Table of Contents

State/Territory Name: Maryland

State Plan Amendment (SPA) #: MD-24-0005-CHIP

This file contains the following documents in the order listed:

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

Children and Adults Health Programs Group

October 3, 2024

Tricia Roddy
Maryland Department of Health
201 W. Preston St., 5th Floor
Baltimore, MD 21201

Dear Director Roddy:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), MD-24-0005-CHIP, submitted on July 22, 2024, has been approved. This SPA has an effective date of July 1, 2024.

Through this SPA, Maryland makes technical updates to the CHIP state plan to indicate that beginning April 9, 2024, the state permanently eliminated premiums for Medicaid Expansion CHIP enrollees in the Maryland Children's Health Program, as approved under Medicaid SPA MD-24-0012 on September 10, 2024. This SPA also updates Maryland's strategic objectives and performance goals to assess health outcomes for the from-conception-to-end-of-pregnancy (FCEP) population. To measure progress on these goals, the state will use Medicaid claims data. The state agrees to submit a future SPA to update all performance goals to be measurable, quantifiable, and convey a target the state is working towards.

Your Project Officer is Ticia Jones. Ticia is available to answer your questions concerning this amendment and other CHIP-related matters. Ticia's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8145
E-mail: Ticia.Jones@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Sarah deLone/

Sarah deLone
Director

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. X A combination of both of the above. (Section 2101(a)(2))

Beginning in 1998, Maryland expanded access to health insurance under the terms specified in the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act, through creation of the Maryland Children's Health Program.

Maryland implemented a Medicaid expansion, called MCHP, effective July 1, 1998, and a SCHIP separate State program called MCHP Premium, effective July 1, 2001.

Maryland modified MCHP Premium effective July 1, 2003, and MCHP, effective September 1, 2003.

Maryland modified MCHP and MCHP Premium effective July 1, 2004.

Maryland Medicaid Expansion (Title XIX) (Section 2101(a)(2))

MCHP

MCHP, the Medicaid expansion, implemented July 1, 1998:

- Extended Medicaid coverage (using enhanced match funds) to eligible children under age 19 who were born after September 30, 1983, in families with income too high to qualify for SOBRA, but at or below 200 percent of FPL;
- Before October 1, 1983, in families with income above 40 percent FPL, but at or below 200 percent of FPL.

Beginning July 1, 2003, Maryland made the following adjustments to MCHP and MCHP Premium:

MCHP (the Medicaid Expansion)

Eliminated MCHP coverage for children enrolled in the Medicaid expansion program whose family income is above 185 percent of the Federal Poverty Level (FPL) but at or below 200 percent FPL. Note: This change became effective September 1, 2003, and these children were offered coverage through MCHP Premium, the State's separate child health program.
MCHP (the Medicaid Expansion Program)

Reinstated free MCHP coverage for children whose family income is above 185 percent FPL but at or below 200 percent FPL.

MCHP

Effective in 2010, the Title XXI expansion program and the Title XIX Medicaid program adopted the CHIPRA 2009 "lawfully residing" option for women pregnant and 2 months postpartum (Medicaid only) and for children with age under 19 (CHIP and Medicaid) and children age 19 up to 21 (Medicaid only).

Maryland Separate CHIP program, Title XXI (Section 2101) (a)(1)); (42 CFR 457.70)

Effective July 1, 2023, Maryland will adopt a separate CHIP program to cover prenatal coverage for the targeted low income unborn children (pregnant individuals) with income up to 259% of the FPL, and who would be eligible to receive Medicaid benefits except for immigration status requirements. Maryland will use CHIP HSI funds for other child health assistance as authorized under § 2105(a)(2) of the Act. Such assistance will provide for the payment of services through the end of the month in which the 120th postpartum day occurs to birthing parents of targeted low-income children covered under the unborn child option.

MCHP Premium Program Changes Effective April 9, 2024: Permanent Elimination

Effective April 9, 2024, Maryland will permanently eliminate the premium payment requirement for children enrolled in MCHP with a family income 212 to 322 percent of the federal poverty limit. This change aligns program operations with statutory changes enacted by Maryland House Bill 1521– Maryland Children's Health Program - Eligibility and Administration (Chapter 47 of the Acts of 2024).

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2. ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3. ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

The State assures that it complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: July 1, 2017

Implementation Date: July 1, 2024
SPA #MD-24-0005-CHIP
Purpose of SPA:

Effective April 9, 2024, Maryland will permanently eliminate premiums for MCHP enrollees. This change aligns program operations with statutory changes enacted by Maryland *House Bill 1521– Maryland Children's Health Program - Eligibility and Administration (Chapter 47 of the Acts of 2024)*. . This amendment will also be used to update the State's strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children and performance goals in Section 9. Strategic Objectives and Performance Goals and Plan Administration of the Maryland CHIP State Plan, related to the From Conception to End of Pregnancy coverage group

