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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

April 26, 2022

Steve Schuh
Deputy Secretary and Medicaid Director
State of Maryland, Department of Health
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Mr. Schuh:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Substance Use Disorder (SUD) Monitoring Protocol, which is required by the Special Terms and Conditions (STC), specifically, STC #46, of Maryland's section 1115 demonstration, "HealthChoice Medicaid Section 1115 Demonstration" (Project No: 11-W-00099/3), effective through December 31, 2021. CMS determined that the Monitoring Protocol that the state updated and resubmitted to CMS on March 11, 2022, meets the requirements set forth in the STCs, and thereby approves the state's SUD Monitoring Protocol.

The Monitoring Protocol is approved for the demonstration period through December 31, 2021 and is hereby incorporated into the demonstration STCs as Attachment G (see attached). In accordance with STC 86 (Public Access), the approved SUD Monitoring Protocol may now be posted to your state's Medicaid website.

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

Sincerely,

Danielle Daly -S
Digitally signed by Danielle Daly -S
Date: 2022.04.26 14:56:23 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

ATTACHMENT A

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

REM Program Benefits

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

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

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

ICS Program Benefits

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

ATTACHMENT B
Quarterly Report Template

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

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

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

NARRATIVE REPORT FORMAT:

Title Line One – Maryland HealthChoice Demonstration

Title Line Two - Section 1115 Quarterly Report

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

Introduction

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

Enrollment Information

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

Enrollment Counts

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

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

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

ATTACHMENT C
Evaluation Design

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

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

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

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

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

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

Table One: Description of Services

Service	Description of Service
Prenatal Home Visit	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

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

Per STC #28, the following protocol outlines the services and payment methodologies for the Assistance in Community Integration Services (ACIS) Pilot Program. Under this pilot program, the state will provide a set of Home and Community Based Services (HCBS) to a population that meets the needs-based criteria specified below, capped at 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

Attachment G: HealthChoice SUD Monitoring Protocol

What follows are the Planned Metrics, Planned Subpopulations, and Reporting Schedule tabs from the SUD monitoring protocol workbook (part A). The full workbook is also available in spreadsheet format on Medicaid.gov.

Medicaid Section 1115 SUD Demonstrations Monitoring Protocol (Part A) - Planned Metrics (Version 6.0)
State: Maryland
Demonstration Name: Maryland HealthChoice

