the individual in the community must be less than the cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.

36. Specific Reporting Requirements for Demonstration Populations 11 and 12.

a. The State is eligible to receive title XXI funds for expenditures for these children, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver in accordance with the instructions in section 2115 of the State Medicaid Manual.
b. Title XIX funds are available under this Demonstration if the State exhausts its title XXI allotment once timely notification as described in subparagraph (c) has been provided.
c. If the State exhausts its title XXI allotment prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for MCHP and MCHP Premium children. During the period when title XIX funds are used, expenditures related to this Demonstration Population must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver. To initiate this:
    1) The State shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for this Demonstration population; and
    2) The State shall 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 shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed change which isolates (by Eligibility Group) the impact of the change;
        b) An up-to-date CHIP allotment neutrality worksheet.
        c) Expenditures subject to the budget agreement. For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all title XIX expenditures provided to individuals who are enrolled in this Demonstration as described in paragraph 36 (c)(i-xv). All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

37. **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.l0 Waiver and/or 64.l0P Waiver.

38. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration

period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

39. **Reporting Member Months.** For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 30, the actual number of eligible member months for the Demonstration Populations defined in paragraph 35. The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

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

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

40. **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 Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall 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.

41. **Extent of (Federal Financial Participation) FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in paragraph 58:

    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 shall provide FFP for family planning and family planning-related services and supplies at the applicable Federal matching rates described in paragraph 21, subject to the limits and processes described below:
   1) For family planning services, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.
   2) Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in paragraph 21, should be entered in Column (D) on the Forms CMS-64.9 Waiver.
   3) Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in paragraph 21, should be entered in Column (B) on the Forms CMS-64.9 Waiver.
   4) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, no FFP will be available.

42. **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 shall not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

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

43. **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 oftitle XIX payments. Under all circumstances, health care providers must retain 100 percent ofthe 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.

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

VI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

45. **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.

46. **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.

47. **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).

48. **Claiming Period.** All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State

made the expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

49. **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.l2 (Narrative) for both Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). On the CMS-37.12, the State must separately identify estimates of expenditures for the Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 waiver forms with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

50. **Administrative Costs.** Administrative costs under title XXI may be claimed on the CMS21 for the enhanced match or the CMS64.21 at the regular FMAP if the State has met the title XXI 10 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.

51. **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.

52. **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.

53. **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

shall report expenditures for these children, identified as MCHP and MCHP Premium, as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with paragraph 36.

54. **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.

VII. MONITORING BUDGET NEUTRALITY

55. **Limit on Title XIX Funding.** The State shall 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.

56. **Risk.** The State shall 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 shall 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.

57. **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:

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

    a. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 30 for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (2) below.

        1) The PMPM costs in this subparagraph reflect the agreed-upon case-mix adjustment that was applied for each year of the budget neutrality agreement.
        2) In addition, the Family Planning Expansion population is structured as a “pass-through" or a "hypothetical state plan population" beginning in DY 15. Therefore, the State may not derive savings from this component. A PMPM cost was constructed

based on State expenditures for DY 10 through 12 and increased by the rate of growth using the President's Budget trend for adults.

Eligibility Group	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM	DY 15-17 Growth Rate
TANF Adults	$729.84	$768.52	$809.25	5.3 percent
TANF Children	$391.34	$410.52	$430.64	4.9 percent
SSI/BD Adults	$1,729.08	$1,827.64	$1,931.82	6 percent
SSI/BD Children	$1,567.04	$1,656.36	$1,750.77	6 percent
Medically Needy Adults	$4,269.89	$4,496.19	$4,734.64	5.3 percent
Medically Needy Children	$1,982.74	$2,064.16	$2,165.30	4.9 percent
SOBRA Adults	$3,293.81	$3,468.38	$3,652.20	5.3 percent
SOBRA Children	$473.93	$497.15	$521.51	4.9 percent
MCHP	N/A	N/A	N/A	N/A
MCHP Premium	N/A	N/A	N/A	N/A
Family Planning Program Individuals	$39.96	$42.36	$44.91	6.1 percent

3) The annual budget neutrality expenditure cap for the Demonstration is the sum of the annual EO estimate for each EO calculated in subparagraph 1) above as well as, the actual expenditures for the MCHP and MCHP Premium EOs claimed as title XIX expenditures as approved in the Medicaid State plan when the State has exhausted title XXI funding.

b. The overall budget neutrality expenditure limit for the Demonstration is the sum of the annual budget neutrality cap calculated in subparagraph iii, that includes the actual expenditures for the MCHP and MCHP Premium EOs 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 described in subparagraphs 1) and 3) above during the Demonstration period reported.

59. **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.

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

Demonstration Year	**Cumulative Expenditure Cap Definition**	**Percentage**
Year 15	Budget neutrality expenditure cap plus	1 percent
Year 15 and 16	Combined budget neutrality expenditure caps plus	0.5 percent
Year 16 through 17	Combined budget neutrality expenditure caps 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.

61. **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 shall be based on the time elapsed through the termination date.

VIII. EVALUATION OF THE DEMONSTRATION

62. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraph (a), the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding all programs in the Demonstration. The State must submit to CMS for approval a draft evaluation design no later than October 1, 2011.

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

63. **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.