Proposed effective date: July 1, 2024

Proposed implementation date: July 1, 2024

Maryland's Modified Adjusted Gross Income (MAGI) SPA Roster

Transmittal Number	SPA Group	PDF Number	Description	Superseded Plan Section(s)
MD-14-0010 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	MAGI-equivalent standards, by age group; Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0

MD-14-0011 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
MD-23-0003 Effective/Implementation Date: July 1, 2023	MAGI Eligibility and Methods	CS9 CS15	Eligibility- Coverage from Conception to Birth MAGI-Based Income Methodologies	CS-9 Supersedes the current sections Geographic Area, Age and Income sections 4.1.1, 4.1.2, 4.1. CS-15 incorporate within a separate subsection under section 4.3
MD-23-0004 Effective/Implementation Date: July 1, 2023	Non-Financial Eligibility SPA Group	CS17	Non-Financial Eligibility - Residency	Supersedes the current section 4.1.5
MD-24-0002-CHIP Effective/Implementation Date: January 1, 2024	Non-Financial Eligibility	CS27	Continuous Eligibility	Supersedes the current section 4.1.8

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The State consulted with a representative from Native American LifeLines, an Urban Indian Health Program. On June 20, 2024, the State shared a redline version of the proposed CHIP HSI SPA along with a document summarizing the new benefit and asked for feedback. Ms. Lessard, Medical Case Manager at Native American LifeLines reviewed the proposed amendment and on June 20, 2024, responded that she had no changes to suggest.

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

1. Population
2. Number of uninsured
3. Race demographics

4. Age Demographics
5. Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified, by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

PUBLIC PROGRAMS PROVIDING HEALTH BENEFITS COVERAGE IN MARYLAND

Public programs in Maryland provide health coverage to children and adults across the State. The Maryland Medical Assistance program, which includes the Maryland Children's Health Program, provides creditable health coverage to eligible recipients and enrollees. Individuals who do not qualify for either Medicaid or the Maryland Children's Health Program may be eligible for programs funded exclusively with State funds or for Federally funded programs (e.g., Children's Medical Services, funded under Title V of the Social Security Act.) These programs provide services that complement the Maryland Medical Assistance program or that target populations not eligible for Medical Assistance. An individual's eligibility for these public programs is generally determined by case managers at Local Departments of Social Services (LDSS) and Local Health Departments (LHDs).

Maryland Medical Assistance, MCHP and MCHP Premium

The Maryland Medical Assistance Program provides comprehensive health coverage on a statewide basis to low-income children and adults. As a result of Maryland's MCHP expansion in July 1998, eligibility for this creditable health coverage extended to eligible children under age 19 with family income at or below 200 percent of the Federal Poverty Level (FPL). In general, these individuals have been enrolled in Maryland's Medicaid managed care program, HealthChoice.

Effective April 9, 2024, Maryland will permanently eliminate the premium payment requirement for children enrolled in MCHP with a family income 212 to 332 percent of the federal poverty limit. These changes align program operations with statutory changes enacted by Maryland House Bill 1521– Maryland Children's Health Program - Eligibility and Administration (Chapter 47 of the Acts of 2024).

NON-MEDICAID, PUBLIC PROGRAMS

In addition to Medical Assistance and the Maryland Children's Health Program, Maryland has in place a number of alternative programs that enable children to access

health care services. These include Children's Medical Services (CMS) (the Title V program for children with special health care needs), Community Health Centers (CHCs), and several local jurisdiction initiatives. While all of these programs provide vital services to low income and uninsured or underinsured individu als, they all have significant restrictions in the benefits they provide (capped funding, limited benefit packages, etc.). None of the programs described below provide creditable coverage as defined by Title XXI.

Children's Medical Services (CMS)

The Children's Medical Services (CMS) program is the Title V Program in Maryland that has traditionally assisted families in planning and obtaining specialty medical and rehabilitative care. The program has provided for both direct and wrap-around specialty care services to eligible children with special health care needs. Program activities have concentrated on the purchase of direct care services through community providers, local health departments and academic institutions through both fee-for-service reimbursement and grants.

Prior to Maryland's MCHP expansion in July 1998, the CMS program provided specialty care services to approximately 6,500 children. Most of these children have since become eligible for the Maryland Children's Health Program and enrolled in the HealthChoice Program. As a result, the CMS program's focus is shifting from that of providing direct and wrap around services to that of systems building activities. During the transition, the program will continue to pay for direct and wrap around services for underinsured

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. X Medicaid Expansion

4.0.1. Ages of each eligibility group and the income standard for that group:

Superseded by Title XXI amendment CS3.

MCHP is a Medicaid Expansion and available statewide.

4.1. X **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 ☐ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

4.1.1 ☐ Geographic area served by the Plan if less than Statewide:

4.1.2 X Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

For the unborn child option, individuals will be covered up to 259% FPL.

4.1.2.1-PC X Age: conception through birth (SHO #02-004, issued November 12, 2002)

4.1.3 X Income of each separate eligibility group (if applicable):

See SPA pages CS9 and CS15 for income standards under the CHIP State Plan.