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic*	Metric type	Reporting continuous	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc.)**	State plans to phase in reporting (Y/N)	SUD monitoring report in which metric will be phased in (Format DYxQx-Qx - DYxQx)	Explanation of any plans to phase in reporting over time
EXAMPLE: 1 (Do not delete or edit this row)	*EXAMPLE: Assessed for SUD Treatment Needs Using a Standardized Screening Tool*	*EXAMPLE: Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period*	*EXAMPLE: Assessment of need and qualification for SUD treatment services*	*EXAMPLE: CMS-constructed*	*EXAMPLE: Other monthly and quarterly metrics*	*EXAMPLE: Medical record review or claims*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 07/01/2018-06/30/2019*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (for specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: D3Q1*	*EXAMPLE: This measure requires an update to the Adult Needs and Strengths Assessment tool that reflects an ASAM level of treatment. The work is in the testing phase with anticipated go live in mid to late 2021.*
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Medical record review or claims	Month	Quarterly	Recommended	N								
2	Medicaid Beneficiaries with Newly Initiated SUD TreatmentDiagnosis	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Recommended	N								
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Consistent	Consistent	Y		N		
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Consistent	Consistent	Y		N		
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period.	Milestone 2	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	N	Any instance of procedure code 'W7310', 'W7330', 'W7350', 'W7370', or 'W7375'; or, revenue code '0124' and '0169' with an SUD primary diagnosis and an MRD diagnosis in a subsequent diagnosis field.	N		
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	N	-Rather than the HCPCS and CPT codes listed in CMS specifications, Maryland uses the following codes for SBIRT services: procedure codes (99408, 99409, W7000, W7010, W7020, W7021, and W7022). The CMS-provided codes cannot be used to identify SBIRT services in the state.	N		
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
12	Medication-Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y	All Medicaid enrolled OTPs (PT 32), ADAA Certified Addiction Outpatient Programs (PT 50), Data 2000 Waived Practitioners (PT 20-Physician, PT 25- Nurse Practitioners, and PT 80- Physician Assistants), Adult Residential SUD Programs (PT 54), and ICF-A Programs (PT 55) with active	N		
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims; SAMHSA datasets	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y	All Medicaid enrolled OTPs (PT 32), ADAA Certified Addiction Outpatient Programs (PT 50), Data 2000 Waived Practitioners (PT 20-Physician, PT 25- Nurse Practitioners, and PT 80- Physician Assistants), and ICF-A Programs (PT 55) with active enrollment during the reporting period. Data Source: Adhoc report from MMIS of SUD Medicaid providers with active enrollment during the reporting period.	N		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	N								
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission]	SUB-3: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Medical record review or claims	Year	Annually	Recommended	N								
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure][1]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: - Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). - Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	N								
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #3489; Medicaid Adult Core Set; Adjusted HEDIS measure][1]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	N								
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA; NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	Y		N		
19	Use of Opioids from Multiple Providers in Persons without Cancer (UMP) [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (UHDMP) [PQA; NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA; NQF #3389; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	Y		N		
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 1	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2016 - 12/31/2017	Increase	Increase	Y		N		
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Milestone 5	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	Y		N		
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	N	The metric will be generated using HEDIS proprietary software according to the current HEDIS specifications.	N		
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	Milestone 6	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	N	The metric will be generated using HEDIS proprietary software according to the current HEDIS specifications.	N		
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	N	Public release of overdose deaths within the Medicaid Program is currently restricted. Maryland is working with its partners in Vital Statistics to resolve this issue. Release of this information will be contingent on approval. Overdose deaths will not be categorized based on diagnosis. The cause of death provided from the Department of Vital Statistics is not coded as an ICD 10 diagnosis. The cause of death generally provides the substance used in the overdose, but the intent (e.g. unintentional, intentional, homicide) is not included. In addition, a majority of overdose deaths include multiple agents (i.e. synthetic and natural opioids).	N		
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Milestone 5	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	N	Public release of overdose deaths within the Medicaid Program is currently restricted. Maryland is working with its partners in Vital Statistics to resolve this issue. Release of this information will be contingent on approval. Overdose deaths will not be categorized based on diagnosis. The cause of death provided from the Department of Vital Statistics is not coded as an ICD 10 diagnosis. The cause of death generally provides the substance used in the overdose, but the intent (e.g. unintentional, intentional, homicide) is not included. In addition, a majority of overdose deaths include multiple agents (i.e. synthetic and natural opioids).	N		
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
29	SUD Spending Within IMDs	Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
50	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
51	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
52	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	N								
53	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[1]	Administrative records	Quarter	Quarterly	Recommended	N								
54	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[1]	Administrative records	Quarter	Quarterly	Recommended	N								
55	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[1]	Administrative records	Quarter	Quarterly	Recommended	N								
56	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	Milestone 2	CMS-constructed	Other annual metrics	Claims; State-specific IMD database	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	No more than 30 days	N	Any instance of procedure code 'W7310', 'W7330', 'W7350', 'W7370', or 'W7375'; or, revenue code '0124' and '0169' with an SUD primary diagnosis and an MED diagnosis in a subsequent diagnosis field.	N		