64. **Final Evaluation Plan and Implementation.**

a. CMS shall provide comments on the draft designs within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 62, within 60 days of receipt of CMS comments.
b. The State must implement the evaluation designs and report its progress on each in the quarterly reports. The evaluation design shall be modified to incorporate specific research questions assessing the impact of the ICS program on participants' quality of life as well as costs to the Demonstration.
c. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

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

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

Date – Specific	Deliverable	Reference
October 1, 2011	Submit Draft Evaluation Plan	paragraph 62
July 1, 2012	Transition Plan	paragraph 32
April 30, 2014	Submit Final Evaluation Report, if Not Requesting Extension	paragraph 64
Annual		
	By October 1st – Draft Annual Report	paragraph 31
Each Quarter		
	Quarterly Operational Reports	paragraph 30
	Quarterly Enrollment Reports	paragraph 30
	CMS-64 Reports	paragraph 35
	Eligible Member Months	paragraph 30

ATTACHMENT A

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

PAC Program Benefits
An MCO shall provide an enrollee the primary care services listed below: ▪ Primary and preventive services; ▪ Family planning services and supplies; ▪ Physician services (other than specialty services); ▪ Pharmacy (excluding specialty mental health drugs and HIVIAIDS drugs); ▪ Primary mental health services; ▪ The following laboratory services: o Complete blood count and chemistry panel including lipid profile o Urinalysis, urine dipstick, and urine culture and sensitivity studies o Family planning labs o PAP smear o PSA o STis o Fecal occult blood o Blood glucose and glucose tolerance testing o Hemoglobin A_1C o Therapeutic drug monitoring (excluding some HIV/AIDS related tests) ▪ Radiology services, including certain x-rays, EKGs and mammograms; ▪ Services for diabetics, including podiatry, vision care, nutrition education and the following DME: o Diabetic supplies; o Non custom Orthotics and footwear; o Glucose meters and related supplies; and o Insulin syringes. ▪ All medically necessary services performed in an Emergency Room setting. ▪ Community-based substance abuse treatment services, excluding those services provided in a hospital regulated setting ▪ All medically necessary specialty services performed in office based settings. ▪ All medically necessary outpatient hospital services, including surgeries. PAC enrollees receive the following benefits through the fee-for-service system: • Freestanding clinic and office-based limited specialty mental health services; • Outpatient psychiatric rehabilitation services; • Specialty mental health drugs; • HIV/AIDs related drugs.

ATTACHMENT A

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

REM Program Benefits
The REM Program provides all medically necessary services to individuals with specific qualifying conditions. In addition to State plan benefits, REM provides: • Chiropractic services for over 21* • Dental coverage for over 21* • Nutritional counseling for over 21* • Nutritional supplements • Physician participation in development of a treatment plan • Occupational therapy for over 21* • Speech, Hearing and Language services for over 21* • Shift nursing services for over 21* • Certified nursing assistant for over 21* • Home health aide for over 21* • Private duty nursing for dually eligible Medicaid and Medicare services *These services are covered under the EPSDT benefit for children.

ICS Program Benefits
The ICS Program provides home and community-based services in addition to those authorized under the State plan. These include: Assisted Living Assistive Technology Attendant Care Behavior Consultation Case Management Dietitian / Nutritionist Services Environmental Accessibility Adaptations/Modifications Environmental Assessments Family and Consumer Training Fiscal Intermediary Services for individuals who self-direct attendant care services Home-Delivered Meals Medical Day Care Nurse Supervision Personal Emergency Response System Senior Center Plus

ATTACHMENT B
Quarterly Operational Report Format

Under Section VIII, paragraph 31, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration.

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

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

NARRATIVE REPORT FORMAT:

Title Line One - Maryland HealthChoice Demonstration

Title Line Two- Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 12 (July 1, 2011, through June 30, 2012)
Federal Fiscal Quarter: 4/2011 (711/2011 - 9/30/2011)

Introduction

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 Thru 29		
TANF Children Thru 29		
TANF Adults 30-116		
TANF Children 30-116		
SSI/BD Adults		

SS/BD Children		
Medically Needy Adults		
Medically Needy Children		
SOBRA Adults		
SOBRA Children		
MCHP		
MCHP Premium		
Family Planning		
PAC		
ICS		

Outreach/Innovative Activities

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

Operational/Policy Developments/Issues

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

Family Planning Program

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

REM Program

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

PAC Program

- Enrollment Activities and/or Backlog
- Benefit Expansion Status

ICS Program

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

MCHP and MCHP Premium Status/Update/Projections

ATTACHMENT B
Quarterly Operational Report Format

Expenditure Containment Initiatives

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

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting

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

A. For Use in Budget Neutrality Calculations

Eligibility Group	Previous QTR Month 1	Previous QTR Month 2	Previous QTR Month 2	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 Thru 29								
TANF Children Thru 29								
TANF Adults 30-116								
TANF Children 30-116								
SSI/BD Adults								
SSI/BD Children								
Medically Needy Children								
SOBRA Adults								
SOBRA Children								
MCHP								
MCHP Premium								
Family Planning Program								

B. For informational Purposes Only

ATTACHMENT B
Quarterly Operational Report Format

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

Consumer Issues

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

Legislative Update

Discussion of health care initiatives, funding for PAC expansion status, 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