4.1.3.1-PC ☐ 0% of the FPL (and not eligible for Medicaid) through 317% of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 X Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

The eligibility determination for MCHP considers only the applicant's family income; assets are not considered.

4.1.5 X Residency (so long as residency requirement is not based on length of time in state):

Current residency in the State is required.
A resident must have an address in the State and intend to remain.

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7 ☐ Access to or coverage under other health coverage:

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll

requirements:

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42 CFR 457.80(b))

MARYLAND CHILDREN'S HEALTH PROGRAM OUTREACH STRATEGY

The effective date for MCHP outreach was July 1, 1998. The effective date for MCHP Premium outreach was July 1, 2001. The outreach strategy for the Maryland Children's Health Program is guided by the following goals:

- Design a program that is easy for the general public to understand and access;
- Conduct a culturally sensitive public information campaign, targeted to those individuals and organizations that have the most direct contact with the low-income uninsured population;

- Identify, inform, and enroll the low-income uninsured population into either the State's Medicaid program, MCHP or MCHP Premium, as appropriate; and

- Coordinate enrollment into these programs with other public or private health insurance.

To effectively achieve the goals of enrolling the targeted uninsured population into the Maryland Children's Health Program, Maryland uses a multifaceted strategy. In order to target families, Maryland will continue with a grassroots information dissemination campaign involving collaboration with the following entities:

- State agencies;
- Advocacy and community-based groups; and
- Provider organizations.

This grassroots approach complements Maryland's comprehensive HealthChoice education and outreach campaigns targeted at low income pregnant women and children. Maryland has conducted public media and advertising campaigns using some of the same strategies which have been effective during the implementation of HealthChoice.

Grassroots Information Dissemination Campaign

The primary objective of the grassroots public information campaign is to educate families of the eligibility provisions and benefits under the Maryland Children's Health Program. State agencies as well as local community-based organizations, advocacy groups, and providers serve as information links to low-income working families. Each of these groups is asked to distribute brochures and other forms of information, assist with mail-in applications, use their own newsletter for communication, and host meetings for others to be educated on the outreach process. In all of these activities, the State serves as a central contact and clearinghouse, as well as providing technical assistance.

The State coordinates its outreach efforts closely with Local Health Departments, Community Health Centers, Managed Care Organizations, (MCOs) and other public and private providers with historic experience in providing information, services, and referrals for low income uninsured populations. The State also works through children's services providers such as schools, licensed day care providers, and Head Start programs. Each of the grassroots outreach entities are outlined below with a description of their major area of responsibility.

STATE AGENCIES

Maryland Department of Health (MDH)

MDH is responsible for strategic planning of Statewide outreach. MDH efforts include the following:

- *Consultation with the Maryland Medicaid Advisory Committee.* MDH, in consultation with the Maryland Medicaid Advisory Committee, refines mechanisms for outreach with a special emphasis on identifying children who may be eligible for program benefits under the Maryland Children's Health Program.

- *Toll Free Information Line*. MDH operates a toll free information line to field questions about the program and take requests for enrollment applications. DHMH's toll free line is linked to the national 1-877-KIDSNOW hotline.
- *Printed Materials*. The following materials are distributed to those groups who have the most direct contact with the uninsured population such as Community Health Centers, Local Health Departments, the Department of Social Services offices, advocacy groups for children, school systems, community outreach organizations, and churches:

  - Mail-in applications
  - Brochures, posters, and flyers
  - Question and answer information packets for enrollees
  - Question and answer information packets for professionals
  - Training materials for Local Health Departments
  - Training materials for public speaking engagements
  - Scripts for newsletters and newsprint.

□ *Web based materials. Materials are posted on a public-access agency website, to include applications, general information, eligibility updates and topic specific information*

The largest percentage of non-English speaking populations in the State speak Spanish and Vietnamese. Outreach for HealthChoice and MCHP included specific efforts to reach these populations.Other identified languages spoken frequently in the State include Russian, Korean and Chinese. Maryland provides application forms and brochures in English and Spanish, and will evaluate whether to translate additional outreach brochures and posters into other languages for jurisdictions with large non-English speaking populations.

Local Health Departments (LHD)

Public health services in Maryland are provided through a network of 24 local health departments that have a longstanding history of service delivery to maternal and child health populations through the
following programs: Family Planning Services (Title X); preventive health care and

specialty care to low income children and prenatal care to low-income pregnant women (Title V); WIC; and immunization programs.

Through funding from the HealthChoice program, each LHD has created a care coordination unit responsible for outreach to low-income families, as well as follow-up of certain hard-to-reach and special needs populations enrolled in HealthChoice who fail to keep appointments. These Statewide networks of Medicaid supported outreach units have the knowledge, skills, and tools to conduct outreach activities to identify, track, enroll, and educate the low-income uninsured population into the Maryland Children's Health Program. LHDs perform community outreach through collaborative efforts with schools, family and center-based day care centers, family support centers, churches, medical and mental health providers, work site wellness programs, business and service organizations (e.g., Chamber of Commerce), non-profit organizations (e.g., March of Dimes), youth activity, and sports programs.