Q1	*PMDP users*	Number of PDMP checks	Health IT	State-specific	Health IT	State data from BHA	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			Y	The Department is currently working with it's behavioral health administration and its behavioral health administrative services organization to generate this data. It will be included in future reports when available.	The Department is currently working with it's behavioral health administration and its behavioral health administrative services organization to generate this data. It will be included in future reports when available.
Q2	*SUD data sharing consent management*	Number of individuals for whom consent to disclose or access their SUD treatment information is	Health IT	State-specific	Health IT	ASO data from BHA	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Consistent	Consistent			Y		The Department is currently working with it's behavioral health administration and its behavioral health administrative services organization to generate this data. It will be included in future reports when available.
Q3	*SUD authorization*	Number of SUD authorizations per month, in support of reducing duplication and ensuring medic	Health IT	State-specific	Health IT	ASO data from BHA	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			Y		The Department is currently working with it's behavioral health administration and its behavioral health administrative services organization to generate this data. It will be included in future reports when available.
State-specific metrics																		
S1	Number of HealthChoice participants enrolled in corrective managed care program	Number of HealthChoice-enrolled participants in the Corrective managed care program each month	Health IT	State-specific	Health IT	State data from IRD	Month	Quarterly	Recommended	Y	01/01/2017 - 12/31/2017	Consistent	Consistent			N		
S2	Adjusted Initiation of AOD Treatment - Alcohol abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 or older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the initiation of AOD treatment with 14 days of the diagnosis One rate is reported: Percentage of beneficiaries with an alcohol abuse or dependence diagnosis who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. This metric differs from rate one of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S3	Adjusted Initiation of AOD Treatment - Opioid abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 or older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the initiation of AOD treatment with 14 days of the diagnosis One rate is reported: Percentage of beneficiaries with an opioid abuse or dependence diagnosis who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. This metric differs from rate two of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S4	Adjusted Initiation of AOD Treatment - Other drug abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 or older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the initiation of AOD treatment with 14 days of the diagnosis One rate is reported: Percentage of beneficiaries with another drug abuse or dependence diagnosis who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. This metric differs from rate three of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S5	Adjusted Initiation of AOD Treatment - Total AOD abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 or older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the initiation of AOD treatment with 14 days of the diagnosis One rate is reported: Total beneficiaries with an alcohol or other drug abuse or dependence diagnosis who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. This metric differs from rate four of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S6	Adjusted Engagement of AOD Treatment - Alcohol abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. One rate is reported: Percentage of beneficiaries with an alcohol abuse or dependence diagnosis who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. This metric differs from rate five of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S7	Adjusted Engagement of AOD Treatment - Opioid abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. One rate is reported: Percentage of beneficiaries with an opioid abuse or dependence diagnosis who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. This metric differs from rate six of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S8	Adjusted Engagement of AOD Treatment -Other drug abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. One rate is reported: Percentage of beneficiaries with an other drug abuse or dependence diagnosis who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. This metric differs from rate seven of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S9	Adjusted Engagement of AOD Treatment - Total AOD abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. One rate is reported: Total number of beneficiaries with an alcohol or other drug abuse or dependence diagnosis who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. This metric differs from rate eight of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S10	Adjusted 31-Day Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits to beneficiaries age 18 and older with a principle diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. One rate is reported: - Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 days total) This metric differs from rate one of Metric #17(1) in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S11	Adjusted 8-Day Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits to beneficiaries age 18 and older with a principle diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. One rate is reported: - Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 days total) This metric differs from rate two of Metric #17(1) in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics												Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual	Phased-in metrics reporting	
512	Adjusted 31-Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #0576; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 an older with a principle diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. One rate is reported: Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 days total) This metric differs from rate one of Metric #17(2) in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase		N	
513	Adjusted 8 Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #0576; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 an older with a principle diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. One rate is reported: Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 days total) This metric differs from rate two of Metric #17(2) in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase		N	
514	Adjusted Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period. This metric differs from Metric #32 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Other SUD-related metrics	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase		N	

[a] There are no CMS-provided metrics related to milestone 3

[b] If the state is not reporting a required metric (i.e., column K = "N"), enter explanation in corresponding row in column P.

[c] The state should use column P to outline calculation methods for specific metrics as explained in Version 4.0 of the Medicaid Section 1115 Substance Use Disorder Demonstrations Monitoring Protocol Instructions.

[d] Rates 1 and 2 reported for Metric #17(1) correspond to rates 2 and 3 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

[e] Rates 1 and 2 reported for Metric #17(2) correspond to rates 1 and 2 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

[f] While grievances and appeals metrics are recommended for reporting, the state is required, per 42 CFR 431.428(a)(5, to provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, in in its annual (Q4) monitoring report.

Medicaid Section 1115 SUD Demonstrations Protocol (Part A) - Planned Subpopulations (Version 6.0)

State: Maryland
Demonstration Name: Maryland HealthChoice

Table: Substance Use Disorder Demonstration Planned Subpopulations

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[a,b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: *Age group* ***(Do not delete or edit this row)***	*EXAMPLE:* *Children <18, adults 18–64, and older adults 65+*	*EXAMPLE:* *Required*	*EXAMPLE:* *Metrics #1-3, 6-12, 23, 24, 26, 27*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *N*	*EXAMPLE:* *Children/Young adults 12-21, Adults 21-65*	*EXAMPLE:* *N*	*EXAMPLE:* *1, 2, 3*
Age group	Children <18, adults 18–64, and older adults 65+	Required	Metrics #1-3, 6-12, 23, 24, 26, 27	CMS-provided	Y	Y		Y	
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	Metrics #1-3, 6-12	CMS-provided	Y	Y	Maryland started covering IMD services for duals on 1/1/20 (ASAM 3.1 through 3.7WM) and will begin to include data on this subpopulation starting with the CY 2020 performance period.	Y	
Pregnancy status	Pregnant, Not pregnant	Required	Metrics #1-3, 6-12	CMS-provided	Y	Y	Maryland will calculate the pregnant subpopulations using the "MACBIS Pregnancy Code List.xls" file provided by CMS.	Y	
Criminal justice status	Criminally involved, Not criminally involved	Required	Metrics #1-3, 6-12	CMS-provided	N		Data use agreements with correctional facilities and jails specifically prohibit use of the information received for any reason other than freezing Medicaid enrollment during periods of incarceration.		
OUD population	Opioid diagnosis	Recommended	Metrics #2-12, 23, 24, 26, 27, 36	CMS-provided	Y	Y		N	The OUD subpopulation is identified using the HEDIS 2020 Opioid Abuse and Dependence value set. It includes the following ICD-10 diagnosis codes: F1110, F11120, F11121, F111122, F11129, F1114, F11150, F11151, F11159, F11181, F11182, F11188, F1119, F1120, F11220, F11221, F11222, F11229, F1123, F1124, F11250, F11251, F11259, F11281, F11282, F11288, F1129
[Insert row(s) for any state-specific subpopulation(s)]									

[a] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[b] If the state is reporting on the Dual-eligible status, Pregnancy status, Criminal justice status, and OUD population subpopulation categories, the state should use column H to outline its subpopulation identification approach as explained in Version 4.0 of the Medicaid Section 1115 Substance Use Disorder Demonstrations Monitoring

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should (1) select N in column G and (2) provide an explanation and the

Medicaid Section 1115 SUD Demonstrations Monitoring Protocol (Part A) - Reporting Schedule (Version 6.0)
State Maryland
Demonstration Name Maryland HealthChoice

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the SUD demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety and in the correct format for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the SUD demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column F, select Y or N in column H, "Deviation from standard reporting schedule (Y/N)" to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category (i.e., column H="Y"), the state should describe these deviations in column I, "Explanation for deviations (if column H="Y")" and use column J, "Proposed deviations from standard reporting schedule," to indicate the SUD measurement periods with which it wishes to overwrite the standard schedule (column G). All other columns are locked for editing and should not be altered by the state.