Department staff meet regularly with LHD outreach staff to keep them abreast of changes in the Maryland Children's Health Program, to ensure that all grantees understand outreach goals, and to provide information on statewide outreach strategies. MDH will also seek input from grantees regarding the development of performance measures for these activities. Local health department outreach staff will also be asked to evaluate local strategies.

Department of Human Services (DHS)

DHS works closely with MDH to coordinate eligibility issues especially for those who fall between the 200 and 300 percent of FPL. The introduction of the family contribution requirement and Maryland's efforts to assure that Maryland Children's Health Program enrollees do not have any other creditable coverage present challenges for the eligibility process. MDH and DHS (which does CARES eligibility processing for MCHP and MCHP Premium) work closely to identify and resolve any issues relating to eligibility determination for the Maryland Children's Health Program.

Maryland State Department of Education (MSDE)

MSDE plays a key role in encouraging low income families to apply for insurance coverage for their children by developing and implementing a school based outreach program. Examples of cooperative efforts with MDH include:

- *Boards of Education*. MDH may enter into contracts with county boards of education to provide information at public schools on the Maryland Children's Health Program.

  - *National Free and Reduced Price School Lunch Program*. The Maryland State Department of Education (MSDE) maintains information concerning public school children who participate in the National Free and Reduced Price School Lunch program for children in families with income below 185 percent of the Federal poverty line (FPL). MDH and MSDE have developed a two-part targeted outreach strategy that permissively uses the National Free and Reduced Price School Lunch Program to direct outreach information to children who are likely to be eligible for

public health insurance coverage under either Medicaid or the Maryland Children's Health Program. This strategy will concentrate on schools that (based on their relatively high proportion of children who qualify for the National Free and Reduced Price Lunch Program) are likely to enroll a relatively high number of children who are eligible for Medicaid or the Maryland Children's Health Program. When a child applies for the National Free and Reduced Price School Lunch Program and is determined to be eligible, the school will send a notice of eligibility to the child's parents; outreach information about the Maryland Children's Health Program will be included with the notice; and

- For school years 2000 and 2002, a Maryland Children's Health Program application was sent home with every child. For school year 2001, new entrants in prekindergarten, kindergarten and first grade received applications.

- *School-Based Health Centers*. School-based health centers are located in schools in Maryland which serve large numbers of children in low income families. SBHCs will encourage families of uninsured children to apply for Maryland Children's Health Program coverage.

- *Licensed Day Care Centers*. The Child Care Administration (CCA) is responsible for licensing and monitoring day care centers and family day care programs in Maryland. In addition, it administers the child care subsidy payment program for eligible families. CCA will provide general information about the Maryland Children's Health Program through education articles in a quarterly newsletter and by distributing outreach materials to 2,200 day care centers and 14,400 family day care providers.

Head Start

Head Start programs serve over 7,200 children in Maryland. The program predominantly serves four year old children with some available space for younger children. One component of Head Start is to promote access to health care for the children and families served in each program. Ten percent of the children served must have documented disabilities and ten percent of the children enrolled may come from families whose income exceeds the Head Start income guidelines, which are at the Federal poverty line. The Maryland Head Start Collaboration Network project was established to facilitate coordination of services between Head Start and Health care providers, education agencies, child care programs, employment projects, and other community organizations. It provides an open access arena for communication to the 31 Head Start programs in every county in the State. The project collaborates with the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program to improve access to health care services and to make sure that children enrolled in Head Start receive EPSDT screening and treatment services. Local Head Start programs provide Medicaid and Maryland Children's Health Program eligibility information and explain the importance of obtaining an EPSDT screen and immunizations during their annual spring recruitment phase.

Governor's Office on Children, Youth and Families

MDH coordinates with this agency, as appropriate to assist in its outreach efforts.

Office of the State Comptroller

MDH coordinates with this agency, as appropriate, to assist in its outreach efforts. Effective April ,2010, MDH uses this agency as an Express Lane agency that uses income information from State tax records to identify children financially eligible for CHIP.

ADVOCACY AND COMMUNITY BASED ORGANIZATIONS

HealthChoice Linkages

Maryland has been highly successful in working in partnership with advocacy organizations for HealthChoice outreach and education activities. These partnerships will be strengthened to enhance outreach efforts as we move forward with the Maryland Children's Health Program. These advocacy organizations represent children and pregnant women of varying health status, geographic location and ethnic backgrounds. The advocacy organizations have a vested interest in child health and have grounded experience in overcoming the barriers that keep children and pregnant women from getting care.