Table 1. Substance Use Disorder Demonstration Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SUD demonstration year (SUD DY1)	
Start date	01/01/2017
End date	12/31/2017
Dates of first quarter of the baseline reporting period for CMS-constructed metrics	
Reporting period (SUD DY and Q)	DY1Q1
Start date	01/01/2017
End date	03/31/2017
Broader section 1115 demonstration reporting period corresponding with the first SUD reporting quarter, if applicable. If there is no broader demonstration, fill in the first SUD reporting period. (Format DY#Q#; e.g., DY3Q1)	DY20Q3
First SUD monitoring report due date (per STCs) (MM/DD/YYYY)	05/30/2017
First SUD monitoring report in which the state plans to report annual metrics that are established quality measures (EQMs)	
Baseline period for EQMs	CY2017
SUD DY and Q associated with monitoring report	DY2Q3
SUD DY and Q start date (MM/DD/YYYY)	07/01/2018
SUD DY and Q end date (MM/DD/YYYY)	09/30/2018
Dates of last SUD reporting quarter:	
Start date	10/01/2021
End date	12/31/2021

Table 2. Substance Use Disorder Demonstration Reporting Schedule

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
01/01/2017	03/31/2017	05/30/2017	DY20Q3	DY1Q1	Narrative information	DY1Q1	N		
					Grievances and appeals	DY1Q1	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
04/01/2017	06/30/2017	09/28/2017	DY20Q4	DY1Q2	Narrative information	DY1Q2	N		
					Grievances and appeals	DY1Q2	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY1Q1	Y	State and CMS agreed to 2 quarter claims lag.	n.a - will not be reported in this monitoring report.
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
07/01/2017	09/30/2017	11/29/2017	DY21Q1	DY1Q3	Narrative information	DY1Q3	N		
					Grievances and appeals	DY1Q3	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY1Q2	Y	State and CMS agreed to 2 quarter claims lag.	DY1Q1
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
10/01/2017	12/31/2017	03/01/2018	DY21Q2	DY1Q4	Narrative information	DY1Q4	N		
					Grievances and appeals	DY1Q4	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY1Q3	Y	State and CMS agreed to 2 quarter claims lag.	DY1Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
01/01/2018	03/31/2018	05/30/2018	DY21Q3	DY2Q1	Narrative information	DY2Q1	N		
					Grievances and appeals	DY2Q1	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY1Q4	Y	State and CMS agreed to 2 quarter claims lag.	DY1Q3
					Annual metrics that are established quality measures		N		
					Other annual metrics	DY1	Y	State and CMS agreed to 2 quarter claims lag.	n.a - will not be reported in this monitoring report.
04/01/2018	06/30/2018	09/28/2018	DY21Q4	DY2Q2	Narrative information	DY2Q2	N		
					Grievances and appeals	DY2Q2	Y	n.a - state not reporting	n.a - state not reporting