During the planning stages for MCHP, regional meetings were conducted to seek input from the public. Numerous advocacy organizations participated in these regional meetings and expressed their willingness to assist in outreach efforts. A few examples of these established groups that have proven their commitment to reach the uninsured include:

- The Maryland Committee on Children
- Advocates for Children and Youth
- The Maryland Developmental Disabilities Council
- The Maryland Association of Resources for Families and Youth
- Workgroup on Managed Care for Children in State-Supervised Care
- The Lutheran Office on Public Policy
-
- The United Baptist Missionary Convention and Auxiliaries, Inc.
- Collington Life Center (Senior Center)
- The Mid-Atlantic Association of Community Health Centers

MDH works closely with these and other groups to implement an outreach plan that complements other simultaneous outreach efforts and that specifically attempts to identify potential eligibles who are in rural areas, who are homeless, or who are members of special needs populations. Such activities as creating meeting participant lists, providing input on brochures and applications, distributing materials through churches and libraries, and speaking to parent groups are requested of these organizations.

Linkage with Robert Wood Johnson Outreach Grant - Covering Kids and Families - Maryland

Discontinued/Grant Period Ended June 30, 2006**.**

Linkage with Insurance Brokers

When issuing or renewing group health insurance policies with an employer that does not include dependent coverage, insurers and non-profit health service plans (those that issue or deliver group health insurance policies in the State) provide enrollment information to insured employees regarding methods for enrolling dependents of the insured employee.

PROVIDER OUTREACH

Primary and Specialty Care Providers

Health care providers are an invaluable resource in providing information concerning Medicaid coverage for low income children, children with special health care needs, and families. Primary care and specialty providers are encouraged by DHMH to identify individuals, especially pregnant women and children, in need of health care coverage and to make appropriate referral to local and State agencies for assistance.

Professional Medical Organizations

MDH coordinates with recognized medical organizations such as the American College of Obstetrics and Gynecology (ACOG), the American Academy of Pediatrics (AAP) and the Maryland Association of Family Practitioners to promote access to Medicaid coverage. These organizations provide information to their providers through their professional meetings and newsletters. The EPSDT program supplies primary care physician's offices with outreach materials such as flyers and brochures to inform patients about Medicaid and the Maryland Children's Health Program.

Managed Care Organizations (MCOs)

Through a variety of existing communication forums including biweekly information sharing meetings, MDH works closely with its HealthChoice MCOs to request assistance in the distribution of applications and information to its community networks.

Community Based Diagnostic and Treatment Centers

Maryland has a number of community-based diagnostic and treatment centers such as the Diagnostic and Evaluation Service Centers for individuals with HIV/AIDS and Planned Parenthood offering women's health services, where the most current information on the Maryland Children's Health Program will be disseminated.

Community Based Providers

As discussed in Section II of this application, Maryland has a number of locally operated programs (e.g., Montgomery County Care For Kids Program) as well as community health

centers that already serve the uninsured. These programs provide direct information to the families that they serve so that children who receive partial benefits under these programs can receive comprehensive medical coverage.

GENERAL OUTREACH

Public Information Campaign-Media Relations and Advertising

Maryland has conducted three grassroots public information dissemination campaigns intended to target those families of the working uninsured who might have children eligible for the Maryland Children's Health Program. Designed to complement the outreach activities described above, the Statewide media campaigns have been successful in reaching individuals and families who were not contacted through these other mechanisms or who may have been ineligible at the time they received the information and had a change in their financial situation.

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

5.1.1. (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

5.1.1. (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

Maryland uses a variety of methods to identify and enroll all eligible children in Maryland for Medicaid and the Children's Health Program. We have implemented a broad-based and diverse outreach program. Some of our activities include:

- Brochures, flyers and posters;
- Radio and TV public service announcements;
- Outreach through primary care provider offices and pediatric specialty providers;
- Outreach and information and enrollment at the Local Health Departments and the Local Departments of Social Services;

- Direct mailings to individuals receiving unemployment checks;
- Outreach through schools, licensed child care providers, the Maryland Infants and Toddler's Program and Head Start;
- Outreach by established advocacy groups such as the Maryland Committee for Children and the Advocates for Children, Youth and Families; and
- Public presentations by members of the MDH speakers bureau.
- Web-based materials provided to inform the public of new issues and requirements.

In addition, Maryland has taken the following actions to streamline the eligibility process:

- Allowing applicants several application options—applying online at www.marylandhealthconnection .gov or via mobile phone app; applying by telephone; applying by mail; or applying face-to-face at local health departments or local departments of social services.
- Allowing self-declaration of income.

As demonstrated by the higher than anticipated enrollment levels during MCHP Phase I, Maryland's

outreach efforts have been quite successful. These efforts, as well as Maryland's plans for additional outreach consistent with the goals of MCHP Phase II, are discussed in detail in Section 5 of this application.

Maryland uses a combined application for Medicaid and MCHP. Applicants determined eligible to participate in Medicaid or MCHP who subsequently have a change in circumstances which qualifies them for the other program are reassigned without requirement for completion of another application and without any impact on their HealthChoice enrollment.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

There are currently no public-private partnerships in Maryland that provide creditable health insurance coverage.

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. X No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. X Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. X No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42 CFR 457.475)

8.8.6. X No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

1. Reduce the number of uninsured children
2. Increase in percentage of children with a usual source of care, as measured by the number of ED visits
3. Increase in percentage of children with a well-child visit
4. Increase in percentage of individuals in the FCEP coverage group who received timely prenatal care
5. Increase in percentage of individuals in the targeted low-income child (unborn) population receiving postpartum care

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

1. Reduce the number of uninsured children
    a. Year-over-year increase the number of Medicaid-eligibles enrolled in Maryland Medicaid and the Maryland Children's Health Program as

compared to projections; and reduce the percentage of non-covered children in the State of Maryland.

2. Increase in percentage of children with a usual source of care
    a. Year-over-year, decrease the total number of children 0-18 enrolled in managed care who had an ED visit
    b. This measure shall be considered in comparison with the following measure related to increasing the percentage of children with a well-child visit
3. Increase in percentage of children with a well-child visit
    a. Year-over-year, increase the number of children who turned 15 months old during the measurement year with six or more well-child visits
4. Increase in percentage of individuals in the FCEP coverage group who received timely prenatal care
    a. Year over year, increase the percent of individuals enrolled in the FCEP coverage group with 60 days of enrollment prior to delivery who had a prenatal visit any time prior to delivery
5. Increase in percentage of individuals in the targeted low-income child (unborn) population receiving postpartum care
    a. Year over year, increase the percent of birthing parents of targeted low-income children with any period of enrollment after delivery, who had a postpartum visit on or between 7 and 84 days after delivery.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

1. Reduce the number of uninsured children: Medicaid, including MCHP, eligibility data

2. Increase in percentage of children with a usual source of care, as measured by the number of ED visits: Medicaid claims data
3. Increase in percentage of children with a well-child visit: Medicaid claims data.
4. Increase in percentage of individuals in the FCEP coverage group who received timely prenatal care: Medicaid claims data
5. Increase in percentage of individuals in the targeted low-income child (unborn) population receiving postpartum care: Medicaid claims data

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

MCHP:

In 1997, Governor Parris N. Glendening and the Secretary of the Department of Health and Mental Hygiene Martin P. Wasserman engaged in an extensive public process to obtain input on the design and implementation of the Maryland Children's Health Program. To ensure broad public input, the process began with four public hearings throughout the State and culminated with Governor's Round Table on Children's Health Insurance, which Governor Glendening personally chaired. The hearings and Round Table were followed by four regional briefings. Finally, there was an extensive legislative process which resulted in the Children and Families First Health Care Act of 1998. The Department of Health and Mental Hygiene will assure ongoing public involvement in the Maryland Children's Health Program through consultation with the Maryland Medicaid Advisory Committee and through monthly communication with the Local Health Department's health officers. The strategies used by the Department in this public involvement process are described below.

Public Input—Design and Implementation

- **Public Hearings**

  The four public hearings were publicized through appropriate advocacy and provider groups as well as direct mailings to over 200 representatives of consumers, providers and advocacy groups. The first public hearing, for Western Maryland, was held in Hagerstown on October 28, 1997; the second public hearing, for Central Maryland, was held in College Park on October 30, 1997. The third public hearing, for the Eastern Shore, was held in Wye Mills on November 3, 1997; the fourth public hearing, for Baltimore City, was held in Baltimore on November 6, 1997. All hearings were held at 7 p.m. to assure maximum public participation. Each hearing began with the Governor's representative explaining the provisions of the Children's Health Insurance Program under Title XXI and the options available for implementing the program in Maryland. Individuals were then given an opportunity to offer their views. A total of 193 individuals attended the four hearings and 94 testified. Of those individuals who addressed the issue, 60 recommended implementing Title XXI by expanding the current Medicaid program. Only five individuals recommended establishing a new program rather than expanding Medicaid.

- **Governor's Round Table on Children's Health Insurance**

Governor Glendening chaired the Governor's Round Table on Children's Health Insurance in Baltimore on November 18, 1997. There were approximately 20 participants in the Round Table, including several key members of the Maryland General Assembly, representatives of provider and advocacy groups, community leaders, and a representative from the Children's Defense Fund and the National Governor's Association. The representative of the National Governor's Association explained the provisions of the Federal law and the Secretary of Health and Mental Hygiene explained the current situation in Maryland and options for implementing the new program. The Governor then chaired a discussion focusing on the expansion population, the benefit package, options for implementation, and whether there should be co-payments and premiums for enrollees. The discussion included all of the Round Table participants. Of those Round Table members who expressed a preference, all recommended implementing Title XXI through expanding the current Medicaid program. In addition to the participants, there were approximately 250 people in the audience observing the proceedings of the Round Table. Approximately 15 members of the audience made comments or raised questions during a question-and-answer session; only one person expressed opposition to implementing the program by expanding the Medicaid program.