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
					Other monthly and quarterly metrics	DY2Q1	Y	State and CMS agreed to 2 quarter claims lag.	DY1Q4
					Annual metrics that are established quality measures	CY2017	Y	Column G was overwritten for EQM reporting occurring prior to CY2020 to reflect previous instructions for EQM reporting CY2019 and earlier. EQMs being reported in CY2020 and later will not be overwritten as they align with the current instructions.	
					Other annual metrics		Y	State and CMS agreed to 2 quarter claims lag.	DY1
07/01/2018	09/30/2018	11/29/2018	DY22Q1	DY2Q3	Narrative information	DY2Q3	N		
					Grievances and appeals	DY2Q3	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY2Q2	Y	State and CMS agreed to 2 quarter claims lag.	DY2Q1
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
10/01/2018	12/31/2018	03/01/2019	DY22Q2	DY2Q4	Narrative information	DY2Q4	N		
					Grievances and appeals	DY2Q4	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY2Q3	Y	State and CMS agreed to 2 quarter claims lag.	DY2Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
01/01/2019	03/31/2019	05/30/2019	DY22Q3	DY3Q1	Narrative information	DY3Q1	N		
					Grievances and appeals	DY3Q1	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY2Q4	Y	State and CMS agreed to 2 quarter claims lag.	DY2Q3
					Annual metrics that are established quality measures		N		
					Other annual metrics	DY2	Y	State and CMS agreed to 2 quarter claims lag.	n.a - will not be reported in this monitoring report.
04/01/2019	06/30/2019	09/28/2019	DY22Q4	DY3Q2	Narrative information	DY3Q2	N		
					Grievances and appeals	DY3Q2	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY3Q1	Y	State and CMS agreed to 2 quarter claims lag.	DY2Q4
					Annual metrics that are established quality measures	CY2018	Y	Column G was overwritten for EQM reporting occurring prior to CY2020 to reflect previous instructions for EQM reporting CY2019 and earlier. EQMs being reported in CY2020 and later will not be overwritten as they align with the current instructions.	
					Other annual metrics		Y	State and CMS agreed to 2 quarter claims lag.	DY2
07/01/2019	09/30/2019	11/29/2019	DY23Q1	DY3Q3	Narrative information	DY3Q3	N		
					Grievances and appeals	DY3Q3	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY3Q2	Y	State and CMS agreed to 2 quarter claims lag.	DY3Q1
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
10/01/2019	12/31/2019	02/29/2020	DY23Q2	DY3Q4	Narrative information	DY3Q4	N		
					Grievances and appeals	DY3Q4	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY3Q3	Y	State and CMS agreed to 2 quarter claims lag.	DY3Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
01/01/2020	03/31/2020	05/30/2020	DY23Q3	DY4Q1	Narrative information	DY4Q1	N		
					Grievances and appeals	DY4Q1	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY3Q4	Y	State and CMS agreed to 2 quarter claims lag.	DY3Q3
					Annual metrics that are established quality measures		N		
					Other annual metrics	DY3	Y	State and CMS agreed to 2 quarter claims lag.	n.a - will not be reported in this monitoring report.
04/01/2020	06/30/2020	09/28/2020	DY23Q4	DY4Q2	Narrative information	DY4Q2	N		
					Grievances and appeals	DY4Q2	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY4Q1	Y	State and CMS agreed to 2 quarter claims lag.	DY3Q4
					Annual metrics that are established quality measures	CY2019	Y	Column G was overwritten for EQM reporting occurring prior to CY2020 to reflect previous instructions for EQM reporting CY2019 and earlier. EQMs being reported in CY2020 and later will not be overwritten as they align with the current instructions.	
					Other annual metrics		Y	State and CMS agreed to 2 quarter claims lag.	DY3
07/01/2020	09/30/2020	11/29/2020	DY24Q1	DY4Q3	Narrative information	DY4Q3	N		
					Grievances and appeals	DY4Q3	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY4Q2	Y	State and CMS agreed to 2 quarter claims lag.	DY4Q1
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
10/01/2020	12/31/2020	03/01/2021	DY24Q2	DY4Q4	Narrative information	DY4Q4	N		
					Grievances and appeals	DY4Q4	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY4Q3	Y	State and CMS agreed to 2 quarter claims lag.	DY4Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
01/01/2021	03/31/2021	05/30/2021	DY24Q3	DY5Q1	Narrative information	DY5Q1	N		
					Grievances and appeals	DY5Q1	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY4Q4	Y	State and CMS agreed to 2 quarter claims lag.	DY4Q3
					Annual metrics that are established quality measures		N		
					Other annual metrics	DY4	Y	State and CMS agreed to 2 quarter claims lag.	n.a - will not be reported in this monitoring report.
04/01/2021	06/30/2021	09/28/2021	DY24Q4	DY5Q2	Narrative information	DY5Q2	N		
					Grievances and appeals	DY5Q2	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY5Q1	Y	State and CMS agreed to 2 quarter claims lag.	DY4Q4
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State and CMS agreed to 2 quarter claims lag.	DY4
07/01/2021	09/30/2021	11/29/2021	DY25Q1	DY5Q3	Narrative information	DY5Q3	N		
					Grievances and appeals	DY5Q3	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY5Q2	Y	State and CMS agreed to 2 quarter claims lag.	DY5Q1
					Annual metrics that are established quality measures	CY2020	N		
					Other annual metrics		N		
10/01/2021	12/31/2021	03/01/2022	DY25Q2	DY5Q4	Narrative information	DY5Q4	N		
					Grievances and appeals	DY5Q4	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY5Q3	Y	State and CMS agreed to 2 quarter claims lag.	DY5Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		