- **Regional Briefings on Maryland Children's Health Program**

Subsequent to the four regional Public Hearings and the Governor's Round Table Discussion, the Department and the Governor's Office conducted four regional briefings. These briefings were held in eastern, central, southern, and western regions of Maryland. This provided an opportunity for the public, consumers, advocates, Local Health Departments, and service providers to learn about the legislative proposal submitted by the Governor to the Maryland General Assembly. The briefings offered an additional opportunity for local and regional recommendations regarding the design and implementation of the Maryland Children's Health Program. The regional briefings were conducted by the Secretary or Deputy Secretary of the Department of Health and Mental Hygiene and a member of the Governor's executive staff. Interested parties, including State Legislators and Local Health Departments, were notified about the briefings through mailings and press releases.

The dates and locations of the briefings were as follows:

- Eastern Maryland—Salisbury, MD, January 22, 1998
- Central Maryland—Baltimore, MD, January 28, 1998
- Southern Maryland—Rockville, MD, February 2, 1998
- Western Maryland—Cumberland, MD, February 2, 1998

- **Maryland Legislature 1998**

The expansion of coverage to uninsured children was one of the major policy initiatives of Governor Glendening and the 1998 Maryland legislative session. Prior to the start of the

session the Governor proposed legislation to address the needs of uninsured children. The legislature then engaged in an extensive debate on proposals regarding uninsured children. The legislative process included the formation of a work group of key legislative leaders who met regularly throughout the session. The work group invited representatives from the insurance industry, hospital, physician, provider and child advocacy groups to attend and participate in their work sessions. April 11, 1998, legislation entitled The Children and Families First Health Care Act of 1998, authorizing the Maryland Children's Health Program passed with overwhelming bipartisan support. This legislation closely follows the legislation originally proposed by Governor Glendening.

Ongoing Public Involvement

- **Maryland Medicaid Advisory Committee**

  The Maryland Medicaid Advisory Committee reviewed and discussed the provisions of Title XXI and the options available to the State at its meetings of October 23 and November 24, 1997. The Committee recommended expanding the existing Medicaid program to implement the new program.

  In order to assure on-going public involvement and input in program implementation and continuing administration, the State uses the Maryland Medicaid Advisory Committee, established under the Section 1115 Maryland Medicaid waiver for the HealthChoice program.[1] The Maryland Medicaid Advisory Committee consists of 27 members including State legislators, consumers, and providers. The Committee is currently charged with advising the Department of Health and Mental Hygiene on the implementation, operation and evaluation of the Medicaid program, including the following activities: reviewing and making recommendations on regulations; reviewing and making recommendations on standards used in contracts with Managed Care Organizations; reviewing and making recommendations on the Department's oversight of quality assurance standards; reviewing data collected from Managed Care Organizations and data collected by the Maryland Health Care Access and Cost Commission; promoting the dissemination of Managed Care Organization performance information; assisting the Department in the evaluation of the enrollment process; reviewing reports of the Ombudsman; and publishing an annual report to the Governor and Maryland General Assembly. The Committee has added the Title XXI program to each of these areas of its responsibility, as appropriate. The Committee meets monthly and periodically conducts regional public hearings.

- **Monthly Meetings with the Local Health Departments**

  On a monthly basis, local health officers representing the 24 LHDs have a round table discussion on issues affecting the implementation of the HealthChoice program

[1]. The role of the Medicaid Advisory Committee is explicitly outlined in the "Children and Families First Health Care Act of 1998."

MCHP Premium

The Maryland General Assembly, in its 1999 session, enacted Senate Bill 738, requiring the Department of Health (the Department or MHD) to study how to expand eligibility for the Maryland Children's Health Program by using private market insurance (private option) coverage. SB 738 directed the Department to:

> Study and make recommendations regarding the ability of the State to expand the Children and Families Health Care Program beyond the current income eligibility level to individuals who would qualify for the enhanced federal match provided for under Title XXI of the Social Security Act as part of the program established under §15-301 of this subtitle through private market, employer-sponsored health benefits plans and private market, individual health benefit plans.

To fulfill this legislative mandate, the Department formed a Technical Advisory Committee (TAC) composed of representatives of the Department, the Maryland Insurance Administration, the Maryland Health Care Foundation, the Maryland Health Care Commission, the business community, the health care insurance industry, and State employees. In the interest of gaining as broad and informed a perspective as possible, the Department expanded the membership of the TAC to also include advocates representing additional relevant interest groups.
The University of Maryland, Baltimore County (UMBC), Center for Health Program Development and Management (CHPDM), conducted all relevant research and provided staff to support the TAC. The Department and the TAC pursued an open and inclusive approach to soliciting information and assuring that complex (and potentially contentious) design issues were thoroughly reviewed and discussed. Two methods were used:

- *Full meetings of the TAC.* The full TAC met on five separate occasions from June to October 1999. Each of these meetings lasted for roughly three hours and, in the aggregate, touched on all aspects of the private option. At its initial meetings, the TAC reviewed proposed approaches to the private option, adopted a workplan, and addressed basic issues, such as benefit design. At later meetings, staff recommendations were presented, discussed, and modified.