[Add rows for all additional demonstration reporting quarters]

[a] **SUD demonstration start date**: For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "SUD reporting schedule tab" should align with the first day of a month. If a state's SUD demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "SUD reporting schedule" tab. Please see Appendix A for more information on determining demonstration quarter timing.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each demonstration year and quarter. However, states are not expected to begin reporting any metrics data until after monitoring protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

Medicaid Section 1115 Substance Use Disorder Demonstrations
Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's substance use disorder (SUD) demonstration or the SUD component of the broader demonstration

The state should complete this title page as part of its SUD monitoring protocol. Definitions for certain rows are provided below the table. The Performance Metrics Database and Analytics (PMDA) system will populate some rows of the table. The state should complete the rest of the table. The state can revise the demonstration goals and objectives if needed. PMDA will use this information to populate part of the title page of the state's monitoring reports.

State	Maryland
Demonstration name	Maryland HealthChoice
Approval period for section 1115 demonstration	*Enter the current approval period for the section 1115 demonstration as listed in the current special terms and conditions (STC), including the start date and end date (MM/DD/YYYY – MM/DD/YYYY).* *Start Date:* 01/01/2017 *End Date:* 12/31/2021
SUD demonstration start date[a]	*Enter the start date for the section 1115 SUD demonstration or SUD component if part of a broader demonstration (MM/DD/YYYY).* 01/01/2017
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*Enter SUD demonstration implementation date (MM/DD/YYYY).* 07/01/2017
SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives	*Enter summary of the SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives.* The coverage of residential treatment and withdrawal management services expands 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 participants aged 21-64 with the exception of dual eligibles. ASAM levels 3.3-3.7WM will be covered beginning July 1, 2017. ASAM level 3.1 will be covered beginning January 1, 2019. Dual eligibles will be covered for SUD residential treatment services for ASAM levels 3.1-3.7WM beginning January 1, 2020. ASAM level 4.0 coverage for all Maryland Medicaid participants aged 21-64 with a primary diagnosis of SUD and a secondary mental health condition will begin July 1, 2019. An independent evaluation will assess whether the SUD program reforms and services delivered through this demonstration are effective in improving health outcomes and decreasing healthcare 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.

[a] **SUD demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the

effective date listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD demonstration:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook (which can be accessed via PMDA – see Monitoring Protocol Instructions for more details) and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 SUD demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data— in its second monitoring report submission that contains metrics. The retrospective monitoring report for a state with a first SUD demonstration year (DY) of less than 12 months, should include data for any baseline period Qs preceding the demonstration, as described in Part A of the state's monitoring protocols. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first SUD DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 SUD demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Section 3: Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in the metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metric changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its retrospective metrics

data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the number of medication-assisted treatment (MAT) providers (Metric #14) over the course of the retrospective reporting period. This state may decide to highlight this trend for CMS in Part B of its monitoring report (under Milestone 4) by briefly summarizing the trend and explaining that during this period, a grant supporting training for new MAT providers throughout its state was implemented.

For further information on how to compile and submit a retrospective monitoring report, the state should review Section B of the Monitoring Report Instructions document.

☐ The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☒ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. Regardless of the proposed plan, retrospective reporting should include retrospective metrics data and a general assessment of metric trends for the period. The state should provide justification for its proposed alternative plan.*

The state will report retrospectively for quarters prior to monitoring protocol approval as described above, i.e., in the second monitoring report submission that contains metrics after protocol approval; however, per conversation with CMS and as identified in Part A, the state will phase in certain metrics that required more rigorous programming. Maryland will provide status updates in its SUD Monitoring Report Part B submissions.