- *Issue-specific workgroups.* Five workgroups supplemented the deliberations of the full TAC. The workgroups were composed primarily of TAC members, but also included additional individuals with relevant expertise or experience (e.g., employers). The workgroups explored the following issues: benefit design, administrative concerns for employers and insurers, outreach processes, and cost sharing requirements. At the recommendation of the TAC, a sixth workgroup of consumers met in November, 1999 and discussed the program's overall design and implementation. The consumer focus group paid particular attention to the potential effects of various cost sharing mechanisms.

In addition to discussions designed to capture input from the TAC and the workgroups, staff researched and analyzed a number of topics necessary to inform these groups' deliberations. Staff prepared the following:

- *Discussion papers.* Staff produced a series of papers presenting pertinent research and
- analysis of key issues that are central to the design and development of a private option program under Title XXI. Discussion papers on the following topics were distributed to workgroup participants and the TAC as a whole:

    - Benefit Design Options;
    - Estimating the Target Population; and
    - Cost Sharing Issues.

- *Employer survey*. Maryland has always been concerned that the HCFA guidance calling for an employer contribution of at least 60 percent of the cost of family coverage for employer-sponsored coverage under Title XXI, represented a significant barrier to employer participation in a private option program. Therefore, Maryland was very interested in collecting Maryland-specific data on this issue. In cooperation with TAC members, staff developed a brief employer contribution survey to gather information on employee health insurance contribution patterns among Maryland employers. The survey was mailed to over 23,000 Maryland employers and responses were received from over 2,600 employers. The results of the survey provide a strong basis for Maryland seeking a lower employer contribution threshold of 50 percent for the private option. Based on final federal regulations and Maryland's experience since July, 2001 in implementing and operating the private option program, Maryland reduced the required employer contribution threshold to 30 percent. This allowed the State to provide access to the MCHP Premium through employer-sponsored insurance for children in families where the family size was large enough to meet the cost-effectiveness test.

- *Research of approaches being used by other states.* A very limited number of other states have either developed or attempted to develop employer-sponsored approaches to providing health insurance coverage for children through a separate state plan under Title XXI. To understand how they designed and implemented their Title XXI employer-sponsored insurance programs, and to assess their current status, staff contacted each of the states (Massachusetts, Wisconsin, Mississippi, and Oregon) that have either been approved by, or submitted a proposal to, HCFA to use an employer-based approach to Title XXI.

- *Interim Report.* As required by SB 738, the Department prepared an interim report recounting the TAC process and progress. The interim report (submitted September 15, 1999) did the following. It:

    - Presented TAC discussions of major policy issues, especially benefit design;
    - Outlined the remaining issues to be addressed;
    - Described a strategy for completing the Committee's efforts; and,
    - Included copies of all issue papers.

The process outlined above was invaluable in the development of workable recommendations for a Maryland Children's Health Program private option that adhered to the goals and requirements

detailed in SB 738. The Department especially benefited from the active participation of the membership of the TAC, in particular from the TAC's willingness to openly discuss issues and consider opposing viewpoints. The TAC's spirited and insightful discussions were indispensable to understanding the complexities of the private option.

Using the final December 3, 1999 report of the TAC as a starting point, the Maryland legislature passed the HB2, the Maryland Health Programs Expansion Act of 2000. Thus, this state plan amendment is the culmination of an extensive public process.

Since enactment of the legislation in April of 2000, MDH has reconvened the TAC to discuss its implementation plans. MDH will continue to hold regular meetings with the TAC and arrange meetings with technical experts as needed.

Separate CHIP Program

In 2022, HB 1080–Healthy Babies Equity Act (Ch. 28 of the Acts of 2022) was enacted to require the State to provide comprehensive medical care and other health care services to noncitizen pregnant individuals who would qualify for Medicaid but for their immigration status. Since this coverage was enacted through the State's legislative process, this benefit required the public's input through bill hearings and stakeholder testimonies.

Legislative Adjustments to MCHP Premium effective April 9, 2024

Effective April 9, 2024, Maryland will permanently eliminate premiums for MCHP enrollees. This change aligns program operations with statutory changes enacted by Maryland *House Bill 1521– Maryland Children's Health Program - Eligibility and Administration (Chapter 47 of the Acts of 2024)*. MCHP premium plan payments were suspended during the COVID-19 Public Health Emergency, effective March 1, 2020. However, Maryland further extended the pause on premiums through April 30, 2024, as authorized by the State's Medicaid Disaster SPA (MD-SPA-20-0001). The federal Consolidated Appropriations Act of 2023 requires that all states provide continuous eligibility to children enrolled in Medicaid or MCHP for 12 months, beginning January 1, 2024. Maryland implemented this requirement effective September 1, 2023. As a result, eligibility for children enrolled in the MCHP premium plan is no longer contingent on timely payment of a monthly premium and Maryland Medicaid cannot enforce collection of premium payments throughout the year.

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

Maryland has no federally recognized Indian tribes. Maryland has multiple State-recognized Indian tribes. This includes the following groups: