



Center for Medicaid and CHIP Services

JUN 27 2011:

Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Mr. Hales:

We are pleased to inform you that your July 1, 2010 request for an extension of the State of Maryland's Medicaid section 1115 demonstration, entitled "HealthChoice" (Waiver number 11-W-00099/3) under authority of section 1115(a) of the Social Security Act (the Act), has been granted for the period July 1, 2011, through December 31, 2013 unless otherwise specified.

This Demonstration will continue and strengthen coverage available to Medicaid beneficiaries in Maryland. The Special Terms and Conditions (STCs) include provisions that:

- Allow the State to mandatorily enroll Demonstration eligibles into a managed care organization for comprehensive primary and acute care;
- Create health care programs that serve targeted populations through the "Rare and Expensive Case Management" (REM) program, the "Primary Adult Care" (PAC) program, and the "Increasing Community Services" (ICS) program which provide select health care services to targeted populations; and
- Integrate requested State revisions to the Family Planning program into the Demonstration.

The Department of Health and Human Services' approval of the Demonstration extension, including the waivers and the costs not otherwise matchable authority that are described in the enclosed list, are conditioned on the State's acceptance of the STCs within the proceeding 30 days for the date of this approval. The STCs will be effective July 1, 2011, unless otherwise specified. All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the Demonstration. Your project officer is Ms. Robin Preston. She is available to answer any questions concerning your section 1115 demonstration. Ms. Preston's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-3420
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E-mail: Robin.Preston@cms.hhs.gov

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

The Public Ledger Building
150 South Independence Mall West Suite 216
Philadelphia, PA 19106

If you have questions regarding this correspondence, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid, CHIP and Survey & Certification, at (410) 786-5647.

The CMS is looking forward to continuing to strengthen this partnership and is committed to working collaboratively with the State to help deliver health care to the residents of Maryland in a more efficient and cost effective manner.

Sincerely,

/Bill Lasowski/ for

Cindy Mann
Director

Enclosures

cc: Ted Gallagher, ARA, Philadelphia Regional Office
Victoria Wachino, CMCS
Robin Preston, CMCS

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W -00099/3
TITLE: HealthChoice Medicaid Section 1115 Demonstration
AWARDEE: Maryland Department of Health and Mental Hygiene

I. PREFACE

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

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

The STCs have been arranged into the following subject areas:

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

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

The HealthChoice section 1115(a) Demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage and/or targeted benefits to certain individuals who would otherwise be without health insurance or without access to benefits tailored to the beneficiary's specific medical needs. The initial

HealthChoice Demonstration was approved in 1996 to enroll most Medicaid recipients into managed care organizations (MCOs) beginning July 1, 1997.

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

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

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

The HealthChoice Demonstration continued to evolve during the 2008 to 2011 extension period by providing both eligibility and a benefit expansion, which were approved by the Maryland General Assembly in State fiscal year (SFY) 2008. The eligibility expansion allowed coverage through the Medicaid State plan to categorically eligible parent and caretaker adults with income above 30 percent of the Federal poverty level (FPL) to 116 percent of the FPL. The benefit expansion added new benefits, on an incremental basis, to the limited benefit package available to PAC program participants. This population will be eligible for full benefits in 2014 when the Medicaid expansion occurs under the Affordable Care Act.

The State also began applying a lower FPL eligibility limit (200 percent FPL rather than 250 percent FPL) in the Family Planning program to all new potential participants and to all existing participants at the time of eligibility redetermination in order to comply with CMS policy directive beginning September 1, 2008. Within this Demonstration extension period, the State is expanding eligibility to include all women who have a family income at or below 200 percent of the FPL, rather than the previous eligibility that included only women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum. The State is also electing to

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

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

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and State Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, court order, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part, must apply to the Demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, court order, or policy directive, come into compliance with any changes in Federal law, regulation, court order, or policy affecting the Medicaid or CHIP programs that occur during this Demonstration approval period, unless the provision being changed is explicitly waived under the STCs herein governing the Demonstration.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.** To the extent that a change in Federal law, regulation, final court order, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.

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

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population' eligible through the Medicaid or CHIP State plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan is required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Demonstration provisions related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below. The State will notify CMS of proposed Demonstration changes at the monthly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.
7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:
 - a. An explanation of the public process used by the State to reach a decision regarding the requested amendment;
 - b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level though the approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
 - c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - d. If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.
8. **Demonstration Phase Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein should be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval prior to implementation of phase out. If the project is terminated or any relevant waivers

suspended by the State, FFP must be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

9. **Enrollment Limitation During Demonstration Phase Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 8, during the last 6 months of the Demonstration, the State may choose to not enroll individuals into the Demonstration who would not be eligible for Medicaid under the current Medicaid State plan. Enrollment may be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.
10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS must promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.
12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or would promote the objectives of titles XIX and XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
13. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.
14. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 7, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, amendment and/or renewal of this Demonstration.
15. **Compliance with Managed Care Regulations.** The State shall comply with all of the managed care regulations published at 42 CFR section 438 et. seq., except as expressly identified as not applicable in the STCs. The per member, per month fixed amount pursuant to paragraph 58 must be developed and certified as actuarially sound in accordance with 42

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

Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

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

17. Eligibility Overview. Participation in HealthChoice is mandatory for the majority of Maryland's Medicaid eligible population: Medicaid, Maryland Children's Health Program (MCHP) and MCHP Premium eligibles who participate in HealthChoice are enrolled in MCOs, or in the REM Program. In addition, certain individuals otherwise ineligible for Medicaid may be determined eligible for the PAC, Family Planning, or ICS programs.

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

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

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

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

| | | |
|--|---|--|
| children | | |
| SOBRA women and children | Children with incomes above the pre-July 1, 2008 TANF income threshold who are not enrolled in the TANF group: Under age 1: Up to and including 185 percent of the FPL; Ages 1 to 6: Up to and including 133 percent of the FPL; and Ages 6 to 19: Up to and including 100 percent of the FPL; Pregnant women with incomes above the pre-July 1, 2008 standard up to and including 250 percent of the FPL who are not enrolled in the TANF group. | SOBRA Adults or SOBRA Children |
| Non-Dual Blind and Disabled | Individuals whose Medicaid eligibility derives from their status as blind or disabled and who are not entitled to Medicare. SSI FBR: \$674 for individuals and \$1,011 for couples. | SSI/BD Adults or SSI/BD Children |
| Medicaid State Plan Optional Groups | FPL and/or Other Qualifying Criteria | Expenditure and CMS 64 Eligibility Group Reporting |
| Medically Needy adults and children | Families with dependent children, or foster children, whose gross income and resources exceed 116 percent of the FPL but who incur medical expenses such that their income is equal to or less than 116 percent FPL. | MN Adults or MN Children |
| Optional targeted low income children through age 18 | Up to first birthday: between 185 and 200 percent of the FPL; On first birthday through age 5: between 133 and 200 percent of the FPL; and Upon sixth birthday through age 18: between 100 and 200 percent of the FPL | MCHP (Only during periods when title XXI funding is exhausted) |
| Optional targeted low income children through age 18 | Between 200 percent of the FPL and 300 percent of the FPL who pay a premium. | MCHP Premium (Only during periods when title XXI funding is exhausted) |

- b. Health Choice Benefits. The HealthChoice program provides comprehensive Medicaid State plan benefits to Demonstration participants.
- c. Health Choice Cost Sharing. All cost-sharing must be in compliance with Medicaid requirements for State plan populations that are set forth in statute, regulation and policies and all Demonstration participants must be limited to a 5% aggregate cost sharing limit per family. Cost sharing shall be equal to or less than:
- 1) Copayments of \$3.00 per prescription and refill for brand name drugs; and
 - 2) Copayments of \$1.00 per prescription and refill for generic drugs.
 - 3) Copayments of \$1.00 per prescription and refill for preferred drugs provided on a fee-for-service basis (outside of the MCO prescription drug benefit).
 - 4) Premiums for children through age 18 with incomes between 200 percent up to and including 250 percent of the FPL -is calculated at 2 percent of a family household income of two at 200 percent of the FPL per family per month.
 - 5) Premiums for children through age 18 with incomes between 251 percent up to and including 300 percent -is calculated at 2 percent of a family household income of two at 250 percent of the FPL per family per month.

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

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

- a. Maryland Health Choice participants who have specified conditions that are expensive and require complex medical treatment may be enrolled in a special case management program operated by the State. The REM case management program includes certain optional services not otherwise provided under the Medicaid program to assist with the special needs of this population. The State may also enroll in the REM program individuals who are not otherwise participating in the Demonstration, who are under age 65 and receiving Medicare benefits, if the individual was previously enrolled in the REM program and receiving private duty nursing services or home health aide services.
- b. Benefits. Specific benefits provided to beneficiaries enrolled in the REM program are found in Attachment A. Benefits for Medicare beneficiaries will be limited to services not available under Medicare.
- c. Cost Sharing. Applicable State plan cost sharing requirements apply.
- d. Redetermination and Disenrollment. As described in the Medicaid State plan.
- e. Delivery System. An individual choosing to enroll in the REM program is prohibited from enrolling in an MCO. Services are delivered on a FFS basis.

21. Family Planning Program for Demonstration Population 14

- a. Participation. Family planning and family planning-related services are available to all women of childbearing age who are not otherwise eligible for Medicaid, the PAC program, CHIP, or Medicare, and are:
 - i. Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum (e.g. SOBRA women) and who have income at or below 200 percent of the FPL at the time of annual redetermination; or
 - ii. Beginning January 1, 2012, women who have a family income at or below 200 percent of the FPL.
- b. Family Planning Benefits.
 - 1) Family planning services and supplies described in section 1905(a)(4)(c) and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:
 - a) Approved methods of contraception;
 - b) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams;
 - i. Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the

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

- c) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and
 - d) Contraceptive management, patient education, and counseling.
- 2) Family Planning-Related Benefits. Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the State's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:
- a) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
 - b) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
 - c) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.
 - d) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
 - e) Treatment of major complications arising from a family planning procedure such as:
 - i. Treatment of a perforated uterus due to an intrauterine device insertion;
 - ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
 - iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.
- 3) Primary Care Referrals. Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this Demonstration. The State must facilitate access to primary care services for participants, and must assure CMS that written materials concerning access to primary care services are distributed to Demonstration participants. The written materials must explain to the participants how they can access primary care services.
- c. Cost Sharing. There is no cost sharing requirement for this population.

- d. Redetermination. The State must ensure that redeterminations of eligibility for the Family Planning Program are conducted at least every 12 months. Redeterminations may be administrative in nature.
- e. Disenrollment. If a woman becomes pregnant while enrolled in the Demonstration, she may be determined eligible for Medicaid under the State plan. The State must not submit claims under the Demonstration for any woman who is found to be eligible under the Medicaid State plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Demonstration.
- f. Delivery System. Services provided for this Demonstration population are paid fee for service (FFS).

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

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

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

- a. Participation. Expenditures for home and community-based and State plan services provided to individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the State plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, , subject to the following conditions:
 - 1) Individuals must have resided in a nursing facility for at least six months, and been eligible for Medicaid for at least 30 consecutive days immediately prior to being enrolled in this program;
 - 2) Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act; and
 - 3) The cost to Medicaid for the individual in the community must be less than the cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.
- b. Benefits. This program provides home and community-based services identical to those provided under the State's Living At Home (LAH) 1915(c) waiver with three additions - assisted living, behavior consultation services, and senior center plus services. These services enable the participant to live at home with appropriate supports rather than in a nursing facility. The specific benefits provided to participants in this program are listed in Attachment A.
- c. Enrollment Cap. The number of participants that may be enrolled in the ICS program at any one time is limited to 30. The State will create a registry that identifies all individuals eligible for the program who have indicated interest in receiving home and community-based services. The registry will be sorted based on date and time of interest. As slots become available, the State will notify individuals on the registry in numerical order of the opportunity to participate in the ICS program. Interested individuals will have 15 days to indicate whether or not they are still interested in participating. If after 15 days an individual fails to respond, a second letter will be mailed. If there is no response in 7 more days, the State will remove the individual's name from the registry, and offer that slot to the next person on the registry.
- d. Assurances. For the ICS population the State will comply with the HCBS assurances contained in 42 CFR §441.302.
- e. Cost Sharing. All cost-sharing must be in compliance with Medicaid requirements for State plan populations that are set forth in statute, regulation and policies and all Demonstration enrollees must be limited to a 5% aggregate cost sharing limit per family. Except where prohibited by Federal law:
 - 1) \$3.00 per prescription and refill for brand name drugs;
 - 2) \$1.00 per prescription and refill for generic and HIV drugs; and
 - 3) \$1.00 per prescription and refill for preferred drugs provided on a fee-for-service basis (outside of the M CO prescription drug benefit).
- f. Delivery System. The State will operate the ICS program in a manner consistent with its approved LAH 1915(c) waiver program and must meet all quality, administrative, operational and reporting requirements contained therein.
- g. Redetermination and Disenrollment. Made in accordance with the Medicaid State plan.

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

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

IV. GENERAL REPORTING REQUIREMENTS

25. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in section IX.
26. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.
27. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality as set forth in section XI.
28. **Title XXI Reporting Requirements.** The State will provide CMS on a quarterly basis, an enrollment report for the title XXI populations showing end of quarter actual and unduplicated ever enrolled figures. This data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter.
29. **Bi-monthly Calls.** CMS shall schedule bi-monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.
30. **Quarterly Operational Reports.** The State must submit progress reports in the format specified in Attachment C no later than 60 days following the end of each quarter. The intent of these reports is to present the State's data along with an analysis of the status of the

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

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

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

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

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

- a. **Seamless Transitions.** Consistent with the provisions of the Affordable Care Act, the Transition plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL or newly apply for Medicaid) to coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:
 - 1) Determine eligibility for all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(1 O)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
 - 2) Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
 - 3) Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014, eligibility groups for new applicants for Medicaid.
 - 4) Develop a modified adjusted gross income (MAGI) calculation for program eligibility. The State may implement prior to January 1, 2014.
- b. **Access to Care and Provider Payments.**
 - 1) **Provider Participation.** The State must identify the criteria that will be used for reviewing provider participation in (e.g. demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.
 - 2) **Adequate Provider Supply.** The State must provide the process that will be used to assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of the of service delivery. The report must separately address each of the following provider types:
 - a) Primary care providers,
 - b) Mental health services,
 - c) Substance use services, and
 - d) Dental.
 - 3) **Provider Payments.** The State will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective

- payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all inclusive rate (e.g., certain Indian Health providers).
- c. System Development or Remediation. The Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include:
 - 1) Tracking out-of-pocket charges in order to implement a 5 percent aggregate family cost sharing cap for low income population coverage options;
 - 2) Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.
 - d. Pilot Programs. Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act-defined "medical homes," "accountable care organizations," and/or "person-centered health homes" to allow for more efficient and effective management of the highest risk individuals.
 - e. Progress Updates. After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.
 - f. Implementation.
 - 1) By July 1, 2013, the State must begin implementation of a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning, these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.
 - 2) On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination.
 - g. Penalty. CMS reserves the right to impose a 2 percent FFP withhold for the Demonstration should the State fail to implement or operationize milestones listed in paragraph 32. The penalty amount will result in loss of some percentage of expenditures attributable to the Demonstration. If the State continues to fail to meet the Transition Plan requirements or milestones, CMS may impose incrementally larger percentages by which the annually expenditure authority cap will be reduced. The reduction in expenditure authority will be applied to the claims for Federal match of each Federal quarter. Once the requirement or milestone has been met, no further associated penalties will be imposed.

V. GENERAL FINANCIAL REQUIREMENTS

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

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

34. Premiums and other applicable cost sharing contributions from enrollees that are collected by the State under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.
35. For each Demonstration year, 15 separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration populations and Demonstration services. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in bold following the colon. Expenditures should be allocated to these forms based on the guidance found below.
 - a. **Demonstration Population 1**: TANF Adults Thru 29-Eligibility Group (EG) consists of adults whose Medicaid eligibility derives from their status as a relative caring for a child, or a pregnant woman through 30 percent FPL.
 - b. **Demonstration Population 2**: TANF Children Thru 29-EG consists of children whose Medicaid eligibility derives from their status as a minor child through 30 percent FPL.
 - c. **Demonstration Population 3**: TANF Adults 30-116-EG consists of adults whose Medicaid eligibility derives from their status as a relative caring for a child, or a pregnant woman whose income is 31 percent through 116 percent FPL.
 - d. **Demonstration Population 4**: TANF Children 30-116-EG consists of children whose Medicaid eligibility derives from their status as child whose income is 31 percent through 116 percent FPL.
 - e. **Demonstration Population 5**: SSI/BD-Adults EG consists of adults whose Medicaid eligibility derives from their status as blind or disabled.
 - f. **Demonstration Population 6**: SSI/BD-Children EG consists of children whose Medicaid eligibility derives from their status as blind or disabled.
 - g. **Demonstration Population 7**: Medically Needy Adults (MN Adults)-EG consists of adults whose income and resources exceed the categorically needy limits but are within Medicaid State plan limits.

- h. Demonstration Population 8: Medically Needy Children (MN Children)-EG consists of children whose income and resources exceed the categorically needy limits but are within Medicaid State plan limits.
- i. Demonstration Population 9: SOBRA Adult-EG consists of income eligible pregnant women.
- j. Demonstration Population 10: SOBRA Children-EG consists of income eligible children born after September 30, 1983.
- k. Demonstration Population 11: MCHP-EG consists of optional targeted low income children with incomes up to and including 200 percent of the FPL who do not pay premiums and who are eligible to claim title XIX funds under the State's approved title XIX State plan only when the State has exhausted its title XXI allotment and only until the next title XXI allotment becomes available to the State.
- l. Demonstration Population 12: MCHP Premium-EG consists of optional targeted low income children with incomes above 200 percent up to and including 300 percent of the FPL who pay premiums and who are eligible to claim title XIX funds under the State's approved title XIX State plan only when the State has exhausted its title XXI allotment and only until the next title XXI allotment becomes available to the State.
- m. Demonstration Population 13: PAC-EG consists of childless and non-custodial adults up to and including 116 percent of the FPL.
- n. Demonstration Population 14: Family Planning - This EG is eligible for only family planning and family planning related services and the EG consists all women, of childbearing age, who are not otherwise eligible for Medicaid, the PAC program, the Children's Health Insurance Program (CHIP) or Medicare, and are:
 - 1) Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum (e.g. SOBRA women) and who have income at or below 200 percent of the FPL at the time of annual redetermination; or
 - 2) Beginning, January 1, 2012, women who have income at or below 200 percent of the FPL.
- o. Demonstration Population 15: ICS-EG consists individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the State plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, , subject to the following conditions:
 - 1) Individuals must have resided in a nursing facility for at least six months, and been eligible for Medicaid for at least 30 consecutive days immediately prior to being enrolled in this program;

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

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

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

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

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

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

39. **Reporting Member Months.** For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 30, the actual number of eligible member months for the Demonstration Populations defined in paragraph 35. The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.
- a. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
 - b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.
40. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
41. **Extent of (Federal Financial Participation) FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in paragraph 58:
- a. Administrative costs, including those associated with the administration of the Demonstration;
 - b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and

- c. Net medical assistance expenditures authorized under section 1115 Demonstration for the HealthChoice program.
- d. CMS shall provide FFP for family planning and family planning-related services and supplies at the applicable Federal matching rates described in paragraph 21, subject to the limits and processes described below:
 - 1) For family planning services, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.
 - 2) Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in paragraph 21, should be entered in Column (D) on the Forms CMS-64.9 Waiver.
 - 3) Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in paragraph 21, should be entered in Column (B) on the Forms CMS-64.9 Waiver.
 - 4) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, no FFP will be available.

42. **Sources of Non-Federal Share.** The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds shall not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

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

43. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.
- b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed

explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

- c. To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.
- d. The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share 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.

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

VI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

45. **Expenditures Subject to the Allotment Neutrality Limit.** Eligible title XXI Demonstration expenditures subject to the allotment neutrality agreement are expenditures for services provided through this Demonstration to title XXI children with FPL levels within the approved CHIP State plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the State's available title XXI funding.
46. **Quarterly Expenditure Reporting through the MBES/CBES.** In order to track title XXI expenditures under this Demonstration, the State must report quarterly Demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual.
47. **Title XXI expenditures** must be reported on separate Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made). Once the appropriate waiver form is selected for reporting expenditures, the State is required to identify the program code and coverage (i.e., children).
48. **Claiming Period.** All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State

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

49. **Standard Medicaid Funding Process.** The standard CHIP funding process will be used during the Demonstration. The State must estimate matchable Medicaid expansion CHIP (MCHP) expenditures on the quarterly Form CMS-37.12 (Narrative) for both Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). On the CMS-37.12, the State must separately identify estimates of expenditures for the Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 waiver forms with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
50. **Administrative Costs.** Administrative costs under title XXI may be claimed on the CMS21 for the enhanced match or the CMS64.21 at the regular FMAP if the State has met the title XXI 10 percent cap or if the State is concerned about having sufficient title XXI funds for services. If title XXI funding is ever exhausted, administrative costs will be claimed on the CMS 64 at the regular FMAP.
51. **State Certification of Funding Conditions.** The State will certify that State/local monies are used as matching funds for the Demonstration. The State further certifies that such funds must not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS must be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
52. **Limitation on Title XXI Funding.** Maryland will be subject to a limit on the amount of Federal title XXI funding that the State may receive for Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the Demonstration children until the next allotment becomes available.
53. **Exhaustion of Title XXI Funds.** After the State has exhausted title XXI funds, expenditures for optional targeted low income children within CHIP State plan-approved income levels, may be claimed as title XIX expenditures as approved in the Medicaid State plan. The State

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

54. **Exhaustion of Title XXI Funds Notification.** The State must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures. The State must follow Medicaid State plan criteria for the beneficiaries unless specific waiver and expenditure authorities are granted through this Demonstration.

VII. MONITORING BUDGET NEUTRALITY

55. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
56. **Risk.** The State shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles. Because CMS provides FFP for all Demonstration eligibles, Maryland shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Maryland at risk for the per capita costs for current eligibles, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures had there been no Demonstration.
57. **Demonstration Populations Used to Calculate the Budget Neutrality Expenditure Limit.** The following describes the method for calculating the budget neutrality expenditure limit for the Demonstration:
58. For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each EG described as follows:
- a. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 30 for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (2) below.
 - 1) The PMPM costs in this subparagraph reflect the agreed-upon case-mix adjustment that was applied for each year of the budget neutrality agreement.
 - 2) In addition, the Family Planning Expansion population is structured as a "pass-through" or a "hypothetical state plan population" beginning in DY 15. Therefore, the State may not derive savings from this component. A PMPM cost was constructed

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

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

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

b. The overall budget neutrality expenditure limit for the Demonstration is the sum of the annual budget neutrality cap calculated in subparagraph iii, that includes the actual expenditures for the MCHP and MCHP Premium EOs claimed as title XIX expenditures as approved in the Medicaid State plan when the State has exhausted title XXI funding. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations described in subparagraphs 1) and 3) above during the Demonstration period reported.

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

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

| Demonstration Year | Cumulative Expenditure Cap Definition | Percentage |
|---------------------------|--|-------------------|
| Year 15 | Budget neutrality expenditure cap plus | 1 percent |
| Year 15 and 16 | Combined budget neutrality expenditure caps plus | 0.5 percent |
| Year 16 through 17 | Combined budget neutrality expenditure caps plus | 0 percent |

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

61. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period, the budget neutrality expenditure limit has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

VIII. EVALUATION OF THE DEMONSTRATION

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

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

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

64. Final Evaluation Plan and Implementation.

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

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

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

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

ATTACHMENT A

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

PAC Program Benefits

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

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

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

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

ATTACHMENT A

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

REM Program Benefits

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

- Chiropractic services for over 21*
- Dental coverage for over 21*
- Nutritional counseling for over 21*
- Nutritional supplements
- Physician participation in development of a treatment plan
- Occupational therapy for over 21*
- Speech, Hearing and Language services for over 21*
- Shift nursing services for over 21*
- Certified nursing assistant for over 21*
- Home health aide for over 21*
- Private duty nursing for dually eligible Medicaid and Medicare services

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

ICS Program Benefits

The ICS Program provides home and community-based services in addition to those authorized under the State plan. These include:

Assisted Living

Assistive Technology

Attendant Care

Behavior Consultation

Case Management

Dietitian / Nutritionist Services

Environmental Accessibility Adaptations/Modifications

Environmental Assessments

Family and Consumer Training

Fiscal Intermediary Services for individuals who self-direct attendant care services

Home-Delivered Meals

Medical Day Care

Nurse Supervision

Personal Emergency Response System

Senior Center Plus

ATTACHMENT B
Quarterly Operational Report Format

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

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

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

NARRATIVE REPORT FORMAT:

Title Line One - Maryland HealthChoice Demonstration

Title Line Two- Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 12 (July 1, 2011, through June 30, 2012)

Federal Fiscal Quarter: 4/2011 (7/1/2011 - 9/30/2011)

Introduction

Information describing the goal of the Demonstration, what it does, and key dates of approval/operation.

(This should be the same for each report.)

Enrollment Information

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

Enrollment Counts

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

| Demonstration Populations (as hard coded in the CMS 64) | Previous Quarter (last day of previous quarter) | Current Enrollees (to date) |
|--|--|--|
| TANF Adults Thru 29 | | |
| TANF Children Thru 29 | | |
| TANF Adults 30-116 | | |
| TANF Children 30-116 | | |
| SSI/BD Adults | | |

ATTACHMENT B
Quarterly Operational Report Format

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

Outreach/Innovative Activities

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

Operational/Policy Developments/Issues

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

Family Planning Program

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

REM Program

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

PAC Program

- Enrollment Activities and/or Backlog
- Benefit Expansion Status

ICS Program

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

MCHP and MCHP Premium Status/Update/Projections

ATTACHMENT B
Quarterly Operational Report Format

Expenditure Containment Initiatives

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

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting

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

A. For Use in Budget Neutrality Calculations

| Eligibility Group | Previous QTR Month 1 | Previous QTR Month 2 | Previous QTR Month 2 | Total For Previous Quarter Ending XX/XX | Current QTR Month 1 | Current QTR Month 2 | Current QTR Month 3 | Total for Quarter Ending XX/XX |
|--------------------------|----------------------|----------------------|----------------------|---|---------------------|---------------------|---------------------|--------------------------------|
| TANF Adults Thru 29 | | | | | | | | |
| TANF Children Thru 29 | | | | | | | | |
| TANF Adults 30-116 | | | | | | | | |
| TANF Children 30-116 | | | | | | | | |
| SSI/BD Adults | | | | | | | | |
| SSI/BD Children | | | | | | | | |
| Medically Needy Children | | | | | | | | |
| SOBRA Adults | | | | | | | | |
| SOBRA Children | | | | | | | | |
| MCHP | | | | | | | | |
| MCHP Premium | | | | | | | | |
| Family Planning Program | | | | | | | | |

B. For informational Purposes Only

ATTACHMENT B
Quarterly Operational Report Format

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

Consumer Issues

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

Legislative Update

Discussion of health care initiatives, funding for PAC expansion status, or other pertinent pending legislation.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

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

State Contact(s)

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

Date Submitted to CMS

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health and Mental Hygiene

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Maryland for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration extension, be regarded as expenditures under the State's title XIX plan.

The following expenditure authority shall enable Maryland to operate its section 1115 Medicaid HealthChoice Demonstration.

- 1. Demonstration Population 13 [Primary Adult Care (PAC)].** Expenditures on behalf of childless and non-custodial adults ages 19 and above, not otherwise eligible for Medicaid, Medicare or the Children's Health Insurance Program (CHIP), with incomes at or below 116 percent of the Federal poverty level (FPL).
- 2. Demonstration Population 14 [Family Planning].** Expenditures for family planning and family planning related services for women, of childbearing age, who are not otherwise eligible for Medicaid, the PAC program, or Medicare, and are:
 - a. Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum (e.g. SOBRA women) and who have income at or below 200 percent of the FPL at the time of annual redetermination; or
 - b. Beginning, January 1, 2012, all women of childbearing age, who have income at or below 200 percent of the FPL.
- 3. Demonstration Population 15 [Increasing Community Services].** Expenditures for home and community-based services provided to individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the State plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, subject to the following conditions:
 - 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.

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

- 4. Medicaid Eligibility Quality Control.** Expenditures that would have been disallowed as erroneous excess payments under section 1903(u) of the Act.
- 5. 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.
- 6. Demonstration Operations.** Expenditures for capitation payments made to managed care organizations (MCOs) under a contract that does not require the MCO to:
 - a. Provide an enrollee with the disenrollment rights required by sections 1903(m)(2)(A)(vi) and 1932(a)(4) of the Act, when the enrollee is automatically re-enrolled into the enrollee's prior MCO after an eligibility lapse of no more than 120 days.
 - b. Enforce the requirement that an enrollee's verbal appeal be confirmed in writing as specified in sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 42 CFR 438.402(b)(3)(ii) and 42 CFR 438.406(b)(1).
 - c. Send a written notice of action for a denial of payment [as specified in 42 CFR 438.400(b)(3)] when the beneficiary has no liability, as required by sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 438.404(c)(2).

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Demonstration Populations 13 and 14.

Title XIX Requirements Not Applicable to Demonstration Populations 13 and 14 and 15:

Amount, Duration, and Scope

Section 1902(a)(10)(B)

To enable the State to provide a limited benefit package to demonstration participants in the limited benefit family planning, PAC and ICS program.

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

Section 1902(a)(15)

To enable the State to establish reimbursement levels to these clinics for a limited benefit package provided to PAC program participants, which is different from reimbursement levels established by the prospective payment system.

To enable the State to establish reimbursement levels to these clinics that would compensate them solely for family planning and family planning-related services rendered only to women enrolled in Demonstration Population 14.

Retroactive Eligibility

Section 1902(a)(34)

To exempt the State from extending eligibility prior to the date of application for Demonstration Populations 13 and 14.

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

Section 1902(a)(43)

To exempt the State from furnishing or arranging for EPSDT services for Demonstration Population 13 who are ages 19 or 20, and for Demonstration Population 14.

Title XIX Requirements Not Applicable to Demonstration Population 13 only:

Cost Sharing and Denial of Service

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

To enable the State to allow pharmacy providers to deny service to enrollees for failure to pay the required cost sharing for pharmacy services.

Reasonable Promptness

Section 1902(a)(3) and 1902(a)(8)

To enable the State to implement an enrollment cap for the PAC Demonstration Population.

Title XIX Requirements Not Applicable to Demonstration Population 14 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 (individual under the age of 18) eligibility.

**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 beginning July 1, 2011, through December 31, 2013. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

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

| | |
|---------------------------------------|---|
| Presumptive Eligibility Option | Section 1902(a)(47) insofar as it incorporates sections 1920 and 1920A |
|---------------------------------------|---|

To permit the State to provide presumptive eligibility for pregnant women and children using a method for determining presumptive eligibility that is not in accordance with sections 1920 and 1920A.

| | |
|---|---|
| Reasonable Promptness Providing Medical Assistance | Section 1902(a)(8) Section 1902(a)(10)(A)(ii)(XIV) |
|---|---|

To enable the State to delay the provision of medical assistance with reasonable promptness to optional targeted low income children, who are not 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), whose creditable health insurance coverage was voluntarily terminated during the 6-month period prior to an application for such assistance. The delay is in order for the State to impose a 6-month period of uninsurance before an optional targeted low-child is considered eligible for medical assistance if the child's private health insurance was voluntarily terminated in the 6 months prior to the child's application for assistance.

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

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

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

- a. To enable the State to restrict freedom of choice of provider, other than for family planning services, for children with special needs, as identified in section 1932(a)(2)(A)(i-v) of the Act, who are participants in the Demonstration.
- b. To enable the State to require that all populations participating in the Demonstration receive outpatient mental health services from providers with the public mental health system.

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

To exempt the State from extending eligibility prior to the date of application to optional targeted low-income children, except for infants under age 1 described in subsection 1902(a)(10)(A)(i)(IV), or children described in subsections 1902(a)(10)(A)(i)(VI) or 1902(a)(10)(A)(i)(VII).

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



Children and Adults Health Programs Group

July 12, 2013

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

Dear Mr. Milligan:

Thank you for your recent request to extend the state's HealthChoice section 1115 demonstration (11-W-00099/3). The Centers for Medicare & Medicaid Services (CMS) received your extension request on June 28, 2013. We have completed a preliminary review of the application and have determined that the state's extension request has met the requirements for a complete extension request as specified under section 42 CFR 431.412(c).

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the state's extension request. The documents will be posted on [Medicaid.gov](http://medicaid.gov) and the comment period will last 30 days. The state's extension request is available at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

We look forward to working with you and your staff to extend the state's demonstration. If you have additional questions or concerns, please contact your project officer Heather Hostetler, Division of State Demonstrations and Waivers, at (410) 786-4514, or at heather.hostetler@cms.hhs.gov.

Sincerely,

/ s /

Diane T. Gerrits
Division Director

cc: Jennifer Ryan, CMCS
Francis McCullough, ARA, Region III
Andrea Cunningham, Philadelphia Regional Office



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

August 9, 2013

Cindy Mann
Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop S2-26-12
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Mann,

On behalf of the Maryland Medicaid program, I am writing to request two additional waiver authorities to be included in our §1115 HealthChoice renewal application.

Presumptive Eligibility

Starting January 1, 2014, regardless of whether a state has chosen to implement presumptive eligibility for certain eligible populations, participating Medicaid hospitals have the option to elect to become an entity that is qualified to make a presumptive eligibility determination. Maryland does not currently permit presumptive eligibility determinations in its Medicaid program. The Department is concerned about the number of system changes that is required to implement the presumptive eligibility requirements by hospitals. The federal statutory requirement -- 42 CFR § 435.1103(a) -- requires that states only determine pregnant women to be eligible for ambulatory prenatal care during the presumptive eligibility period. The system requirements to assure inpatient stays and other State Plan services are not provided for pregnant women during the presumptive eligibility period are significant. The Department, therefore, requests a waiver to this requirement and that it be allowed to provide the entire State Plan benefit package to pregnant woman.

Rare and Expensive Management Program

The Rare and Expensive Management (REM) program was created in 1997 in the original HealthChoice §1115 waiver. Under REM, individuals with delineated diagnoses may opt out of capitated managed care, and remain in fee-for-service. REM now includes approximately 4,000

Letter to Cindy Mann, Director

August 9, 2013

Page 2

recipients with complex needs. Individuals in the REM program also have a REM case manager to help them navigate across all of their medical providers, such as subspecialty pediatricians, DME, specialists, hospitals, etc. The Department has received strong recommendations from the State's physician association (MedCHI) and the State's chapter of the American Academy of Pediatrics that we should selectively contract with a single REM case management agency. We have been urged to select this single case management agency on the basis of quality, enhanced benefits, past performance, a strong work plan, and other factors. We have taken steps in this direction. At present, the Department currently claims these REM case management services as an administrative expense, not a medical service expense. We have two issues related to the renewal of the §1115 waiver. First, starting January 1, 2014, the Department intends to begin to claim REM case management as a medical service expenditure, rather than as an administrative expenditure. We want to make this switch to clarify that a REM case manager is a provider of services to a REM recipient, and is a patient-advocate for the recipient. The function, in other words, is not administrative case management akin to utilization review. The role properly is described as a service. Second, and related, the Department requests a waiver to 42 CFR § 431.51 which requires a choice of REM case management agency providers. Because we have been strongly urged by physicians and other providers who treat REM recipients to selectively contract with a high-quality REM case management agency that understands and can serve complex populations, the Department would like the authority to selectively contract with a case management agency (that includes many individual case managers) based on its evaluation of how best to assure efficiency and quality of care for REM participants. If the Department completes the award to only one contract, REM recipients would have a choice of case manager providers within that single agency.

I look forward to working with your Administration during the §1115 (HealthChoice) Demonstration Waiver renewal process. Should you have any questions or concerns, please contact our Director of the Planning Administration, Tricia Roddy, via email at tricia.rodny@maryland.gov or via telephone at (410) 767-5809.

Sincerely,

/s/

Charles J. Milligan, Jr.
Deputy Secretary
Health Care Financing

cc: Julie Sharp, CMS
Heather Hostetler, CMS
Andrea Cunningham, CMS



STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua, M. Sharfstein, M.D., Secretary

June 28, 2013

Cindy Mann
Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop S2-26-12
7500 Security Blvd.
Baltimore, MD 21244

Dear Ms. Mann:

The Maryland Department of Health and Mental Hygiene is pleased to submit with this letter the State of Maryland's §1115 Demonstration Waiver Renewal Application (11-W-00099/3). This waiver permits Maryland to operate HealthChoice, its Medicaid managed care program that began in 1997. With this application, Maryland enters its fifth renewal cycle with provisions to meet the requirements of the Affordable Care Act (ACA). This application reflects upon the successes HealthChoice has experienced to date, along with introducing future projects and initiatives that will aid in Maryland's goal to provide quality healthcare for the state's growing Medicaid population.

With the implementation of the ACA, Maryland will expand its Medicaid program to offer coverage to adults with incomes up to 138 percent of the federal poverty level. Maryland also plans to eliminate the waiting period for children eligible for Maryland Children's Health Program services who no longer have coverage under their parents' employer-sponsored insurance. We expect these changes, along with others, to significantly aid in reducing Maryland's uninsured population.

My staff and I look forward to working with your Administration during the §1115 (HealthChoice) Demonstration Waiver renewal process. Should you have any questions or concerns, please contact our Director of the Planning Administration, Tricia Roddy, via email at tricia.rodny@maryland.gov or via telephone at (410) 767-5809.

Sincerely,

/s/

Charles J. Milligan, Jr.
Deputy Secretary
Health Care Financing

cc: Heather Hostetler, CMS
Andrea Cunningham, CMS

Maryland HealthChoice Program
§1115 Waiver Renewal Application

Submitted by
The Maryland Department of Health and
Mental Hygiene

June 28, 2013

HealthChoice §1115 Waiver Renewal Application

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HealthChoice §1115 Waiver Renewal Application

Introduction

The Maryland Department of Health and Mental Hygiene (DHMH) is pleased to submit this Section 1115 waiver renewal application for the HealthChoice program. HealthChoice, Maryland's statewide mandatory Medicaid managed care program, was implemented in 1997 under authority of a waiver through Section 1115 of the Social Security Act. This initial waiver was approved for five years. In January 2002, DHMH completed the first comprehensive evaluation of HealthChoice as part of the first 1115 waiver renewal. The 2002 evaluation examined HealthChoice performance by comparing service use during the program's initial years with utilization during the final year without managed care (fiscal year 1997). The Centers for Medicare and Medicaid Services (CMS) approved subsequent waiver renewals in 2005, 2007, and 2010. The 2010 renewal evaluation focused on the HealthChoice goals of expanding coverage to additional Maryland residents with low income, improving access to care, and improving service quality. Between waiver renewals, DHMH continually monitors HealthChoice performance on a variety of measures and completes an annual evaluation for HealthChoice stakeholders. This renewal period will focus on the changes to the program required under the Affordable Care Act (ACA).

This renewal application includes the following sections:

- A discussion of recent changes to the waiver
- A description of special initiatives in the next renewal period
- A list of requested changes in the next renewal period
- A list and description of the requested waiver and expenditure authorities
- A budget neutrality request and description of financial data demonstrating historical and projected expenditures
- A description of DHMH's public input process
- An evaluation report of the demonstration

Recent Changes to the Waiver

During the last renewal period, DHMH focused on improving access to dental and pregnancy-related services and the behavioral health integration process. DHMH received bonus payments from CMS for implementing initiatives to increase Medicaid enrollment.

Dental Services

Maryland convened a broad array of stakeholders to improve dental access and outcomes for children, pregnant women, and adults enrolled in the Rare and Expensive Case Management Program (REM) program. As a result, several changes were made to the program to improve

dental access. DHMH increased dental fees for preventive and diagnostic services. Dental services were carved out of the managed care organization (MCO) benefit package in July 2009 and are now administered by a single statewide administrative services organization (ASO). In addition, DHMH implemented a fluoride varnish program in medical offices to serve children aged 9 through 36 months. Because of these efforts, the Maryland Healthy Smiles Program received the highest ranking in the nation for providing dental services to low-income participants from The Pew Center for the States in 2010 and 2011.

Family Planning Program

In 2008, CMS required the Family Planning Program to perform annual active redeterminations and to reduce the upper income limit from 250 percent to 200 percent of the federal poverty level (FPL). Beginning in January 2012, Maryland expanded eligibility for the Family Planning Program to include all women less than 51 years of age with household income up to 200 percent of the FPL. It previously only covered women losing pregnancy-related Medicaid eligibility 60 days postpartum for no more than five years.

Accelerated Certification of Eligibility Process

DHMH implemented a procedure for prioritizing Medicaid applications for pregnant women, the Accelerated Certification of Eligibility (ACE) process. This process has alleviated barriers to access to prenatal care by granting temporary eligibility in cases where there is insufficient documentation to make an eligibility determination. Temporary eligibility is granted while the case worker completes the case work within 30 days. These procedures assist the State in meeting Governor O'Malley's initiative to decrease infant mortality in Maryland. The program also collaborates with public health officials at DHMH to implement various strategies that support the Governor's initiative to reduce infant mortality.

REM

During the last waiver renewal, Medicaid expanded access to benefits for individuals in the REM program. Specifically, the State asked for waiver approval from CMS to allow individuals receiving private duty nursing or home health aide services through the REM benefit expansion to remain in the REM program after becoming eligible for Medicare. To qualify, individuals must continue to meet the eligibility diagnosis criteria for REM. Should an individual no longer meet the diagnostic criteria for REM, that individual is disenrolled from REM just as other REM beneficiaries are subject to disenrollment. DHMH plans to continue offering this expanded benefit package to REM enrollees during the next waiver period.

Increased Community Services Program

DHMH has been operating the Increased Community Services (ICS) program since 2009. This innovative program removes the barrier that now prevents certain individuals from moving into the community. Specifically, the ICS program allows individuals residing in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community

while also permitting them to keep income up to 300 percent of SSI. Individuals in the ICS program are an expansion population under the HealthChoice waiver. This population is currently capped at 30 individuals. Seven individuals are currently participating in the program. Although small, the ICS program plays an integral role in allowing these individuals to live in the community. DHMH plans to continue to operate this program during the next waiver period. The program will continue to be limited to 30 individuals; however, the eligibility criteria will be updated for consistency with the federal rules under the Money Follows the Person Demonstration and to allow individuals receiving services through the Living at Home or Older Adults waiver (or a successor waiver to these two waivers) with a 300 percent of SSI income limit to transition directly into the ICS program if their income exceeds 300 percent of SSI by no more than 5 percent. The new eligibility criteria prevent a certain group of individuals at risk of losing their current waiver eligibility because of small cost-of-living adjustment or other small increases in income from having to abandon successful community living arrangements and enter a nursing home in order to regain eligibility for waiver services they currently receive. Specifically, eligibility will be available to an individual who:

- Resides (and has resided for a period of not less than 90 consecutive days) in a nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day nursing home stay requirement and is receiving Medicaid benefits for nursing home services furnished by such nursing facility; or
- Is currently receiving services through the Living at Home or Older Adults waiver, and whose income exceeds the income eligibility threshold by no more than 5 percent, because, for instance, the individual received an automatic cost-of-living adjustment. These individuals would be permitted to transition directly into the ICS program as long as they continued to meet the nursing home level-of-care standard. The 90-day nursing home stay requirement would not apply to these individuals.

CHIPRA Bonus Payments

Maryland received three performance bonus payments from CMS, authorized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Bonus payments are granted to states that implemented at least five CMS-identified initiatives known to promote enrollment and retention in coverage for children and have demonstrated a significant increase in Medicaid enrollment among children. Maryland's first bonus payment was \$10.5 million for federal fiscal year (FFY) 2010, and the bonus payment was \$28.0 million for FFY 2011. Maryland's payment will be \$36.5 million for FFY 2012. FFY 2013 will be the last year that states can qualify for bonus payments.

A Look at the Next Renewal Period

Improving Quality of Care

The HealthChoice program works to improve the quality of health services delivered. DHMH has an extensive system for quality measurement and improvement that uses nationally recognized performance standards. Quality activities include the External Quality Review Organization (EQRO) Systems Performance Review, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, the value-based purchasing (VBP) program, the Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, a provider satisfaction survey, a HealthChoice consumer report card, annual Performance Improvement Projects (PIPs), and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provider compliance review.¹ As Maryland is pursuing the Medicaid expansion under the ACA, DHMH will be reviewing these performance standards to make sure that they more completely represent the new adult populations.

Behavioral Health Integration

Due to the correlation between mental health and substance use disorders, DHMH began a Behavioral Health Integration stakeholder process in 2011. As part of the fiscal year (FY) 2012 budget, the Maryland General Assembly asked DHMH to convene a workgroup and provide recommendations “to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues.” In making this request, the Maryland General Assembly recognized the current need for improved coordination in Maryland’s approach to individuals with behavioral health conditions.

The process began with Phase 1 in 2011 and involved collaborative work between DHMH, a consultant, and stakeholders in order to assess the strengths and weaknesses in Maryland’s current system. While noting the strengths in the current system, including generally good access in each service domain (mental health, substance use treatment, and somatic care), the resulting report reached five conclusions: (1) benefit design and management across the domains are poorly aligned; (2) purchasing and financing are fragmented; (3) care management is not coordinated; (4) performance and risk are lacking; and (5) care integration needs improvement.

Phase 2 of the process began in early 2012 as DHMH and stakeholders set out to develop a broad financing model to better integrate care across the service domains. Between March and September 2012, DHMH held a series of public stakeholder meetings to inform the selection of a financing model. DHMH accepted comments in writing and in 24 public meetings. After review of the various options, a cross-disciplinary leadership steering committee within DHMH offered its recommendation that Maryland pursue a transformative behavioral health carve-out that combines treatment for specialty mental illness and substance use disorders under the management of a single ASO. On April 12, 2013, Secretary Sharfstein announced the decision to

¹ These reports may be found at <https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/CY%202011.aspx>.

move forward with establishing a performance-based carve-out for substance abuse and mental health services.

In order to implement this model, DHMH will develop a robust Request for Proposals to select an ASO to administer the new carve-out, as well as design the related policy changes in the existing program for MCOs. It is our goal to implement the new system in 2015. As we have done to date, we will continue to collaborate with stakeholders to develop:

- Performance measures
- Shared savings models
- Network adequacy policies
- Quality standards
- Access to care standards
- A financing approach that complements emerging clinical models of integration

Maryland Multi-Payer Patient-Centered Medical Home Program

A patient-centered medical home (PCMH) is a model of care delivery that encourages teamwork and care coordination among clinicians to offer patients better access to services and a greater role in making health care decisions. It is intended to strengthen the patient-provider relationship, as well as lower health care costs. In 2011, Maryland began a three-year pilot to test the use of a PCMH; this pilot is called the Maryland Multi-Payer Patient-Centered Medical Home Program (MMPP). The MMPP provides Maryland patients with many services, such as integrated care plans, chronic disease management, medication reconciliation at every visit, and same-day appointments for urgent matters. Across the State, 52 primary and multispecialty practices and federally qualified health centers are participating in MMPP. These practices are paid through the HealthChoice MCOs and private health insurance carriers. The Maryland Health Care Commission will conduct an evaluation of MMPP to examine if health care quality and outcomes improved and costs were reduced.

Chronic Health Home

In the FY 2013 budget, the Maryland General Assembly set aside funds for the development of a chronic health home demonstration to take advantage of the opportunity in Section 2703 of the ACA. Section 2703 allows states to amend their Medicaid State Plans to offer health homes that provide comprehensive systems of care coordination for participants with two or more defined chronic conditions. Anticipated eligibility for Maryland's chronic health home services will extend to individuals diagnosed with a serious and persistent mental illness, children diagnosed with a serious emotional disturbance, or individuals diagnosed with an opioid substance use disorder along with being at-risk for another chronic condition based on tobacco, alcohol, or other non-opioid substance use.

The sites of care include psychiatric rehabilitation programs (PRPs), mobile treatment services, and opioid maintenance therapy programs. Maryland will require interested sites to enroll as Medicaid providers, receive health home accreditation, and demonstrate capabilities to comply with data collection, reporting, and other technological activities. Providers will receive payments per member per month for performing care management activities related to preventive and health promotion, coordination of care, disease self-management, discharge planning, and patient monitoring, among other activities. Maryland will evaluate providers based on a combination of monitoring hospital and emergency department (ED) admissions, cost savings, HEDIS measures, and other measures to be defined further in the State Plan Amendment. DHMH officially uploaded the chronic health home State Plan Amendment to the CMS system on April 8, 2013, and DHMH plans to submit the application by July 3, 2013.

State Innovation Grant

In February 2013, CMS awarded Maryland with a State Innovation Model (SIM) design award of up to \$2.4 million for design activities to occur between April and September 2013. The SIM initiative is providing funding to support the development and testing of state-based models for multi-payer health care delivery and payment system transformation. Maryland is seeking to create a model that integrates patient-centered primary care with innovative community health initiatives. Funds will be used to design a statewide, multi-payer Community-Integrated Medical Home (CIMH) program. The design phase will engage public and private payers and local health improvement coalitions to create a comprehensive plan, establish a governance structure for CIMH, set program standards, and collect baseline data. It is anticipated that these design activities will form a SIM Model Testing grant submission in the spring of 2013. DHMH is leading this initiative, and it will require significant involvement from the Medicaid program.

Covering New Populations

Under the ACA, Maryland will expand its Medicaid program to offer coverage to individuals with incomes up to 138 percent of FPL.² Maryland received guidance from The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) on how the ACA would impact enrollment into the Medicaid program and the Maryland Health Benefit Exchange (MHBE).³ In July 2010, The Hilltop Institute developed a financial model forecasting the fiscal and enrollment effects of Maryland's implementation of the ACA. This model's fiscal estimates were limited to State general funds. The most recent iteration of the model, published in July 2012 for the MHBE, was an expanded analysis to further assess the impact of ACA implementation on Maryland's economy (Fakhraei, 2012).

² The new federal eligibility rules include a 5 percent income disregard, raising the eligibility maximum from 133 to 138 percent FPL.

³ See <http://www.hilltopinstitute.org/publications/MarylandHealthCareReformSimulationModel-July2012.pdf>. To view detailed estimates, go to <http://www.hilltopinstitute.org/publications/SimulationModelProjections-July2012.pdf>.

Pertinent to this evaluation, this model projects a substantial increase in Medicaid enrollment resulting from the expansion of eligibility to 138 percent of the FPL. Between 2014 and 2020, Maryland is estimated to have 187,276 newly eligible individuals enrolled in Medicaid. This represents 73.8 percent of individuals projected to be newly eligible. A significant share of newly eligible individuals will be shifting from the Primary Adult Care (PAC) program (Fakhraei, 2012). Hilltop’s economic model projects State costs for the Medicaid expansion to be \$123 million through 2020. Overall, Maryland’s implementation of the ACA is projected to save between \$504 and \$840 million towards the State budget and lower the unemployment rate to 3.7 percent (Fakhraei, 2012).

Table 1 presents enrollment projections by components of ACA implementation (Medicaid expansion, the Medicaid “woodwork” effect⁴, and the MHBE). By 2020, 471,019 individuals are projected to have new Medicaid or MHBE-based coverage. Conversely, 390,352 individuals are projected to remain uninsured – representing 6.3 percent of Maryland’s total population (Fakhraei, 2012).

Table 1. Total New Medicaid and Exchange Coverage

| | FY 2014 | FY 2015 | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 |
|---|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Medicaid Expansion (Includes PAC Participants) | 90,639 | 112,285 | 119,634 | 126,996 | 133,201 | 138,999 | 143,207 |
| Medicaid "Woodwork" Effect | 11,046 | 23,117 | 32,301 | 40,150 | 41,793 | 42,956 | 44,069 |
| Exchange (138 - 200% FPL) with Subsidy | 37,452 | 42,308 | 45,088 | 49,859 | 55,823 | 61,336 | 67,249 |
| Exchange (200 - 400% FPL) with Subsidy | 67,289 | 77,937 | 84,888 | 96,245 | 108,691 | 119,423 | 131,508 |
| Exchange (Above 400%) without Subsidy | 34,023 | 41,038 | 44,240 | 51,903 | 60,066 | 66,974 | 74,829 |
| Small Business Health Options Program (SHOP) | 8,469 | 8,553 | 10,107 | 10,138 | 10,141 | 10,137 | 10,157 |
| Total New Medicaid and Exchange Coverage | 248,918 | 305,238 | 336,258 | 375,291 | 409,715 | 439,825 | 471,019 |

Request to Waive Title XIX Requirements: New Provisions

1. New Childless Adult Population

With the implementation of health care reform, DHMH will no longer need to operate the PAC program. Rather, childless adults under the age of 65 and with incomes up to 138 percent of the FPL will receive full Medicaid benefits. Because the ACA explicitly permits states to cover this childless adult population, Maryland will no longer have to use budget neutrality savings from

⁴ The “woodwork” effect is comprised of individuals currently eligible but not enrolled in Medicaid, but are likely to enroll with Maryland’s implementation of ACA. For these individuals, the federal match rate is 50 percent.

the HealthChoice 1115 waiver to receive federal matching dollars. This population will remain covered under the HealthChoice 1115 waiver because services will be provided through HealthChoice MCOs. Accordingly, DHMH seeks to move this new childless adult population under the waiver and to remove the PAC program as an expansion population.

2. Pregnant Women

Despite the ACA option of lowering the income limit to 185 percent of the FPL, DHMH will continue to cover pregnant women with income up to 250 percent of the FPL. Women with incomes between 138 and 250 percent of the FPL will receive health care coverage through qualified health plans. Once pregnant, women within these income groups will receive their services through Medicaid. Eligibility will continue through 60 days of postpartum care and includes full Medicaid benefits and dental services.⁵

DHMH considered offering premium assistance to pregnant woman in order to help them maintain provider continuity of care. To meet the pending deadline of January 1, 2014, however, Maryland decided it cannot pursue a premium assistance program for pregnant women. This decision was also influenced by the lack of final federal rules and Maryland's need to finalize eligibility system programming changes. DHMH will cover pregnant women who are not eligible for or receiving advanced premium tax credits.

Maryland does not anticipate needing any specific waivers to cover pregnant women. But if the final federal rules do not match the current eligibility rules programmed into our system, we may need to seek waiver authority in the future.

3. Family Planning Program

DHMH requests that the Maryland Family Planning Program be accorded one additional transition year—from January 1, 2014, to January 1, 2015—to convert income limits to the modified adjusted gross income (MAGI).

Eligibility determinations for the Family Planning Program will be made outside of the Maryland Health Insurance Exchange (HIX). For the Family Planning Program to operate outside of HIX and be converted to MAGI by October 2013, DHMH anticipates substantial changes to the current eligibility system of record. In addition, the program application and outreach materials must reflect the new eligibility rules, and DHMH must train current eligibility staff on these new rules. These changes will require a significant level of effort by the operations and eligibility staff. As you may know, staff resources are severely limited as Maryland prepares to implement the broader health reform changes that become effective in January 2014. Accordingly, additional time is needed to accomplish the MAGI conversion for the Family Planning Program.

⁵ Dental services will discontinue after giving birth.

4. Breast and Cervical Cancer Program

Maryland is requesting permission to continue providing coverage to women who are currently receiving coverage under the federal Breast and Cervical Cancer Prevention and Treatment Act. The program serves women with incomes up to 250 percent of the FPL. As of March 2013, 479 women were enrolled in the program. Any new applicants who are not enrolled in the program on January 1, 2014, will not be found to be eligible. Medicaid will now be covering childless adults up to 138 percent of the FPL, and individuals between 138 percent and 400 percent of the FPL will be eligible for new advanced premium tax credits and cost sharing subsidies through the Exchange. Additionally, insurers in the individual and group markets will be prohibited from imposing pre-existing condition exclusions. In short, DHMH will no longer cover new enrollees but the provisions in the ACA provide individuals served under the Breast and Cervical Cancer Program with other alternatives. Maryland, however, does not want to discontinue Medicaid coverage for women currently in active treatment programs for breast and cervical cancer. So for continuity of care issues, Maryland will grandfather-in existing enrollees.

5. Alternative Benefit Package

Maryland is seeking a waiver to proposed 42 C.F.R §440.345. Specifically, Maryland is requesting that its existing Medicaid benefit package be deemed to meet the alternative benefit plan standards under the Secretary-approved coverage option, without having to supplement benefits from the essential health benefit (EHB) benchmark options.

The proposed rules (42 C.F.R. §440.345) indicate that states will be required to offer EHBs to the newly eligible Medicaid expansion population. This is very problematic for several reasons. Prior to this guidance, Maryland had intended to offer the existing Medicaid State Plan benefit package to the newly eligible population, and Medicaid had planned and budgeted accordingly. In comparing the State Plan services to the EHB benchmark options, Maryland found that the benchmark covers services beyond the State Plan (some of which are ineligible for federal financial participation under the Hyde Amendment). Supplementing coverage will present a series of challenges. For services that are not presently covered, Medicaid would need to enroll new providers, set reimbursement rates, design claims and payment rules, incorporate those rules into Medicaid systems, determine whether the services should be delivered through managed care, and, if the services are delivered in managed care, incorporate the cost of those services into capitation rates. This is not an exclusive list of activities that Medicaid would have to complete in order to realize coverage for new services. There will be a large administrative burden in expanding the benefit package.

Further, the guidance suggests that the policy only applies to the newly eligible category of adults. This creates a situation in which the higher income expansion population would receive a more generous benefit package than the existing populations. These disparities in coverage will create a churn point of covered services within Medicaid. This means that states will likely have to expand coverage for all adult populations to prevent benefit churn. There would be a significant financial cost to states to expand benefits for all adults, as new benefits for the existing population are ineligible for the enhanced matching offered under the ACA for the

newly eligible expansion population. This would have a major impact on the State Medicaid budget. Therefore, Maryland is requesting that its existing Medicaid benefit package be deemed to meet the alternative benefit plan standards under the Secretary-approved coverage option, without having to supplement benefits from the EHB benchmark options. The Secretary has already approved the State Plan benefit package as adequate for the existing low-income Medicaid populations. Thus, it should be adequate for the newly eligible population.

6. Redetermination Option

On May 17, 2013, CMS released a State Health Official letter (SHO#13-003) on *Facilitating Medicaid and CHIP Enrollment and Renewal in 2014*. This letter outlined optional strategies that states may use to help manage the transition to their new eligibility and enrollment systems and coverage of new Medicaid enrollees. Maryland is requesting authority under section 1902(e)(14)(A) to implement Strategy 2, *extending the Medicaid renewal period so that renewals that would otherwise occur during the first quarter of 2014 (January 1, 2014 to March 31, 2014) occur later*. This strategy will allow Maryland to avoid operating two sets of eligibility rules during this time period and ease some of the burden on the new eligibility determination system. Maryland is requesting to delay renewals scheduled to occur between January and March 2014 by 90 days. For example, renewals scheduled for January 2014 will be delayed until April 2014.

Request to Waive Title XIX Requirements

The following table summarizes the current waiver provisions and whether or not DHMH is requesting to continue these provisions in the next renewal period.

| Current Terms and Conditions | Keep / Remove |
|--|---------------|
| Demonstration Population 13 (PAC) | Remove |
| Demonstration Population 14 (Family Planning) <ul style="list-style-type: none"> • Waiver to Section 1902(a)(10)(B) – to allow the State to offer limited benefit • Waiver to Section 1902(a)(34) - to exempt the State from extending eligibility prior to the date of application • Waiver to 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 • Waiver to 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 | Keep |
| Demonstration Population 15 (Increased Community Services) <ul style="list-style-type: none"> • Allow the program to be capped at 30 individuals | Keep |
| REM Benefits – Include expenditures for benefits not under the State Plan and allow individuals receiving private duty nursing | Keep |

| Current Terms and Conditions | Keep / Remove |
|---|---|
| <p>and shift home health aide services who become Medicare eligible to stay in the program if they continue to meet the REM diagnostic eligibility criteria until age 65</p> <ul style="list-style-type: none"> • Waiver to Section 1902(a)(10)(B) – to enable the State to provide benefits specified in the special terms and conditions to Demonstration participants in the Rare and Expensive Case Management program which are not available to other individuals under the Medicaid State plan. | |
| <p>Do not require the MCO to:</p> <ol style="list-style-type: none"> 1. Provide an enrollee with the disenrollment rights required by sections 1903 (m)(2)(A)(vi) and 1932(a)(4) of the Act, when the enrollee is automatically re-enrolled into the enrollee’s prior MCO after an eligibility lapse of no more than 120 days. 2. 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) 3. 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) | <p>Keep: To maintain continuity of care the State requires that individuals who lose Medicaid eligibility for a period of 120 days or less be automatically reenrolled in an MCO.</p> <p>Currently, DHMH does not require that appeals be submitted in writing and neither DHMH nor the MCOs require a signature. In order to maintain continuity of care, we request the provision be waived. Requiring written appeals and signatures would delay processing and resolution of grievances, as well as deter enrollees from filing appeals.</p> <p>Currently, at the time the inquiry is made to the MCO, the MCO representative completes the appeal form for the enrollee; no enrollee signature is required. In order to maintain continuity of care, we request the provision be waived. Requiring written appeals and signatures would delay processing and resolution of grievances, as well as deter enrollees from filing appeals.</p> |
| <p>Reasonable promptness Section 1902(a)(8) Providing Medical Assistance Section 1902(a)(10)(A)(ii)(XIV) – 6-month waiting period for CHIP kids</p> | <p>Remove: DHMH will not require children to wait 6-months after dropping employer-sponsored</p> |

| Current Terms and Conditions | Keep / Remove |
|--|--|
| | coverage to gain eligibility |
| <p>Freedom of Choice Section 1902(a)(23)(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</p> <p>1932(a)(2)(A)(i-v) of the Act, who are participants in the Demonstration</p> <p>To enable the State to require that all populations participating in the Demonstration receive outpatient mental health services from providers with the public mental health system.</p> | Keep |
| <p>Retroactive Eligibility Section 1902(a)(34)</p> <p>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)</p> | <p>Keep: Currently, there is no retroactivity coverage or fee-for-service period for MCHP Premium. MCHP Premium coverage begins once a child is enrolled in an MCO. As of January 1, 2014, the fee-for-service period will be effective on the first day of the month in which the child is found eligible for MCHP Premium until the child is enrolled in an MCO. Retroactivity coverage will not be available for this population.</p> |
| <p>Presumptive Eligibility Option Section 1902(a)(47) insofar as it incorporates sections 1920 and 1920A</p> <p>To permit the State to provide presumptive eligibility for pregnant women and children using a method for determining presumptive eligibility that is not in accordance with sections 1920 and 1920A.</p> | <p>Keep: DHMH will continue to operate the ACE process for pregnant women</p> |

Financing

Section 1115 waivers require states to demonstrate that actual expenditures do not exceed certain cost thresholds. *i.e.*, they may not exceed what the costs of providing those services would have been under a traditional Medicaid FFS program.

Attachment 1 shows that HealthChoice has met this condition and generated savings for both the State and Federal governments. On January 1, 2014, a significant number of Maryland residents will be eligible for Medicaid coverage or health care subsidies through the Exchange. DHMH requests to maintain the existing monthly capitation and trend rates for the current populations eligible today given these significant policy changes.

DHMH is also requesting several changes to the Medicaid eligibility groups (MEGs) as a result of the ACA/expansion implementation. Specifically, DHMH requests the following:

- Create a new eligibility group for expansion parents with income between 116 and 138 percent of the FPL. DHMH requests the same monthly capitation rate as the Temporary Assistance for Needy Families (TANF) parents, \$809.25.
- Remove the PAC program eligibility group.
- Create a new eligibility group for childless adults with income up to 138 percent of the FPL. DHMH requests a monthly capitation rate of \$892.
- Collapse the two TANF adult eligibility groups (one for adults below 30 percent of the FPL and one for adults between 30 and 116 percent of the FPL) into one coverage group for TANF parents with income up to 116 percent of the FPL. DHMH requests a monthly capitation rate of \$809.25. This figure was derived by blending the current rates based on member months.
- Collapse three children's eligibility groups (TANF children below 30 percent of the FPL, TANF children between 30 and 116 percent of the FPL, and SOBRA children) into one coverage group for children up to 21 years of age. DHMH requests a monthly capitation rate of \$445.05. This figure was derived by blending the current rates based on member months.
- The Breast and Cervical Cancer Program and ICS will operate as expansion programs under the waiver.

Attachment 2 highlights our capitation and trend rate request by MEG.

Public Process and Indian Consultation Requirements

DHMH engaged stakeholder participation and provided public notice of this renewal application per the requirements in 45 C.F.R. §431.408. DHMH provided a 30-day public notice and comment period May 3, 2013, through June 3, 2013. This notice was published in *The Maryland Register* on May 3, 2013. DHMH also published an abbreviated version on its website on April 22, 2013.

In addition to publishing these notices, DHMH conducted two public hearings on the renewal application. The first hearing was held on April 25, 2013, in Baltimore subsequent to the Maryland Medicaid Advisory Committee (MMAC) meeting. This hearing was accessible by webinar and audio conference. The second hearing was held on May 9, 2013, in Annapolis. During these hearings, DHMH presented the renewal application and accepted comments from stakeholders. See Appendix A for a summary of the comments raised by the public.

Beyond these requirements, DHMH continually engages stakeholder consultation on the HealthChoice program through the MMAC. The MMAC meets monthly and receives reports on regulatory and waiver changes, including amendments to the 1115 waiver. Annually, the MMAC

provides feedback on the HealthChoice evaluation report. The MMAC also provides extensive input and feedback on the evaluation outline submitted to CMS.

Finally, on April 8, 2013, DHMH sent a draft of the complete 1115 renewal application to Kerry Oberdalhoff of the Office of Urban Indian Health Programs in Maryland for input and comments. The Office approved the application with no additional questions or comments. See Attachment 3 for documentation of the public process.

Evaluation

This section serves as the evaluation required for the renewal request and seeks to address:

- Coverage and access to care
- The extent to which HealthChoice provides a medical home and continuity of care
- The quality of care delivered to participants
- Program financing and budget neutrality
- Special topics, including dental services, behavioral health care, services provided to children in foster care, reproductive health services, REM program, and racial/ethnic disparities in utilization
- Access and quality of care under the PAC program

As with previous HealthChoice evaluations and renewal applications, this renewal application was conducted collaboratively by DHMH and The Hilltop Institute at the University of Maryland, Baltimore County (UMBC).

Overview of the HealthChoice Program

The HealthChoice managed care program currently enrolls over 80 percent of the State's Medicaid and the Maryland Children's Health Program (MCHP) population. Participants in HealthChoice choose one of eight MCOs and a primary care provider (PCP) from the MCOs' network to oversee their medical care. The groups of Medicaid-eligible individuals who enroll in HealthChoice MCOs include:

- Families with low income that have children
- Families receiving TANF
- Children younger than 19 years eligible for MCHP
- Children in foster care
- Low income women who are pregnant or less than 60-days postpartum
- Individuals receiving SSI who are younger than 65 years and ineligible for Medicare

Not all Maryland Medicaid beneficiaries are enrolled in HealthChoice MCOs. Groups ineligible for MCO enrollment include:

- Medicare beneficiaries
- Individuals aged 65 years and older
- Individuals in a "spend-down" eligibility group who are only eligible for Medicaid for a short period of time

- Individuals who are continuously enrolled in a long-term care facility or an institution for mental illness for over 30 days
- Individuals residing in an intermediate care facility for the mentally retarded
- Those enrolled in the Employed Individuals with Disabilities program
- Refugees and certain categories of aliens

Additional populations covered under the HealthChoice waiver include individuals in the Family Planning, REM, and PAC programs. HealthChoice-eligible individuals with certain diagnoses may choose to receive care on a fee-for-service (FFS) basis through the REM program. Family Planning and PAC are both limited benefit packages under the waiver. REM and Family Planning are further discussed in Section IV of this report, and PAC is included in Section V.

HealthChoice participants receive the same comprehensive benefits as those available to Maryland Medicaid participants through the FFS system. Services in the MCO benefit package include, but are not limited to:

- Inpatient and outpatient hospital care
- Physician care
- Clinic services
- Laboratory and x-ray services
- EPSDT services for children
- Prescription drugs, with the exception of mental health and HIV/AIDS drugs, which are provided under the FFS system
- Substance abuse treatment services
- Durable medical equipment and disposable medical supplies
- Home health care
- Vision services
- Dialysis
- The first 30 days of care in a nursing home

Some services are carved out of the MCO benefit package and instead are covered by the Medicaid FFS system. These include:

- Specialty mental health care, which is administered by the DHMH Mental Hygiene Administration
- Dental care for children, pregnant women, and adults in the REM program

- Health-related services and targeted case management services provided to children when the services are specified in the child's Individualized Education Plan or Individualized Family Service Plan
- Therapy services (occupational, physical, speech, and audiology) for children
- Personal care services
- Long-term care services after the first 30 days of care (individuals in long-term care facilities for more than 30 days are disenrolled from HealthChoice)
- Viral load testing services, genotypic, phenotypic, or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS
- HIV/AIDS drugs and specialty mental health drugs
- Services covered under 1915(c) home and community-based services waivers

Section I. Coverage and Access

Two of the goals of the HealthChoice program are to expand coverage to additional residents with low income through resources generated from managed care efficiencies and to improve access to health care services for the Medicaid/MCHP population. This section of the report addresses Maryland's progress in achieving these coverage and access goals. Coverage is examined through several enrollment measures. Access to care is measured by provider network adequacy, ambulatory care service utilization, ED service utilization, and enrollee survey results.

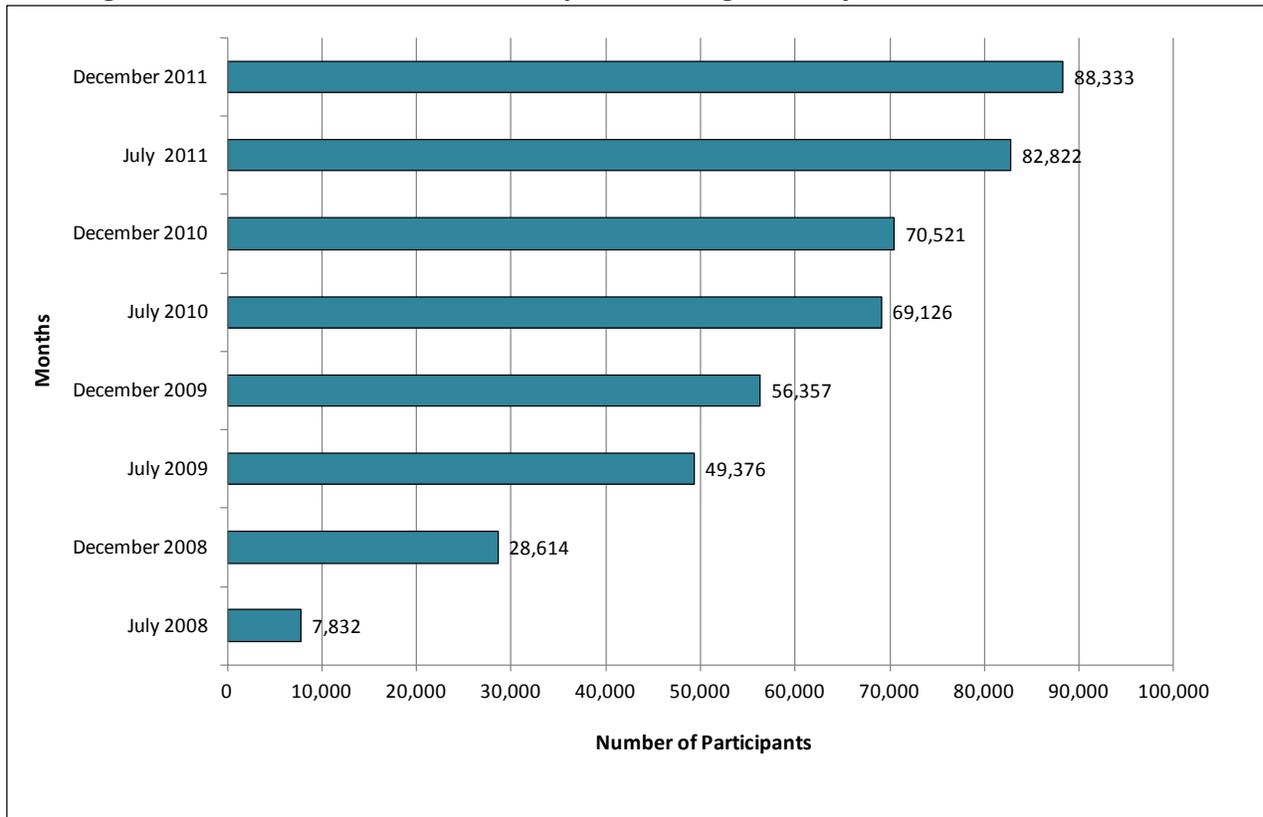
Are More Marylanders Covered?

Major Expansion Initiatives

Maryland has recently engaged in several efforts to increase Medicaid enrollment. Legislation and grant awards have increased DHMH's capacity to enroll uninsured children and adults in programs for which they might be eligible. The most successful of these expansion efforts was the increase in income eligibility for families in Medicaid. Effective July 1, 2008, Maryland expanded the eligibility thresholds for parents and caretaker relatives of children enrolled in Medicaid or MCHP from approximately 40 percent of the FPL to 116 percent of the FPL.

The eligibility expansion occurred at the same time that the economy slipped into recession, resulting in a dramatic increase in enrollment. Figure 1 presents the monthly enrollment in this parent expansion program beginning in July 2008. Enrollment increased from 7,832 participants in July 2008 to 88,333 participants in December 2011.

Figure 1. Enrollment in the Parent Expansion Program, July 2008 – December 2011



Health Choice Enrollment

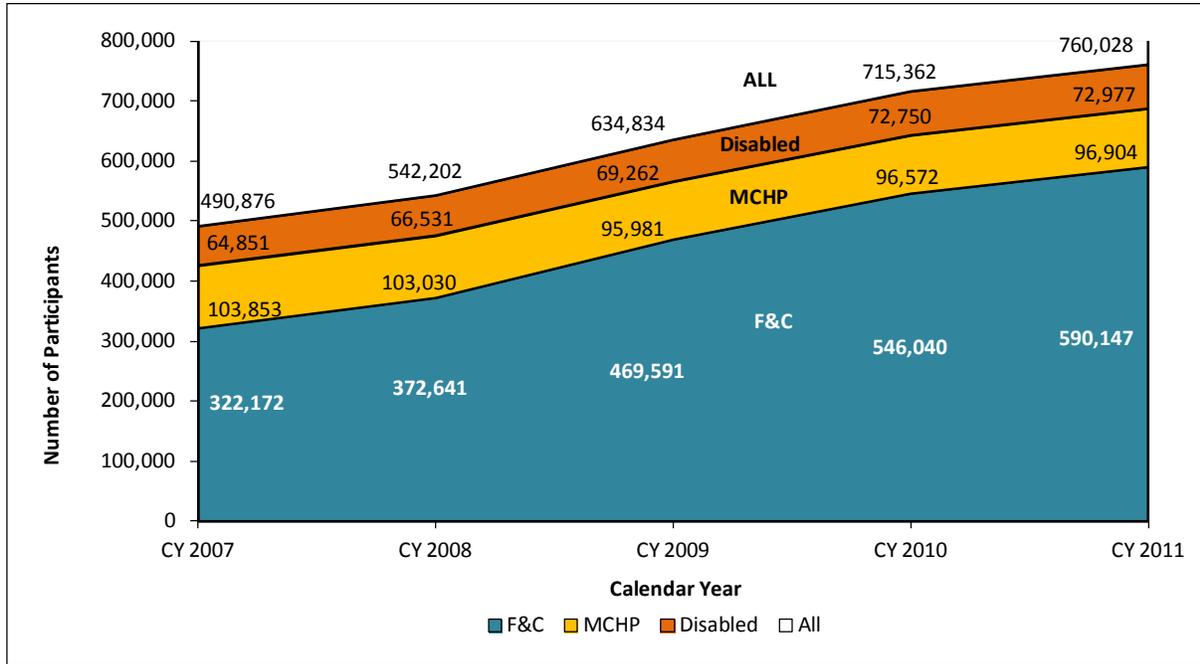
There are several methods available for measuring HealthChoice enrollment. One methodology is to count the number of individuals with any period of enrollment during a given calendar year (CY), including individuals who were only enrolled for a very short period of time. Another method is to count individuals who were enrolled at a certain point in time. Although this yields a smaller number, it provides a snapshot of typical program enrollment on a given day. Unless specified otherwise, the enrollment data in this section of the report use the point-in-time methodology to reflect enrollment as of December 31 of the measurement year.⁶

The overall HealthChoice population grew by nearly 55 percent between CY 2007 and CY 2011 (Figure 2). Most of the enrollment increase occurred between CY 2008 and CY 2009 when HealthChoice grew by more than 17 percent (92,632 new participants). A key factor in this enrollment growth was the expansion of Medicaid eligibility in July 2008. Figure 2 displays HealthChoice enrollment by coverage group between CY 2007 and CY 2011. As of December 31 of each year, most HealthChoice participants were eligible in the families, children, and pregnant women (F&C) category. Overall, F&C enrollment grew by 83 percent between CY

⁶ Enrollment data are presented for individuals aged 0 through 64 years. Age is calculated as of December 31 of the measurement year.

2007 and CY 2011. Individuals with disabilities were the smallest eligibility category in each year under review.⁷

Figure 2. HealthChoice Enrollment by Coverage Group, CY 2007–CY 2011



Enrollment Growth

National enrollment in Medicaid reached an all-time high of 52.6 million by June 2011 (Kaiser Commission on Medicaid and the Uninsured, 2012). According to the Kaiser Commission on Medicaid and the Uninsured, Maryland was one of ten states that accounted for 60 percent of Medicaid enrollment growth between June 2010 and June 2011, and Maryland experienced the seventh highest growth rate of all 50 states and the District of Columbia (2012).

Table 2 shows the percentage of Maryland’s population enrolled in HealthChoice between CY 2007 and CY 2011. These data are presented for individuals enrolled in HealthChoice as of December 31 and for individuals with any period of HealthChoice enrollment. The percentage with any period of HealthChoice enrollment remained at 11 percent between CY 2007 and CY 2008 and increased to 15 percent by CY 2011.

⁷ Individuals who are covered under both Medicare and Medicaid programs are not enrolled in HealthChoice.

Table 2. HealthChoice Enrollment as a Percentage of the Maryland Population, CY 2007 – CY 2011

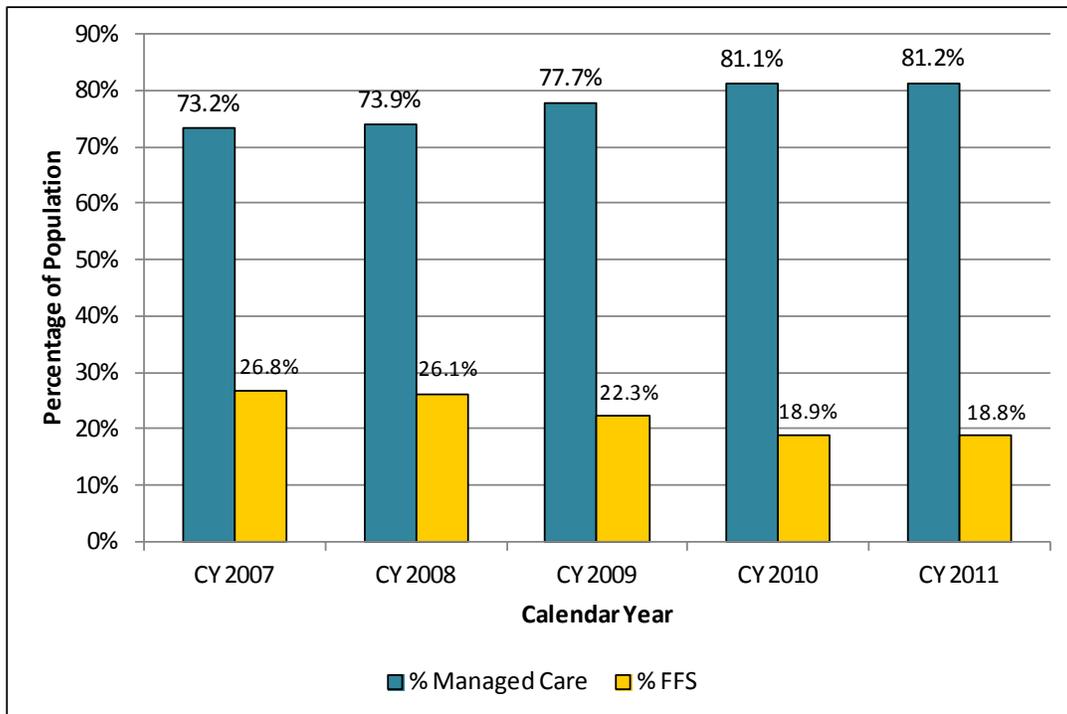
| | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|--|-----------|-----------|-----------|-----------|-----------|
| Maryland Population | 5,634,242 | 5,658,655 | 5,699,478 | 5,773,552 | 5,828,289 |
| Individuals Enrolled in HealthChoice for Any Period of Time During Year | | | | | |
| HealthChoice Population | 623,299 | 654,412 | 743,098 | 832,684 | 893,084 |
| % of Population in HealthChoice | 11.1% | 11.6% | 13.0% | 14.4% | 15.3% |
| Individuals Enrolled in HealthChoice as of December 31 | | | | | |
| HealthChoice Population | 490,876 | 542,202 | 634,834 | 715,362 | 760,028 |
| % of Population in HealthChoice | 8.7% | 9.6% | 11.1% | 12.4% | 13.0% |

* Maryland Population Data Source: United States Census Bureau, 2012; Maryland, Department of Planning, 2010

Are More Maryland Medicaid /MCHP Participants Covered Under Managed Care?

One of the original goals of the HealthChoice program was to enroll most individuals in Medicaid and MCHP into managed care. Figure 3 presents the percentage of Maryland Medicaid/MCHP participants who were enrolled in managed care (including both HealthChoice and PAC MCOs) as compared with FFS enrollment. Between CY 2007 and CY 2011, managed care enrollment increased from 73.2 percent to 81.2 percent.

Figure 3. Percentage of Medicaid/MCHP Participants in Managed Care versus FFS, CY 2007 – CY 2011



Does the Covered Population Access Care?

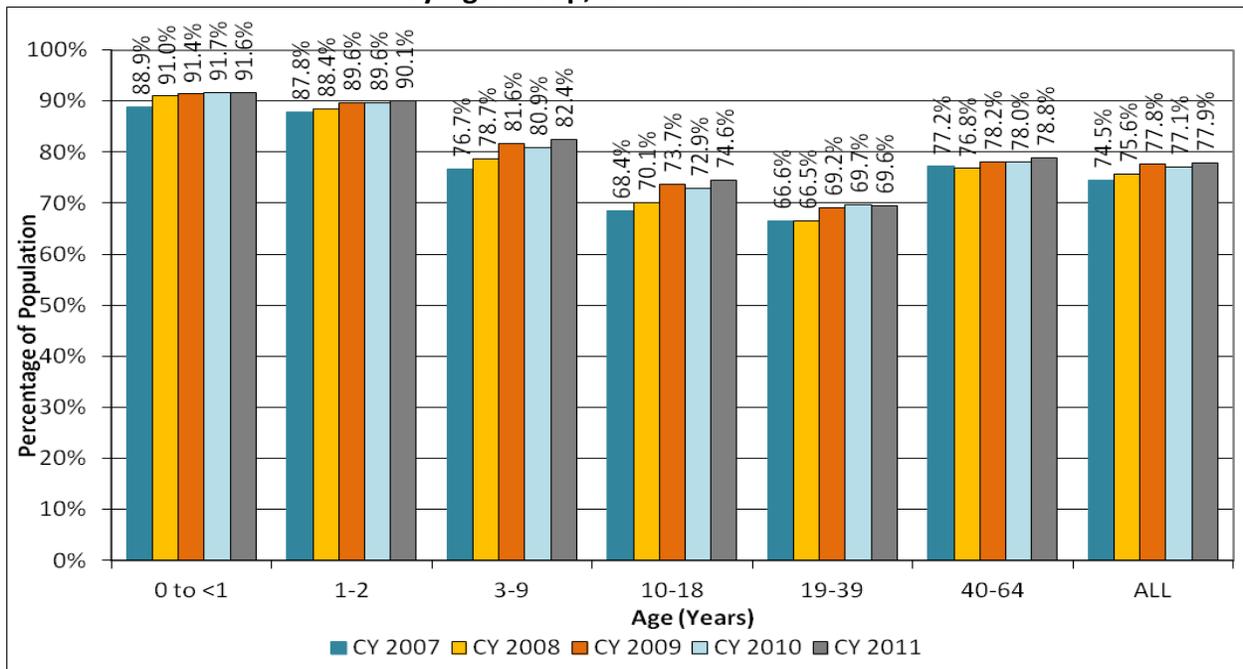
With this increased enrollment, it is important to maintain access to care. This section of the report examines ambulatory care, ED visits, and network adequacy to evaluate access to care. It also discusses results from the CAHPS survey.

Ambulatory Care Visits

DHMH monitors ambulatory care utilization as a measure of access to care. An ambulatory care visit⁸ is defined as a contact with a doctor or nurse practitioner in a clinic, physician’s office, or hospital outpatient department by an individual enrolled in HealthChoice at any time during the measurement year. In this section of the report, ambulatory care visits are measured using MCO and FFS data.

Figure 4 presents the percentage of HealthChoice participants who received an ambulatory care visit during the calendar year by age group. Overall, the ambulatory care visit rate increased from 74.5 percent in CY 2007 to 77.9 percent in CY 2011, and the rate increased for all age groups.

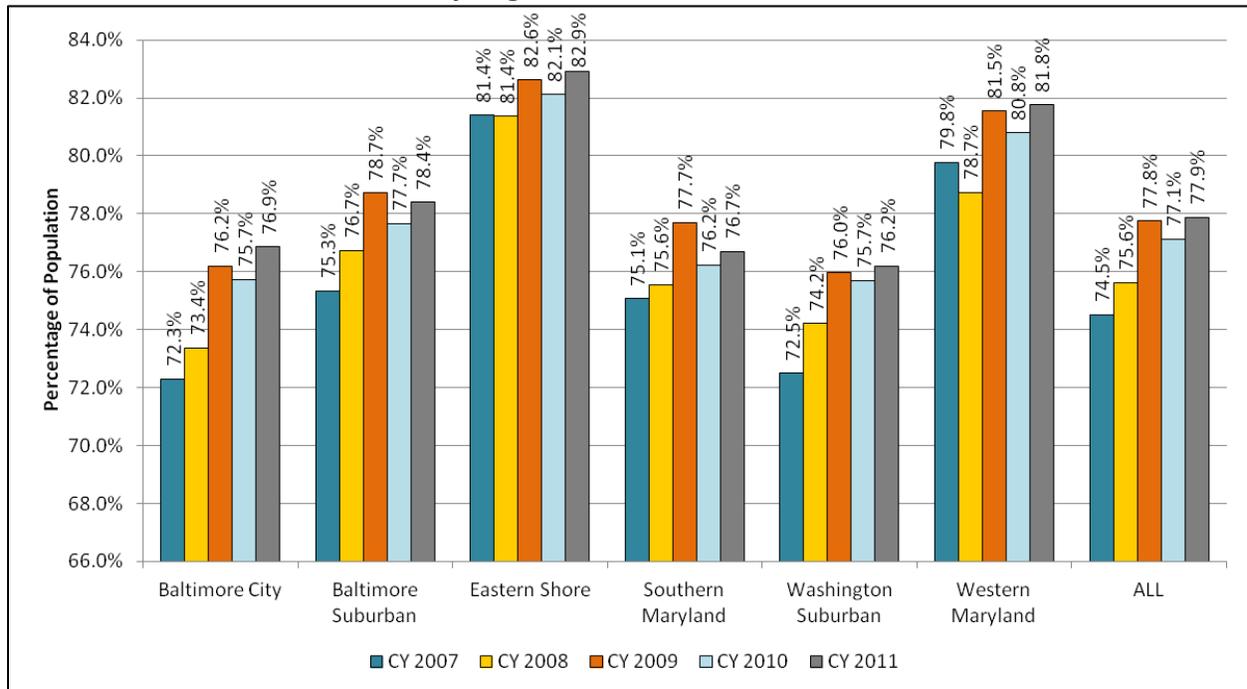
Figure 4. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Age Group, CY 2007 – CY 2011



⁸ This definition excludes ED visits, hospital inpatient services, substance abuse treatment, mental health, home health, x-ray, and laboratory services.

Figure 5 presents the percentage of the HealthChoice population receiving an ambulatory care visit by region. The visit rate increased within each region between CY 2007 and CY 2011, and the Eastern Shore region had the highest percentage each year of the study period.

Figure 5. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Region, CY 2007 – CY 2011



ED Utilization

The primary role of the ED is to treat seriously ill and injured patients. Ideally, ED visits should not occur for conditions that can be treated in an ambulatory care setting. HealthChoice was expected to lower ED use based on the premise that a managed care system is capable of promoting ambulatory and preventive care, thereby reducing the need for emergency services. To assess overall ED utilization, DHMH measures the percentage of individuals with any period of enrollment who visited an ED at least once during the calendar year. This measure excludes ED visits that resulted in an inpatient hospital admission.

Figure 6 presents ED use by coverage group. Overall, ED use among HealthChoice participants increased by 4.3 percentage points between CY 2007 and CY 2011. Participants with disabilities were more likely to utilize ED services than any other coverage group.

Figure 6. Percentage of the HealthChoice Population with at Least One ED Visit by Coverage Group, CY 2007 – CY 2011

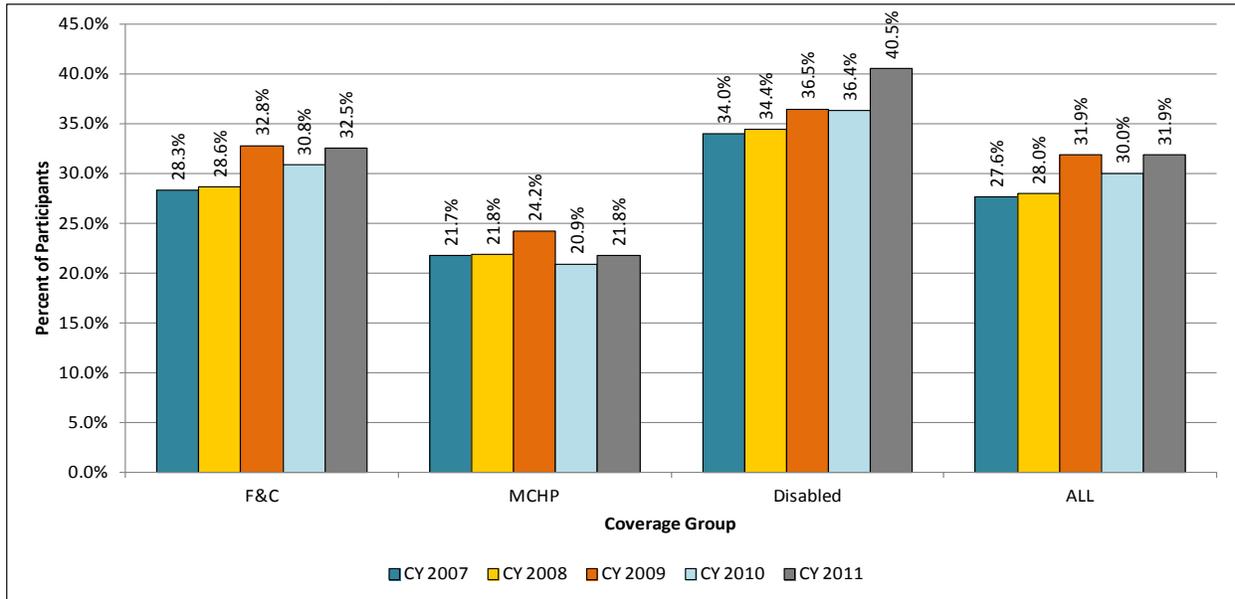
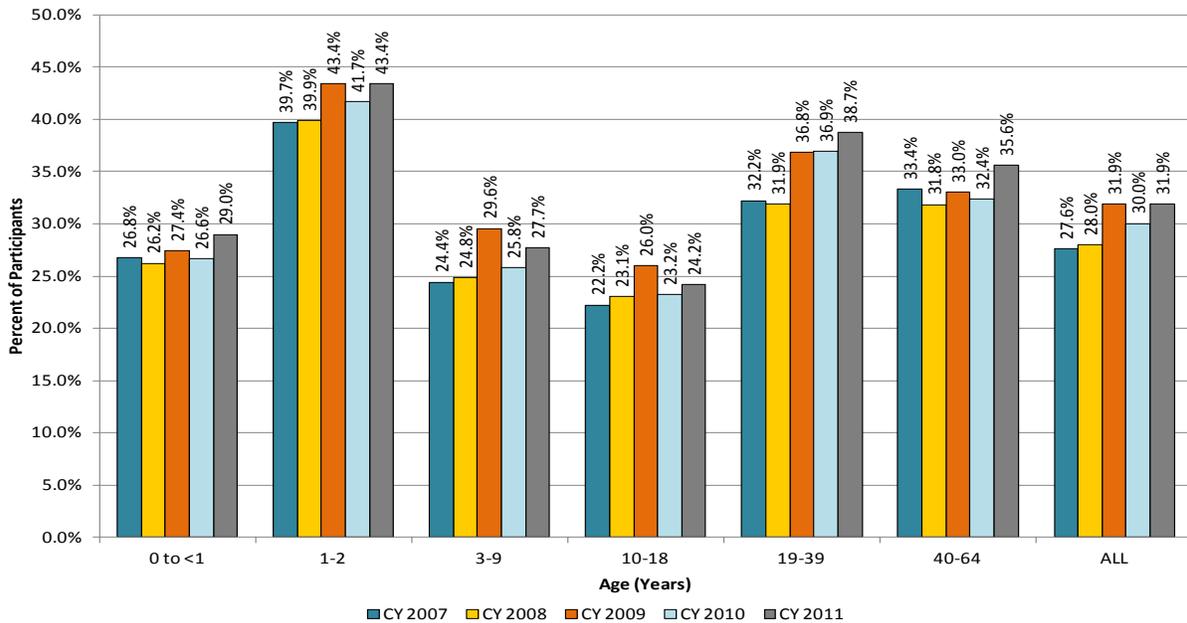


Figure 7 presents ED utilization by age group. Children aged 1 and 2 years consistently had the highest ED utilization throughout the evaluation period.

Figure 7. Percentage of the HealthChoice Population with at least One ED Visit by Age Group, CY 2007 – CY 2011



Are Provider Networks Adequate to Ensure Access?

One method of measuring enrollee access to care is to examine provider network adequacy. This section of the report examines PCP and specialty provider networks.

PCP Network Adequacy

HealthChoice requires every participant to have a PCP, and each MCO must have enough PCPs to serve its enrollee population. HealthChoice regulations require a ratio of 1 PCP to every 200 participants within each of the 40 local access areas (LAAs) in the State. Because some PCPs traditionally serve a high volume of HealthChoice participants at some of their sites (e.g., Federally Qualified Health Center [FQHC] physicians), the regulations permit DHMH to approve a ratio of 2,000 adult participants per high-volume provider and 1,500 participants aged 0 to 21 years per high-volume provider. DHMH assesses network adequacy periodically throughout the year to pinpoint potential network inadequacies and work with the MCOs to resolve capacity issues.

Table 3 shows PCP network adequacy as of September 2012. Two capacity estimates are presented: 200 participants per PCP and 500 participants per PCP. Although regulatory requirements apply to a single MCO, this analysis aggregates data from all seven HealthChoice MCOs. The analysis does not allow a single provider who contracts with multiple MCOs to be counted multiple times; thus, it applies a higher standard than that in regulation.

Table 3.PCP Capacity by Local Access Area, as of September 2012

| Local Access Area | Total PCPs | | | Enrollment | Excess Capacity | |
|---------------------------|-----------------|-------------------|-------------------|-----------------|------------------------|------------------------|
| | September, 2012 | Multiplied by 200 | Multiplied by 500 | September, 2012 | Difference 200:1 Ratio | Difference 500:1 Ratio |
| Allegany | 68 | 13,600 | 34,000 | 12,625 | 975 | 21,375 |
| Anne Arundel North | 218 | 43,600 | 109,000 | 29,582 | 14,018 | 79,418 |
| Anne Arundel South | 210 | 42,000 | 105,000 | 16,590 | 25,410 | 88,410 |
| Baltimore City SE/Dundalk | 235 | 47,000 | 117,500 | 26,108 | 20,892 | 91,392 |
| Baltimore City East | 389 | 77,800 | 194,500 | 30,907 | 46,893 | 163,593 |
| Baltimore City N. Central | 95 | 19,000 | 47,500 | 13,528 | 5,472 | 33,972 |
| Baltimore City N. East | 102 | 20,400 | 51,000 | 27,211 | -6,811 | 23,789 |
| Baltimore City N. West | 248 | 49,600 | 124,000 | 23,908 | 25,692 | 100,092 |
| Baltimore City South | 85 | 17,000 | 42,500 | 19,620 | -2,620 | 22,880 |
| Baltimore City West | 382 | 76,400 | 191,000 | 41,456 | 34,944 | 149,544 |
| Baltimore County East | 235 | 47,000 | 117,500 | 25,828 | 21,172 | 91,672 |
| Baltimore County North | 316 | 63,200 | 158,000 | 15,600 | 47,600 | 142,400 |
| Baltimore County N. West | 133 | 26,600 | 66,500 | 31,977 | -5,377 | 34,523 |
| Baltimore County S. West | 179 | 35,800 | 89,500 | 23,822 | 11,978 | 65,678 |
| Calvert | 60 | 12,000 | 30,000 | 9,085 | 2,915 | 20,915 |
| Caroline | 35 | 7,000 | 17,500 | 7,562 | -562 | 9,938 |
| Carroll | 99 | 19,800 | 49,500 | 13,500 | 6,300 | 36,000 |
| Cecil | 73 | 14,600 | 36,500 | 15,618 | -1,018 | 20,882 |
| Charles | 94 | 18,800 | 47,000 | 16,237 | 2,563 | 30,763 |
| Dorchester | 28 | 5,600 | 14,000 | 7,270 | -1,670 | 6,730 |
| Frederick | 104 | 20,800 | 52,000 | 20,229 | 571 | 31,771 |
| Garrett | 21 | 4,200 | 10,500 | 4,918 | -718 | 5,582 |
| Harford East | 33 | 6,600 | 16,500 | 7,787 | -1,187 | 8,713 |
| Harford West | 93 | 18,600 | 46,500 | 15,756 | 2,844 | 30,744 |
| Howard | 157 | 31,400 | 78,500 | 21,050 | 10,350 | 57,450 |
| Kent | 24 | 4,800 | 12,000 | 3,060 | 1,740 | 8,940 |
| Montgomery-Silver Springs | 201 | 40,200 | 100,500 | 48,901 | -8,701 | 51,599 |
| Montgomery-Mid County | 224 | 44,800 | 112,000 | 15,247 | 29,553 | 96,753 |
| Montgomery-North | 122 | 24,400 | 61,000 | 34,111 | -9,711 | 26,889 |
| Prince George's N East | 106 | 21,200 | 53,000 | 19,071 | 2,129 | 33,929 |
| Prince George's N West | 184 | 36,800 | 92,000 | 65,885 | -29,085 | 26,115 |
| Prince George's S East | 67 | 13,400 | 33,500 | 12,785 | 615 | 20,715 |
| Prince George's S West | 77 | 15,400 | 38,500 | 30,802 | -15,402 | 7,698 |
| Queen Anne's | 24 | 4,800 | 12,000 | 5,478 | -678 | 6,522 |
| Somerset | 31 | 6,200 | 15,500 | 4,772 | 1,428 | 10,728 |
| St. Mary's | 78 | 15,600 | 39,000 | 12,694 | 2,906 | 26,306 |
| Talbot | 47 | 9,400 | 23,500 | 4,611 | 4,789 | 18,889 |
| Washington | 131 | 26,200 | 65,500 | 23,786 | 2,414 | 41,714 |
| Wicomico | 70 | 14,000 | 35,000 | 20,252 | -6,252 | 14,748 |
| Worchester | 36 | 7,200 | 18,000 | 7,162 | 38 | 10,838 |
| Total | 5,114 | 1,022,400 | 2,557,000 | 786,391 | 236,409 | 1,770,609 |

Based on a standard enrollee-to-PCP ratio of 500:1, provider networks in each LAA are more than adequate. However, 14 LAAs do not meet the stricter 200:1 ratio: two in Baltimore City,

one in Baltimore County, one in Harford County, two in Montgomery County, two in Prince George's County, one in Garrett County, and five on the Eastern Shore. Between March 2011 and September 2012, the number of PCPs participating in HealthChoice increased from 4,661 to 5,114, a 9.7 percent increase. The Washington Suburban region⁹ experienced the greatest increase.

Specialty Care Provider Network Adequacy

In addition to ensuring PCP network adequacy, DHMH requires MCOs to provide all medically necessary specialty care. If an MCO does not have the appropriate in-network specialist needed to meet the enrollee's medical needs, then the MCO must arrange for care with an out-of-network specialist and compensate the provider. Regulations for specialty care access require each MCO to have an in-network contract with at least one provider statewide in the following medical specialties: allergy, dermatology, endocrinology, infectious disease, nephrology, and pulmonology. Additionally, each MCO must include at least one in-network specialist in each of the 10 regions throughout the State for the following eight core specialties: cardiology, otolaryngology (ENT), gastroenterology, neurology, ophthalmology, orthopedics, surgery, and urology.

DHMH regularly monitors compliance with these specialty care access standards. As of September 2012, all seven MCOs met specialty coverage requirements for the core and major medical specialties.

CAHPS Survey Results

DHMH uses the CAHPS survey to measure enrollee satisfaction with their medical care (WB&A Market Research, 2012; WB&A Market Research, 2010; WB&A Market Research, 2008). Two CAHPS survey measures relate to access: "getting needed care" and "getting care quickly." "Getting needed care" measures:

- How often it was easy to get appointments with specialists
- How often it was easy to get care, tests, or treatments through their health plans

"Getting care quickly" measures:

- When participants needed care right away, how often they received care as soon as they thought they needed it
- Not counting the times they needed care right away, how often participants received an appointment for health care at a doctor's office or clinic as soon as they thought they needed it

⁹ The Washington Suburban region encompasses the following LAAs: Frederick, Montgomery-Silver Springs, Montgomery-Mid County, Montgomery-North, Prince George's N East, Prince George's N West, Prince George's S East, and Prince George's S West.

The survey responses for these two measures are always, usually, sometimes, or never. In CY 2011, the percentage of adult HealthChoice members who responded that they were “usually” or “always” successful in getting needed care was 71 percent, and 79 percent of adult members responded that they were “usually” or “always” successful in getting care quickly (Table 4). Both of these percentages are slightly lower than the CY 2011 National Committee for Quality Assurance (NCQA) Quality Compass benchmark.

Table 4. Percentage of Adult HealthChoice Participants Responding “Usually” or “Always” Getting Needed Care and Getting Care Quickly Compared with the NCQA Benchmark, CY 2007 – CY 2011

| | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|---|---------|---------|---------|---------|---------|
| Getting Needed Care - Percentage of members who responded “Usually” or “Always” | | | | | |
| HealthChoice | 73% | 74% | 74% | 72% | 71% |
| NCQA Quality Compass Benchmark | 75% | 76% | 75% | 76% | 76% |
| Getting Care Quickly - Percentage of members who responded “Usually” or “Always” | | | | | |
| HealthChoice | 80% | 82% | 80% | 80% | 79% |
| NCQA Quality Compass Benchmark | 80% | 80% | 79% | 81% | 80% |

In CY 2011, 79 percent of parents and guardians of children enrolled in HealthChoice responded “usually” or “always” getting needed care for their children, and 87 percent responded “usually” or “always” getting care quickly (Table 5). Both of these percentages are equal to the CY 2011 NCQA benchmarks.

Table 5. Percentage of Parents/Guardians of Child HealthChoice Participants Responding “Usually” or “Always” Getting Needed Care and Getting Care Quickly Compared with the NCQA Benchmark, CY 2007 – CY 2011

| | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|---|---------|---------|---------|---------|---------|
| Getting Needed Care - Percentage of members who responded “Usually” or “Always” | | | | | |
| HealthChoice | 80% | 76%* | 74% | 77% | 79% |
| NCQA Quality Compass Benchmark | 82% | 79%* | 79% | 79% | 79% |
| Getting Care Quickly - Percentage of members who responded “Usually” or “Always” | | | | | |
| HealthChoice | 79% | 89%* | 88% | 88% | 87% |
| NCQA Quality Compass Benchmark | 78% | 86%* | 87% | 87% | 87% |

*Due to significant changes in the 2009 CAHPS 4.0H Survey (CY 2008), comparison to previous years is not appropriate.

Parents or guardians of children with chronic conditions in HealthChoice were also surveyed (Table 6). In CY 2011, 80 percent responded “usually” or “always” getting needed care for their children, which was one percentage point lower than the NCQA benchmark of 81 percent. Ninety percent reported “usually” or “always” getting care quickly, the same as the NCQA benchmark. National benchmarks for this population were available beginning in CY 2011.

Table 6. Percentage of Parents/Guardians of Children with Chronic Conditions in HealthChoice Responding “Usually” or “Always” Getting Needed Care and Getting Care Quickly, CY 2007 – CY 2011

| | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|---|---------|---------|---------|---------|---------|
| Getting Needed Care - Percentage of members who responded “Usually” or “Always” | | | | | |
| HealthChoice | 77% | 75%* | 75% | 78% | 80% |
| NCQA Quality Compass Benchmark** | | | | | 81% |
| Getting Care Quickly - Percentage of members who responded “Usually” or “Always” | | | | | |
| HealthChoice | 79% | 90%* | 90% | 91% | 90% |
| NCQA Quality Compass Benchmark** | | | | | 90% |

*Due to significant changes in the 2009 CAHPS 4.0H Survey (CY 2008), comparison to previous years is not appropriate.

**NCQA Quality Compass Benchmarks were available for children with chronic conditions beginning in CY 2011.

Section I Summary

This section of the report discussed the HealthChoice program’s progress in achieving its goals of expanding coverage and improving access to care. Related to coverage, Maryland expanded Medicaid eligibility for parents and caretaker relatives of children enrolled in Medicaid or MCHP in July 2008. By December 2011, 88,333 new parents and caretaker relatives were covered under HealthChoice. The overall HealthChoice population grew by nearly 55 percent between CY 2007 and CY 2011. By CY 2011, 15 percent of the State population was enrolled in HealthChoice.

With these expansion activities and increased enrollment, it is important to maintain access to care and ensure program capacity to serve a growing population. Regarding PCP networks, there are several areas in the State that do not meet conservative network adequacy standards. The specialist network standards were met across all MCOs and regions in the State. Looking at service utilization as a measure of access, the percentage of participants receiving an ambulatory care visit increased since CY 2007, with nearly 78 percent of participants receiving a visit in CY 2011. Although CAHPS survey results indicate that most participants report that they usually or always receive needed care and receive care quickly, ED visits also increased, suggesting that there is still room for improvement in access to care.

Section II. Medical Home

One of the goals of the HealthChoice program is to ensure patient-focused, comprehensive, and coordinated care by providing each member with a medical home. HealthChoice participants choose one of seven MCOs and a PCP from the MCOs' network to oversee their medical care and provide a medical home. This section of the report discusses the extent to which HealthChoice provides participants with a medical home by assessing appropriate service utilization and continuity of care.

Appropriate Service Utilization

This section addresses whether participants could identify with and know how to navigate a medical home. With a greater understanding of the resources available to them, participants should be able to seek care in an ambulatory care setting before resorting to using the ED or letting a condition progress to the extent that it warrants an inpatient admission.

Appropriateness of ED Care

A fundamental goal of managed care programs such as HealthChoice is the delivery of the right care at the right time in the right setting. One widely used methodology to evaluate this goal in the ED setting is based on classifications developed by researchers at the New York University Center for Health and Public Service Research (NYU). The algorithm categorizes emergency visits as follows:

1. *Non-emergent*: Immediate care was not required within 12 hours based on patient's presenting symptoms, medical history, and vital signs
2. *Emergent but primary care treatable*: Treatment was required within 12 hours, but it could have been provided effectively in a primary care setting (e.g., CAT scan or certain lab tests)
3. *Emergent but preventable/avoidable*: Emergency care was required, but the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., asthma flare-up)
4. *Emergent, ED care needed, not preventable/avoidable*: Ambulatory care could not have prevented the condition (e.g., trauma or appendicitis)
5. *Injury*: Injury was the principle diagnosis
6. *Alcohol-related*: The principal diagnosis was related to alcohol
7. *Drug-related*: The principal diagnosis was related to drugs
8. *Mental-health related*: The principal diagnosis was related to mental health
9. *Unclassified*: The condition was not classified in one of the above categories by the expert panel

ED visits that fall into categories 1 through 3 may be indicative of problems with access to primary care. Figure 8 presents the distribution of all ED visits by NYU classification for CY 2011 for individuals with any period of HealthChoice enrollment. In CY 2011, 51.8 percent of all ED visits were for potentially avoidable conditions, meaning that the visit could have been avoided with timely and quality primary care. Participants in the F&C and MCHP coverage groups had higher rates of potentially avoidable visits than participants in the disabled coverage group.

ED visits in categories 4 (emergent, ED care needed, not preventable/avoidable) and 5 (injury) are the least likely to be prevented with access to primary care. These two categories accounted for 26.5 percent of all ED visits in CY 2011. Adults aged 40 through 64 years had more ED visits related to category 4 than other age groups. Children aged 3 through 18 years had more injury-related ED visits compared with other age groups. The inpatient category in Figure 8, which is not a part of the NYU classification, represents ED visits that resulted in a hospital admission. Participants with disabilities had a much higher rate of ED visits that led to an inpatient admission than the F&C and MCHP coverage groups.

Figure 8. Classification of ED Visits by HealthChoice Participants, CY 2011

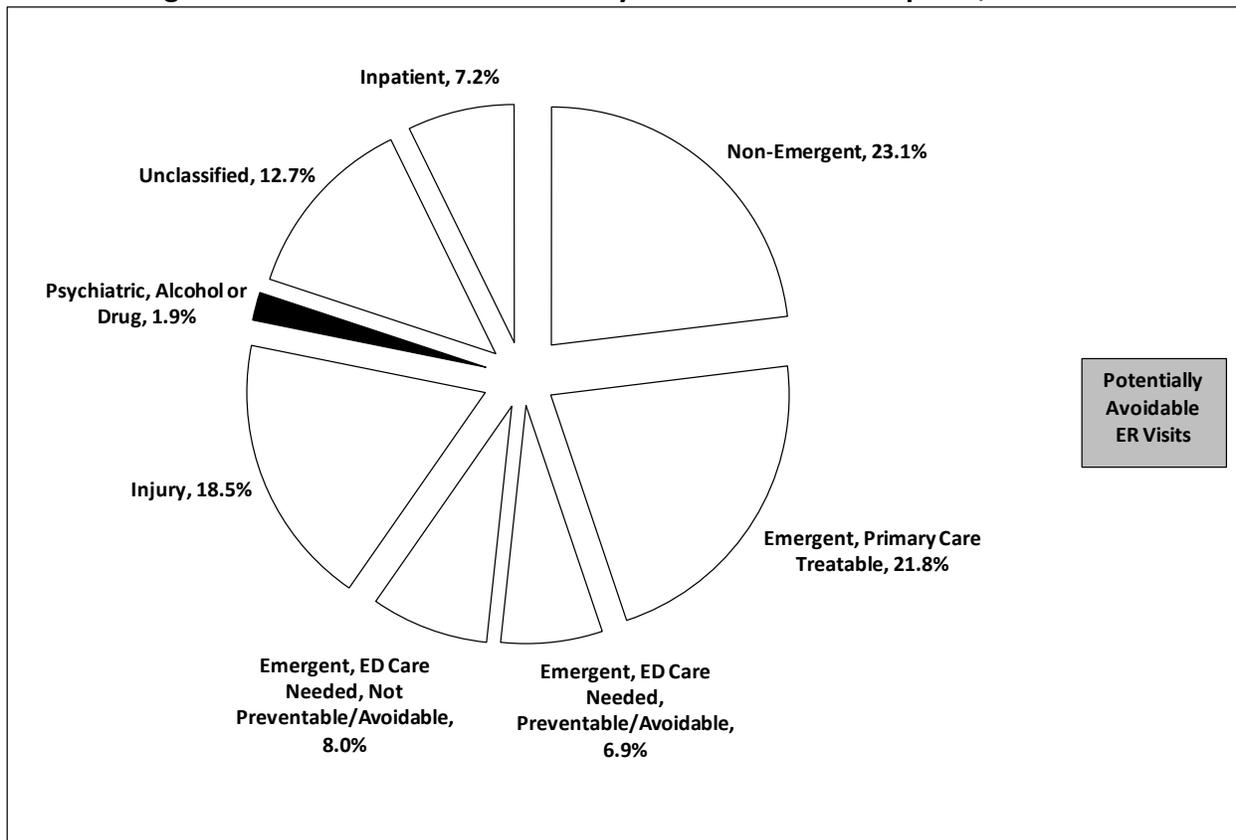
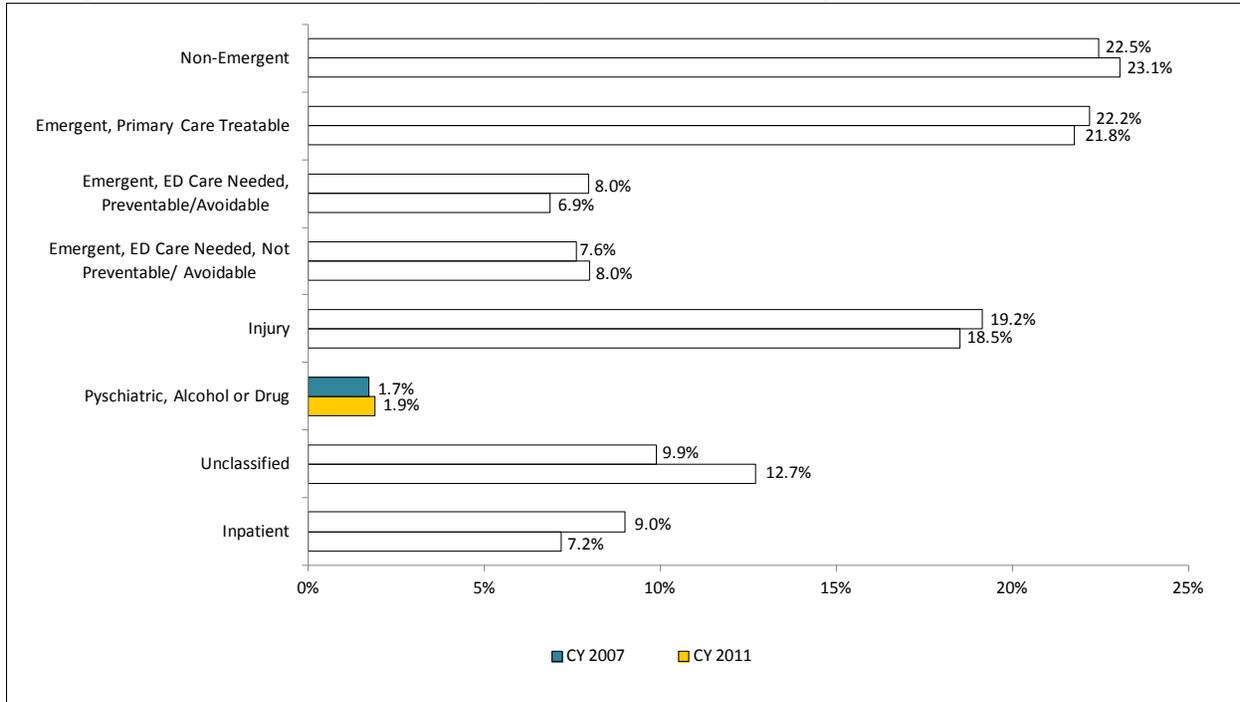


Figure 9 compares the ED visit classifications for CY 2007 with classifications for CY 2011. The data show that potentially avoidable ED visits decreased during the evaluation period, from 52.7 percent to 51.8 percent.

Figure 9. Classification of ED Visits by HealthChoice Participants, CY 2007 and CY 2011



Ambulatory Care Sensitive Hospitalizations

Ambulatory care sensitive hospitalizations (ACSHs), also referred to as preventable or avoidable hospitalizations, are hospital admissions considered preventable if proper ambulatory care had been provided in a timely and effective manner. High numbers of avoidable hospitalizations may be indicative of problems with access to primary care services or deficiencies in outpatient management and follow-up. DHMH monitors avoidable asthma and diabetes admission rates by using a combination of HEDIS enrollment criteria and Agency for Healthcare Research and Quality (AHRQ) clinical criteria to identify participants¹⁰ with a hospital admission who had a primary diagnosis of asthma or short-term diabetes with complications.¹¹

Table 7 presents the rate of diabetes-related admissions for participants aged 21 through 64 years and asthma-related admissions for participants aged 5 through 20 years. The avoidable admission rate for diabetes increased from 22 admissions per 1,000 members in CY 2007 to 24 admissions per 1,000 members in CY 2011, with the highest rate occurring in CY 2010 with 26 admissions. The avoidable admission rate for asthma, however, decreased from 49 admissions per 1,000 members in CY 2007 to 36 admissions per 1,000 members in CY 2011. Overall, the admission rate for both measures decreased between CY 2010 and CY 2011.

¹⁰ Individuals had to be continuously enrolled for 320 days during the calendar year and enrolled as of December 31, with no more than one gap in enrollment of up to 45 days.

¹¹ Participants with gestational diabetes are excluded.

Table 7. Potentially Avoidable Asthma- and Diabetes-Related Admissions per One Thousand Members, CY 2007 – CY 2011

| | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|--|---------|---------|---------|---------|---------|
| Diabetes (Participants Aged 21 – 64 Years) | | | | | |
| Number of Diabetes-Related Avoidable Hospital Admissions | 188 | 182 | 258 | 331 | 364 |
| Rate per 1,000 HEDIS-Eligible Adults with Diabetes | 22 | 21 | 24 | 26 | 24 |
| Asthma (Participants Aged 5 – 20 Years) | | | | | |
| Number of Asthma-Related Avoidable Hospital Admissions | 330 | 290 | 381 | 392 | 389 |
| Rate per 1,000 HEDIS-Eligible Children with Asthma | 49 | 39 | 43 | 40 | 36 |

Does the Waiver Provide Continuity of Care?

In addition to looking at appropriate service utilization, medical homes may be examined by assessing continuity of care. If individuals frequently change MCOs, then it may be difficult to establish a medical home. However, it should be noted that many physicians contract with multiple MCOs. Table 8 presents the percentage of the HealthChoice population enrolled in one or more MCOs over a three-year period. In each evaluation period, between 83 and 88 percent of participants remained within the same MCO over a three-year period, indicating that most participants do not change MCOs frequently and thus have a greater opportunity to establish a medical home. However, this rate dropped 4.6 percentage points between CY 2007 (87.8 percent) and CY 2011 (83.2 percent). This drop may be explained by a CMS-required change that allowed all new HealthChoice participants to change their MCO for any reason within 90 days of initial enrollment. Previously, only participants who were auto-enrolled could change MCOs.

Table 8. Percentage of the HealthChoice Population Enrolled in One or More MCOs, Three-Year Look Back

| Number of MCOs | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|----------------|---------|---------|---------|---------|---------|
| 1 | 87.8% | 87.3% | 86.9% | 85.2% | 83.2% |
| 2 | 11.5% | 12.0% | 12.4% | 13.9% | 15.5% |
| 3 or More | 0.6% | 0.8% | 0.7% | 0.9% | 1.3% |

Section II Summary

This section of the report addressed the extent to which HealthChoice provides participants with a medical home by assessing appropriateness of service utilization and continuity of care. In reviewing appropriateness of care, potentially avoidable ED visits and asthma- and diabetes-related ACSHs decreased during the study period. In reviewing continuity of care, most participants (at least 83 percent) did not change MCOs across multiple years.

Section III. Quality of Care

Another goal of the HealthChoice program is to improve the quality of health services delivered. DHMH has an extensive system for quality measurement and improvement that uses nationally recognized performance standards. Quality activities include the EQRO annual report, the CAHPS survey of consumer satisfaction, the VBP program, and the HEDIS quality measurements. HEDIS data are validated by nationally certified HEDIS vendors to ensure that all plan participants have collected data using identical methodology. This process allows appropriate comparisons across health plans. DHMH also reviews a sample of medical records to ensure that MCOs meet EPSDT standards. This section of the report presents highlights of these quality improvement activities related to preventive care and care for chronic conditions.

Preventive Care

HEDIS Childhood Measures

DHMH uses HEDIS measures to report childhood immunization and well-child visit rates. Immunizations are evidence-based interventions that safely and effectively prevent severe illnesses, such as polio and hepatitis (HealthcareData Company, LLC, 2012). The HEDIS immunization measures include the percentage of two-year-olds who received the following immunizations on or before their second birthday: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (Hib); three hepatitis B; one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines. HEDIS calculates a rate for each vaccine and nine different combination rates. Immunization combination two includes all of these vaccines except the four PCV, while combination three includes each of the above listed vaccines with its appropriate number of doses. DHMH compares health plan rates against immunization combination two and combination three.

The HEDIS well-child measures include the following:

- The percentage of 15-month-old infants who received at least five well-child visits with a PCP
- The percentage of children aged three to six years who received at least one well-child visit
- The percentage of adolescents aged 12 to 21 years who received at least one well-care visit

Table 9 compares HealthChoice with the national HEDIS mean for the immunization and well-child measures. HealthChoice performed above the national HEDIS mean across all measures from CY 2007 through CY 2011. Within the HealthChoice program:

- The percentage of two-year-old children receiving immunization combination two increased by nearly 2 percentage points during the measurement period

- The percentage of two-year-old children receiving immunization combination three increased by 5.6 percentage points during the measurement period
- The percentage of 15-month-old infants who received at least five well-child visits increased by almost 3 percentage point during the measurement period
- The percentage of children aged three to six years who received at least one well-child visit increased by about 8 percentage points during the measurement period
- The percentage of adolescents aged 12 to 21 years who received at least one well-care visit increased by 14.1 percentage points during the measurement period

Table 9. HEDIS Immunizations and Well-Child Visits: HealthChoice Compared with the National HEDIS Mean, CY 2007-CY 2011

| HEDIS Measures | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|--|---------|---------|---------|---------|---------|
| Childhood Immunizations - Combination 2 | | | | | |
| HealthChoice | 80.6% | 81.9% | 80.2% | 79.9% | 82.5% |
| National HEDIS Mean | 72.3% | 73.7% | 74.3% | 74.1% | 74.5% |
| Childhood Immunizations - Combination 3 | | | | | |
| HealthChoice | 74.1% | 76.9% | 76.0% | 76.3% | 79.7% |
| National HEDIS Mean | 65.6% | 67.6% | 69.4% | 69.9% | 70.6% |
| Well Child Visits - 15 Months of Life | | | | | |
| HealthChoice | 82.1% | 83.2% | 83.2% | 82.4% | 85.0% |
| National HEDIS Mean | 70.2% | 75.4% | 75.8% | 76.3% | 77.9% |
| Well Child Visits – 3- to 6-year-olds | | | | | |
| HealthChoice | 77.1% | 76.8% | 81.8% | 80.7% | 85.0% |
| National HEDIS Mean | 65.3% | 69.7% | 71.6% | 71.9% | 72.0% |
| Well-Care Visits - Adolescents | | | | | |
| HealthChoice | 52.9% | 54.7% | 62.6% | 62.8% | 67.0% |
| National HEDIS Mean | 42.0% | 45.9% | 47.7% | 48.1% | 49.7% |

EPSDT Review

The EPSDT program is a required package of benefits for all Medicaid participants under the age of 21 years. The purpose of EPSDT is to ensure that children receive appropriate age-specific physical examinations, developmental assessments, and mental health screenings periodically to identify any deviations from expected growth and development early. Maryland’s EPSDT program aims to support access and increase the availability of quality health care. The goal of the EPSDT review is to examine whether EPSDT services are provided to HealthChoice beneficiaries in a timely manner. The review is conducted annually to assess HealthChoice provider compliance with the following five EPSDT components:

- *Health and developmental history:* A personal and family medical history helps the provider determine health risks and provide appropriate anticipatory guidance and laboratory testing.

- *Comprehensive physical exam:* The exam includes vision and hearing tests, oral assessment, nutritional assessment, and measurements of head circumference and blood pressure.
- *Laboratory tests:* These tests involve assessing the risk factors related to heart disease, anemia, tuberculosis, lead exposure, and sexually transmitted diseases.
- *Immunizations:* Providers who serve HealthChoice participants must offer immunizations according to DHMH’s recommended childhood immunization schedule.
- *Health education/anticipatory guidance:* Maryland requires providers to discuss at least three topics during a visit, such as nutrition, injury prevention, and social interactions. Referrals for dental care are required after a patient turns two years old.

During the evaluation period, provider compliance declined or remained the same for four of the five EPSDT components. However, between CY 2009 and CY 2010, provider compliance in all but one component increased by 2 to 4 percentage points (Table 10) (Delmarva Foundation, 2011; Delmarva Foundation, 2007). The decline in provider compliance with the comprehensive physical exam is partly explained by the addition of body mass index calculation and graphing into the scoring of this component (Delmarva Foundation, 2011).

Table 10. HealthChoice MCO Aggregate Composite Scores for Components of the EPSDT Review, CY 2006 – CY 2010

| EPSDT Components | CY 2006 | CY 2007 | CY 2008 | CY 2009 | CY 2010 |
|---|---------|---------|---------|---------|---------|
| Health and Developmental History | 90% | 81% | 85% | 86% | 89% |
| Comprehensive Physical Exam | 96% | 91% | 92% | 93% | 88% |
| Laboratory Tests/ At Risk Screenings | 78% | 74% | 78% | 80% | 82% |
| Immunizations | 94% | 93% | 93% | 85% | 89% |
| Health Education/ Anticipatory Guidance | 90% | 88% | 89% | 88% | 90% |

Childhood Lead Testing

DHMH is a member of Maryland’s Lead Poisoning Prevention Commission, which advises Maryland executive agencies, the General Assembly, and the Governor on lead poisoning prevention in the State. Maryland’s Plan to Eliminate Childhood Lead Poisoning includes a goal of ensuring that young children receive appropriate lead risk screening and blood lead testing. As part of the work plan for achieving this goal, DHMH provides the MCOs with quarterly reports on children who received blood lead tests and children with elevated blood lead levels so that these children may receive appropriate follow-up. DHMH also includes blood lead testing measures in several of its quality assurance activities, including the VBP and managing-for-results programs.

As part of the EPSDT benefit, Medicaid requires that all children receive a blood lead test at 12 and 24 months of age. DHMH measures the lead testing rates for children aged 12 through 23 months and 24 through 35 months who are continuously enrolled in the same MCO for at least

90 days.¹² A child’s lead test must have occurred during the calendar year or the year prior. For CY 2011, the lead test measure was revised to exclude children who disenrolled from HealthChoice before their birthday. Thus, the lead testing rate for CY 2011 is not comparable to the results of prior years.

Table 11 presents the lead testing rate for children aged 12 through 23 months and 24 through 35 months between CY 2008 and CY 2011. In CY 2011, the lead testing rate was approximately 57 percent for children aged 12 through 23 months and 77 percent for children aged 24 through 35 months.

Table 11. Percentage of HealthChoice Children Aged 12–23 and 24-35 Months who Received a Lead Test During the Calendar Year or the Prior Year, CY 2008–CY 2011

| | CY 2008 | CY 2009 | CY 2010 | CY 2011* |
|----------------|---------|---------|---------|----------|
| 12 - 23 Months | 55.7% | 55.5% | 57.5% | 57.4% |
| 24 - 35 Months | 76.0% | 75.7% | 75.6% | 76.6% |

* The measure was revised in CY 2011 to exclude children who disenrolled before their birthday. Thus, CY 2011 results cannot be compared to previous years.

Breast Cancer Screening

According to the Centers for Disease Control and Prevention (CDC), mammograms are the most effective technique for detecting breast cancer early (CDC, n.d.a). The CDC reports a prevalence of breast cancer of 120.4 cases per 100,000 women (CDC, 2010). Breast cancer represents the most prevalent cancer among women (CDC, 2010). When breast cancer is detected early, women have more treatment options and a greater chance of survival (CDC, n.d.a). HEDIS assesses the percentage of women who received a mammogram within a two-year period. Although there has been recent debate over the appropriate age requirements for mammograms, HEDIS continues to utilize the 40-69 year female cohort for this measure.

Table 12 compares the percentage of women in HealthChoice who received a mammogram for breast cancer screening with the national HEDIS mean for CY 2007 through CY 2011 (HealthcareData Company, LLC, 2012). Between CY 2007 and CY 2011, the percentage of women aged 40 through 69-years¹³ receiving a mammogram increased by 3.3 percentage points. Maryland performed slightly below the national HEDIS mean during the measurement period.

Table 12. Percentage of Women in HealthChoice Receiving a Mammogram for Breast Cancer Screening Compared with the National HEDIS Mean, CY 2007 – CY 2011

| | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|---------------------|---------|---------|---------|---------|---------|
| HealthChoice | 47.0% | 49.0% | 49.5% | 48.3% | 50.3% |
| National HEDIS Mean | 50.0% | 50.8% | 52.4% | 51.3% | 50.4% |

¹² The lead testing measures include lead tests reported in the Medicaid administrative data and the Childhood Lead Registry, which is maintained by the Maryland Department of the Environment.

¹³ Maryland’s HealthChoice program covers individuals through age 64 years.

Cervical Cancer Screening

Cervical cancer is preventable and treatable, and the CDC recommends PAP tests for women who are sexually active or over the age of 21 years (CDC, n.d.b). Because PAP screenings can detect precancerous cells early, cervical cancer can be treated or altogether avoided (CDC, n.d.b). HEDIS measures the percentage of women who received at least one PAP test within a three-year period to screen for cervical cancer.

Table 13 compares the percentage of women aged 21 to 64 years in HealthChoice who received a cervical cancer screening with the national HEDIS mean for CY 2007 through CY 2011 (HealthcareData Company, LLC, 2012). Between CY 2007 and CY 2011, the cervical cancer screening rate increased by nearly 10 percentage points. HealthChoice performed slightly below the national HEDIS mean in CY 2007 but outperformed the national HEDIS mean in the subsequent years.

Table 13. Percentage of Women in HealthChoice Aged 21-64 Years Receiving a Cervical Cancer Screening Compared with the National HEDIS Mean, CY 2007 – CY 2011

| | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|---------------------|---------|---------|---------|---------|---------|
| HealthChoice | 63.2% | 67.2% | 68.1% | 73.2% | 73.1% |
| National HEDIS Mean | 64.8% | 66.0% | 65.8% | 67.2% | 66.7% |

Care for Chronic Conditions

Use of Appropriate Medications for People with Asthma

DHMH uses HEDIS measures to report the use of appropriate medications for people with asthma. Asthma is a common chronic disease that affects nearly 25 million American children and adults (CDC, 2011). In 2009, approximately 823,000 adults and children in Maryland had a history of asthma, and Medicaid spent over \$10 million for asthma ED visits (Bankoski, Hess-Mutinda, McEachern, & De Pinto, 2011). The purpose of asthma medications is to prevent or reduce airway inflammation and narrowing. If appropriate asthma medications are prescribed and used correctly, asthma-related hospitalizations, ED visits, and missed school and work days decrease (CDC, n.d.c).

Table 14 compares the HealthChoice rate of appropriate medications for people with asthma with the national HEDIS mean (HealthcareData Company, LLC, 2012). Between CY 2007 and CY 2008, HEDIS included individuals aged 5 through 56 years in this measure. From CY 2009 onwards, however, HEDIS restricted the measure to individuals aged 5 through 50 years. Because of the change in the age requirement in CY 2009, a comparison to prior years is not appropriate for this measure. Throughout the study period, HealthChoice performed above the national HEDIS mean. In CY 2011, 91 percent of HealthChoice participants aged 5 through 50 years were appropriately prescribed medications for asthma treatment compared to the national HEDIS mean of 85 percent.

Table 14. Percentage of HealthChoice Members Aged 5-50 Years with Persistent Asthma who were Appropriately Prescribed Medications Compared with the National HEDIS Mean, CY 2007 – CY 2011

| | CY 2007 | CY 2008 | CY 2009* | CY 2010 | CY 2011 |
|---------------------|-------------------------|---------|-------------------------|---------|---------|
| | Members Aged 5-56 Years | | Members Aged 5-50 Years | | |
| HealthChoice | 89% | 90% | 90.7% | 90.8% | 91.2% |
| National HEDIS Mean | 87% | 89% | 88.6% | 88.4% | 85.0% |

*Due to significant changes in the specifications for the 2010 HEDIS specifications (CY 2009 data), a comparison to prior years is not appropriate.

Comprehensive Diabetes Care

Diabetes is a disease caused by the inability of the body to make or use the hormone insulin. The complications of diabetes are serious and include heart disease, kidney disease, stroke, and blindness. Screening and treatment can reduce the burden of diabetes complications. To assess appropriate and timely screening and treatment for adults with diabetes (types 1 and 2), HEDIS includes a composite set of measures, comprehensive diabetes care (CDC), that include:

- *HbA1c Testing*: The percentage of participants aged 18 through 75 years with diabetes who received at least one Hemoglobin A1c (HbA1c) test during the measurement year.
- *LDL-C Screening*: The percentage of participants aged 18 through 75 years with diabetes who received at least one low-density lipoprotein cholesterol (LDL-C) screening in the measurement year.
- *Eye Exams*: The percentage of participants aged 18 through 75 years with diabetes who received an eye exam for diabetic retinal disease during the measurement year *or* had a negative retinal exam (no evidence of retinopathy) in the year prior to the measurement year.

Table 15 compares HealthChoice with the national HEDIS mean on the CDC measures for CY 2007 through CY 2011 (DHMH, 2012; HealthcareData Company, LLC, 2012). HealthChoice consistently performed above the national HEDIS mean on eye exams throughout the study period and performed above the average for LDL-C screenings in most years. HealthChoice performed above the national average on HbA1c testing in CY 2007, but remained below the national average in subsequent years. Within the HealthChoice program:

- The percentage of participants with diabetes who received an eye exam increased by 11.3 percentage points during the measurement period.
- The percentage of participants with diabetes who received an HbA1c test increased by 2.4 percentage points during the measurement period.
- The percentage of participants with diabetes who received an LDL-C screening remained same during the measurement period; however, the estimates fluctuated between the years.

Table 15. Percentage of HealthChoice Members Aged 18–75 Years with Diabetes who had an Eye Exam, HbA1C Test, and LDL-C Screening Compared with the National HEDIS Mean, CY 2007-CY 2011

| HEDIS Measures | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|---------------------------|---------|---------|---------|---------|---------|
| Eye Exam (Retinal) | | | | | |
| HealthChoice | 59.7% | 62.6% | 66.6% | 67.9% | 71.0% |
| National HEDIS Mean | 50.1% | 52.8% | 52.7% | 53.1% | 53.4% |
| HbA1c Test | | | | | |
| HealthChoice | 78.6% | 77.9% | 77.1% | 77.6% | 81.0% |
| National HEDIS Mean | 77.4% | 80.5% | 80.6% | 82.0% | 82.5% |
| LDL-C Screening | | | | | |
| HealthChoice | 75.6% | 76.5% | 74.9% | 74.3% | 76.4% |
| National HEDIS Mean | 70.9% | 74.1% | 74.2% | 74.7% | 75.0% |

Section III Summary

This section of the report discussed the HealthChoice goal of improving quality and focused on preventive care and care for chronic conditions. Regarding preventive care for children, HealthChoice well-child visit and immunization screening rates increased during the study period and were consistently higher than the national HEDIS mean. However, the EPSDT record review shows that provider compliance with EPSDT screening components decreased slightly during the evaluation period, suggesting that this is an area requiring improvement. Regarding preventive care for adults, rates of cervical and breast cancer screening improved during the study period. From CY 2008 to CY 2010, the cervical cancer screening rate exceeded the national HEDIS mean, while the breast cancer screening rate continued to fall below the national average although it has improved over the evaluation period. This section also examined the quality of care for chronic conditions, namely diabetes and asthma. The percentage of participants receiving appropriate asthma medications remained the same from CY 2009 to CY 2011, and HealthChoice performed above the national HEDIS mean. For participants with diabetes, rates of eye exams steadily improved during the evaluation period and were consistently higher than the national HEDIS mean. The HbA1c testing and LDL-C screening rates increased between CY 2010 and CY 2011, but the HbA1c testing rate remained below the national average while the LDL-C screening rate was higher than the national average in CY 2011.

Section IV. Special Topics

This section of the report discusses several special topics, including services provided under the dental and mental health carve-outs, services provided to children in foster care, reproductive health services, services provided to individuals with HIV/AIDS, the REM program, and access to care for racial and ethnic minorities.

Dental Services

EPSDT mandates dental care coverage for children younger than 21 years. Children enrolled in Maryland Medicaid, however, historically utilized these services at a low rate. Before Maryland implemented HealthChoice in 1997, only 14 percent of children enrolled in Medicaid for any period of time received at least one dental service, which was below the national average of 21 percent (Academy of Pediatrics State Medicaid Report).

In an effort to increase access to oral health care and service utilization, the Secretary of DHMH convened the Dental Action Committee (DAC) in June 2007. The DAC consisted of a broad-based group of stakeholders concerned about children's access to oral health services. The DAC reviewed dental reports and data and presented its final report to the DHMH Secretary on September 11, 2007.¹⁴ Key recommendations from the report included increased reimbursement for Medicaid dental services and the institution of a single dental ASO. The reforms recommended by the DAC have been supported and, to a great degree, implemented by DHMH to effectively address the barriers to dental care access previously experienced in the State. Expanded access to dental care also has been achieved through initiatives of the Medicaid program and the Office of Oral Health. These include:

- Increasing dental provider payment rates in 2008, with plans to increase rates further as the budget allows.
- Implementing an ASO in July 2009 to oversee Medicaid dental benefits for pregnant women, children, and adults in the REM program (the Maryland Healthy Smiles program).
- Authorizing EPSDT-certified medical providers (pediatricians, family physicians, and nurse practitioners), after successful completion of an Office of Oral Health training program, to receive Medicaid reimbursement for fluoride varnish treatment and oral assessment services provided to children between 9 and 36 months of age. By September 2012, 392 unique EPSDT-certified providers administered over 64,000 fluoride varnish treatments.
- Allowing public health dental hygienists to perform services within their scope of practice without on-site supervision and prior examination of the patient by a dentist.

¹⁴ Dental Action Committee. (2007). Access to Dental Services for Medicaid Children in Maryland. http://fha.dhmdh.maryland.gov/oralhealth/docs1/DAC_report.pdf

This change permits public health dental hygienists to provide services outside of a dental office, e.g., in schools and Head Start centers.¹⁵

Maryland’s current oral health achievements are a direct result of the State’s progress in implementing the 2007 DAC recommendations, which called for increasing access to oral health services through changes to Maryland Medicaid and expansion of the public health dental infrastructure. In 2010 and 2011, the Pew Center on the States named Maryland a national leader in improving dental care access for Marylanders with low income, especially those who are Medicaid-eligible or uninsured. As Maryland is the only state to meet seven of the eight dental policy benchmarks, the Pew Center ranked it first in the nation for oral health (Pew Center on the States, 2011). CMS also recognized Maryland’s improved oral health service delivery by requesting Maryland to share its story at its national quality conference in August 2011, including its story and achievements in its best practices guide for states and their governors through the Medicaid State Technical Assistance Team (MSTAT) process. In addition, Maryland was invited to present in the inaugural *CMS Learning Lab: Improving Oral Health through Access* web seminar series.

DHMH continually monitors a variety of measures of dental service utilization, published in the Annual Oral Health Legislative Report. One measure is closely modeled on the HEDIS measure for Medicaid children’s dental service utilization. The HEDIS measure counts the number of individuals receiving dental services based on two criteria: 1) an age range from 2 through 21 years; and 2) Medicaid enrollment of at least 320 days. DHMH modified the measure to include children aged 4 through 20 years. The dental service utilization rate increased by 17.1 percentage points between CY 2007 and CY 2011 (Table 16). Nevertheless, many children still do not receive the dental services they need.

Table 16. Children Aged 4 – 20 Years in Medicaid (Enrolled for at least 320 Days) Receiving Dental Services, CY 2007 – CY 2011

| Calendar Year | Total Number of Participants | Participants Receiving One or More Dental Service | Percentage Receiving Service | National HEDIS Mean* |
|---------------|------------------------------|---|------------------------------|----------------------|
| 2007 | 263,742 | 130,112 | 49.3% | 43.5% |
| 2008 | 278,063 | 149,673 | 53.8% | 44.2% |
| 2009 | 304,907 | 184,563 | 60.5% | 45.7% |
| 2010 | 335,214 | 214,265 | 63.9% | 47.8% |
| 2011 | 363,465 | 241,149 | 66.4% | ** |

*National HEDIS mean is for children aged 2 – 21 years.

**National HEDIS mean data for CY 2011 are not available.

Dental care is also a benefit for pregnant women. Table 17 presents the percentage of pregnant women aged 21 years and older who received at least one dental service between CY 2007 and CY 2011. During that time period, dental service utilization increased from 14.3 percent in CY

¹⁵ Maryland Department of Health and Mental Hygiene (December 2010). *Maryland’s 2010 Annual Oral Health Legislative Report*. Baltimore, MD. Retrieved from <http://mmcp.dhmh.maryland.gov/docs/dentalJCRfinal10-10.pdf>

2007 to 28 percent in CY 2011. Despite these improvements, dental service utilization by pregnant women remains low.

Table 17. Percentage of Pregnant Women Aged 21+ Years in Medicaid (Enrolled for at Least 90 Days) Receiving Dental Services, CY 2007 – CY 2011

| Calendar Year | Total Number of Participants | Participants Receiving One or More Dental Service | Percent Receiving Service |
|---------------|------------------------------|---|---------------------------|
| 2007 | 35,444 | 5,072 | 14.3% |
| 2008 | 36,458 | 6,272 | 17.2% |
| 2009 | 37,206 | 8,871 | 23.8% |
| 2010 | 40,206 | 10,060 | 25.0% |
| 2011 | 30,882 | 8,653 | 28.0% |

Mental Health Services

HealthChoice participants in need of mental health services are referred to Maryland’s Public Mental Health System, but they continue to receive medically necessary somatic care through their MCO. Mental health services are funded through the FFS Maryland Mental Hygiene Administration using the mental health ASO.

Table 18 presents the percentage of the HealthChoice population diagnosed with/treated for a mental health disorder (MHD)¹⁶ by age group. The percentage of children with an MHD remained at approximately 21 percent throughout the study period. The percentage for adults decreased slightly.

Table 18. Percentage of HealthChoice Population (Any Period of Enrollment) with a Mental Health Disorder by Age Group, FY 2008 – FY 2011

| Age Group (Years) | FY 2008 | FY 2009 | FY 2010 | FY 2011 |
|-------------------|--------------|--------------|--------------|--------------|
| 0-18 | 20.6% | 20.6% | 20.9% | 21.2% |
| 19-64 | 34.6% | 33.6% | 33.0% | 32.4% |
| Total | 24.0% | 24.3% | 24.8% | 25.1% |

Table 19 presents the regional distribution of HealthChoice participants with an MHD. Between FY 2008 and FY 2010, most HealthChoice participants with an MHD resided in Baltimore City. However, in FY 2011, the Baltimore Suburban region contained the most HealthChoice participants with an MHD with 28.5 percent, followed by Baltimore City (26.7 percent).

¹⁶ A person was identified as having MHD if he/she had any diagnoses beginning with "290," "293," "294," "295," "296," "297," "298," "299," "300," "301," "302," "306," "307," "308," "309," "310," "311," "312," "313," "314," "315," "316" or an invoice control number (ICN) beginning with "6."

Table 19. Regional Distribution of HealthChoice Participants (Any Period of Enrollment) with a Mental Health Disorder, FY 2008–FY 2011

| Region | FY 2008 | FY 2009 | FY 2010 | FY 2011 |
|---------------------|-------------|-------------|-------------|-------------|
| Baltimore City | 30.4% | 29.3% | 28.1% | 26.7% |
| Baltimore Suburban | 27.2% | 27.3% | 27.8% | 28.5% |
| Washington Suburban | 19.2% | 19.6% | 20.1% | 20.7% |
| Western Maryland | 7.1% | 7.2% | 7.2% | 7.1% |
| Eastern Maryland | 11.4% | 11.7% | 12.0% | 12.2% |
| Southern Maryland | 4.5% | 4.6% | 4.7% | 4.7% |
| Total | 100% | 100% | 100% | 100% |

DHMH monitors the extent to which participants with an MHD access somatic services through their MCOs. Table 20 compares the percentage of HealthChoice participants with an MHD who received a physician visit for somatic care with the percentage who received an ED visit for somatic care. Between FY 2008 and FY 2011, the percentage of participants with a physician visit for somatic care increased by 3.2 percentage points. During the same time period, the percentage of participants with an ED visit for somatic care increased by 3.5 percentage points.

Table 20. Service Utilization among HealthChoice Participants (Any Period of Enrollment) with a Mental Health Disorder, FY 2008-FY 2011

| Fiscal Year | HealthChoice Participants with an MHD | Percent with a Physician visit for Somatic Care | Percent with an ED visit for Somatic Care |
|-------------|---------------------------------------|---|---|
| 2008 | 125,487 | 87.5% | 42.7% |
| 2009 | 142,619 | 89.0% | 44.9% |
| 2010 | 166,088 | 90.1% | 47.0% |
| 2011 | 183,669 | 90.7% | 46.2% |

Substance Use Disorder Services

Substance use disorder (SUD) services are currently provided under the HealthChoice MCO benefit package. Table 21 shows the percentage of HealthChoice participants diagnosed with/treated for an SUD by age group. The percentage of children aged 0 through 18 years with an SUD remained at approximately 1 percent throughout the study period. The percentage for adults decreased slightly.

Table 21. Percentage of HealthChoice Participants (Any Period of Enrollment) with a Substance Use Disorder by Age Group, FY 2008–FY 2011

| Age Group (Years) | FY 2008 | FY 2009 | FY 2010 | FY 2011 |
|-------------------|-------------|-------------|-------------|-------------|
| 0-18 | 1.0% | 1.0% | 1.1% | 1.0% |
| 19-64 | 14.3% | 13.0% | 13.1% | 12.4% |
| Total | 4.2% | 4.4% | 5.0% | 4.9% |

Table 22 presents the regional distribution of HealthChoice participants with an SUD. In FY 2011, the majority of participants with an SUD (38.2 percent) lived in Baltimore City. This is a 9 percentage point decrease from FY 2008 when 47.3 percent of participants with a SUD resided in Baltimore City.

Table 22. Regional Distribution of HealthChoice Participants (Any Period of Enrollment) with a Substance Use Disorder, FY 2008–FY 2011

| Region | FY 2008 | FY 2009 | FY 2010 | FY 2011 |
|---------------------|-------------|-------------|-------------|-------------|
| Baltimore City | 47.3% | 43.4% | 41.1% | 38.2% |
| Baltimore Suburban | 23.7% | 24.9% | 25.9% | 26.5% |
| Washington Suburban | 10.8% | 11.1% | 11.3% | 12.1% |
| Western Maryland | 5.9% | 6.4% | 6.3% | 6.1% |
| Eastern Maryland | 9.2% | 10.9% | 11.5% | 12.1% |
| Southern Maryland | 3.0% | 3.2% | 3.9% | 4.9% |
| Total | 100% | 100% | 100% | 100% |

DHMH also monitors the extent to which participants with an SUD access somatic care services. Table 23 compares the percentage of HealthChoice participants with an SUD who received a physician visit for somatic care compared to the percentage who received an ED visit for somatic care. Between FY 2008 and FY 2011, the percentage of participants with a physician visit for somatic care or an ED visit for somatic care increased by less than a percentage point.

Table 23. Service Utilization among HealthChoice Participants (Any Period of Enrollment) with a Substance Use Disorder, FY 2008 - FY 2011

| Fiscal Year | HealthChoice Participants with an SUD | Percentage with a Physician visit for Somatic Care | Percentage with an ED visit for Somatic Care |
|-------------|---------------------------------------|--|--|
| 2008 | 22,103 | 91.3% | 66.9% |
| 2009 | 25,784 | 91.9% | 68.4% |
| 2010 | 33,278 | 92.0% | 68.6% |
| 2011 | 36,238 | 92.0% | 67.6% |

Table 24 shows the number and percentage of HealthChoice participants with an SUD and at least one methadone replacement therapy. Between FY 2008 and FY 2011, the percentage of participants with at least one methadone replacement therapy increased by 1.5 percentage points.

Table 24. Number and Percentage of HealthChoice Participants (Any Period of Enrollment) with a Substance Use Disorder and at Least One Methadone Replacement Therapy, FY 2008 – FY 2011

| Fiscal Year | HealthChoice Participants with an SUD | Number of Participants with an SUD and Methadone Replacement Therapy | Percentage of Total Participants with an SUD |
|-------------|---------------------------------------|--|--|
| 2008 | 22,103 | 4,400 | 19.9% |
| 2009 | 25,784 | 5,207 | 20.2% |
| 2010 | 33,278 | 6,809 | 20.5% |
| 2011 | 36,238 | 7,754 | 21.4% |

Behavioral Health Integration Efforts

The number of HealthChoice participants with a dual-diagnosis of mental health and substance use disorder increased from 13,717 in FY 2008 to 22,407 in FY 2011. Table 25 presents the number of participants in FY 2008 through FY 2011 with a dual-diagnosis, MHD only, SUD only, or none of these diagnoses.

Table 25. Number of HealthChoice Participants (Any Period of Enrollment) with a Dual Diagnosis of Mental Health Disorder and Substance Use Disorder, FY 2008 – FY 2011

| Fiscal Year | HealthChoice Participants | | | |
|-------------|---------------------------|----------|----------|---------|
| | Both | MHD Only | SUD Only | None |
| 2008 | 13,717 | 111,770 | 8,386 | 388,808 |
| 2009 | 16,201 | 126,418 | 9,583 | 434,242 |
| 2010 | 21,309 | 144,779 | 11,969 | 492,038 |
| 2011 | 22,407 | 161,262 | 13,831 | 535,177 |

Access to Care for Children in Foster Care

This section of the report examines service utilization for children in foster care with any period of enrollment in HealthChoice during the calendar year.¹⁷ The section also compares service utilization for children in foster care with other HealthChoice children. Unless otherwise stated, all of the measures presented include children aged 0 through 21 years and include their use of FFS and MCO services.

¹⁷ This analysis *excludes* children in the subsidized adoption population.

Figure 10 displays the percentage of children in foster care with any period of enrollment that had at least one ambulatory care visit in CY 2007 and CY 2011 by age group. During the evaluation period, the overall rate decreased by one percentage point, from 75.5 percent to 74.5 percent. Utilization was highest for the youngest children and lowest for the oldest children.

Figure 10. Percentage of Children in Foster Care Receiving at Least One Ambulatory Care Visit by Age Group, CY 2007 and CY 2011

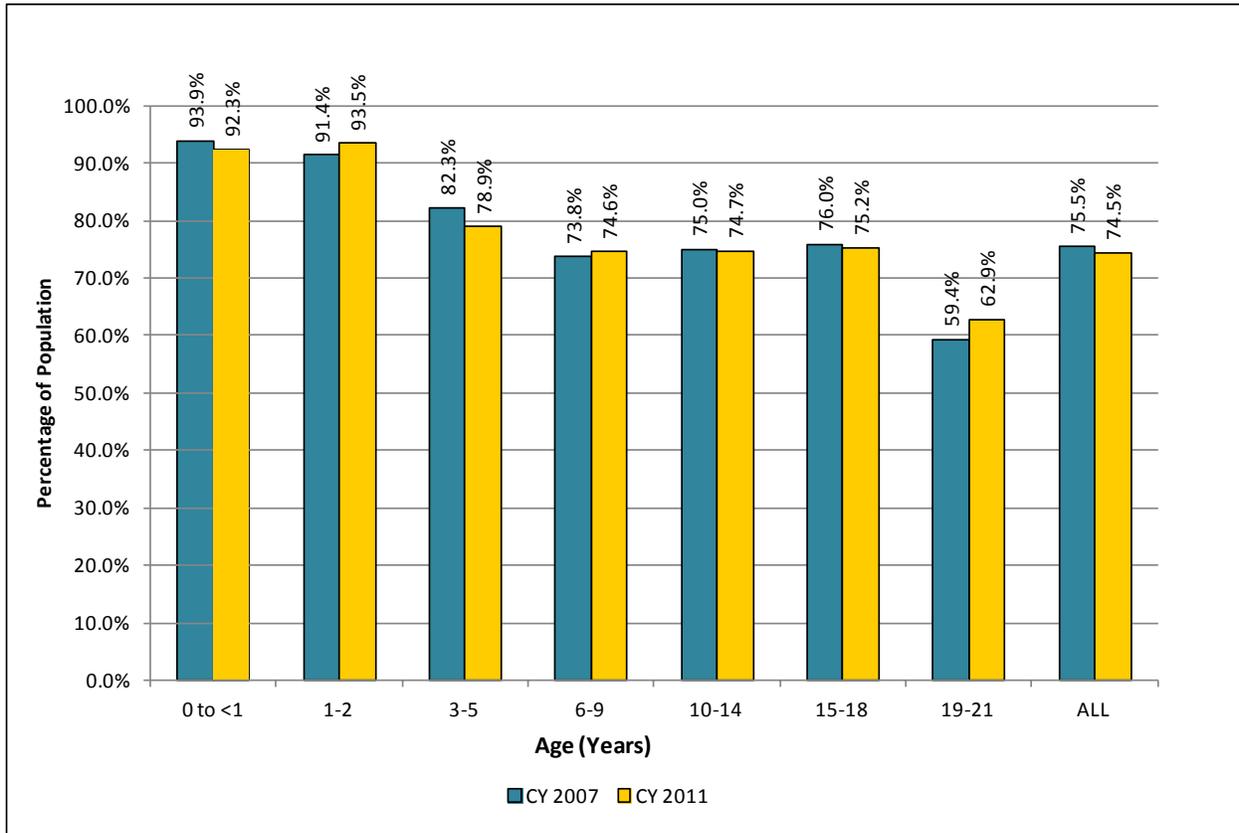


Figure 11 compares the ambulatory care visit rate for children in foster care with the rate for other children enrolled in HealthChoice in CY 2011. Overall, 74.5 percent of children in foster care and 79.2 percent of other HealthChoice children received at least one ambulatory care visit. For the youngest age groups and the oldest age groups, children in foster care accessed ambulatory care services at higher rates than other children in the HealthChoice program.

Figure 11. Percentage of Children in Foster Care vs. HealthChoice (Non-Foster) Children Receiving at Least One Ambulatory Care Visit by Age Group, CY 2011

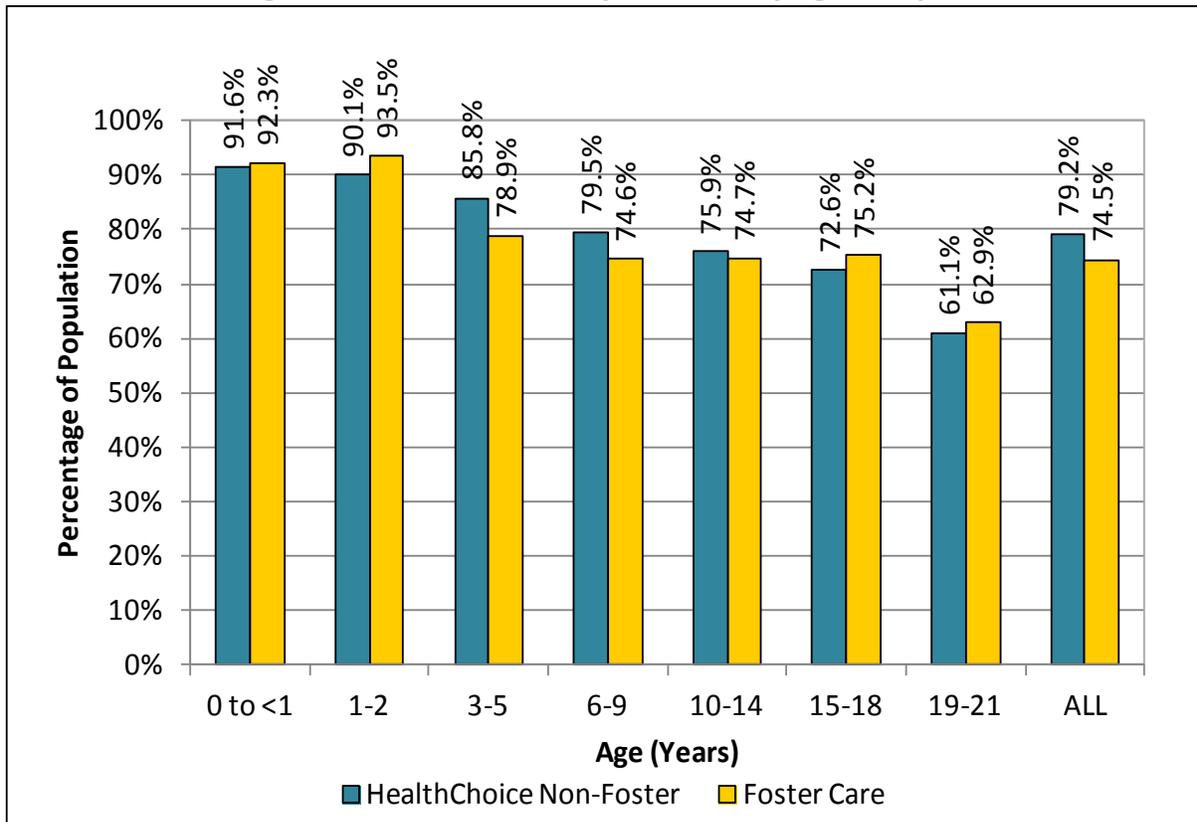


Figure 12 displays the percentage of children in foster care receiving at least one MCO outpatient ED visit in CY 2007 and CY 2011 by age group. The overall rate increased by 4.1 percentage points during the evaluation period. Children aged 1 through 2 years and those aged 19 through 21 years had the highest rates of ED utilization across the study period.

Figure 12. Percentage of Children in Foster Care Receiving at Least One MCO Outpatient ED Visit by Age Group, CY 2007 and CY 2011

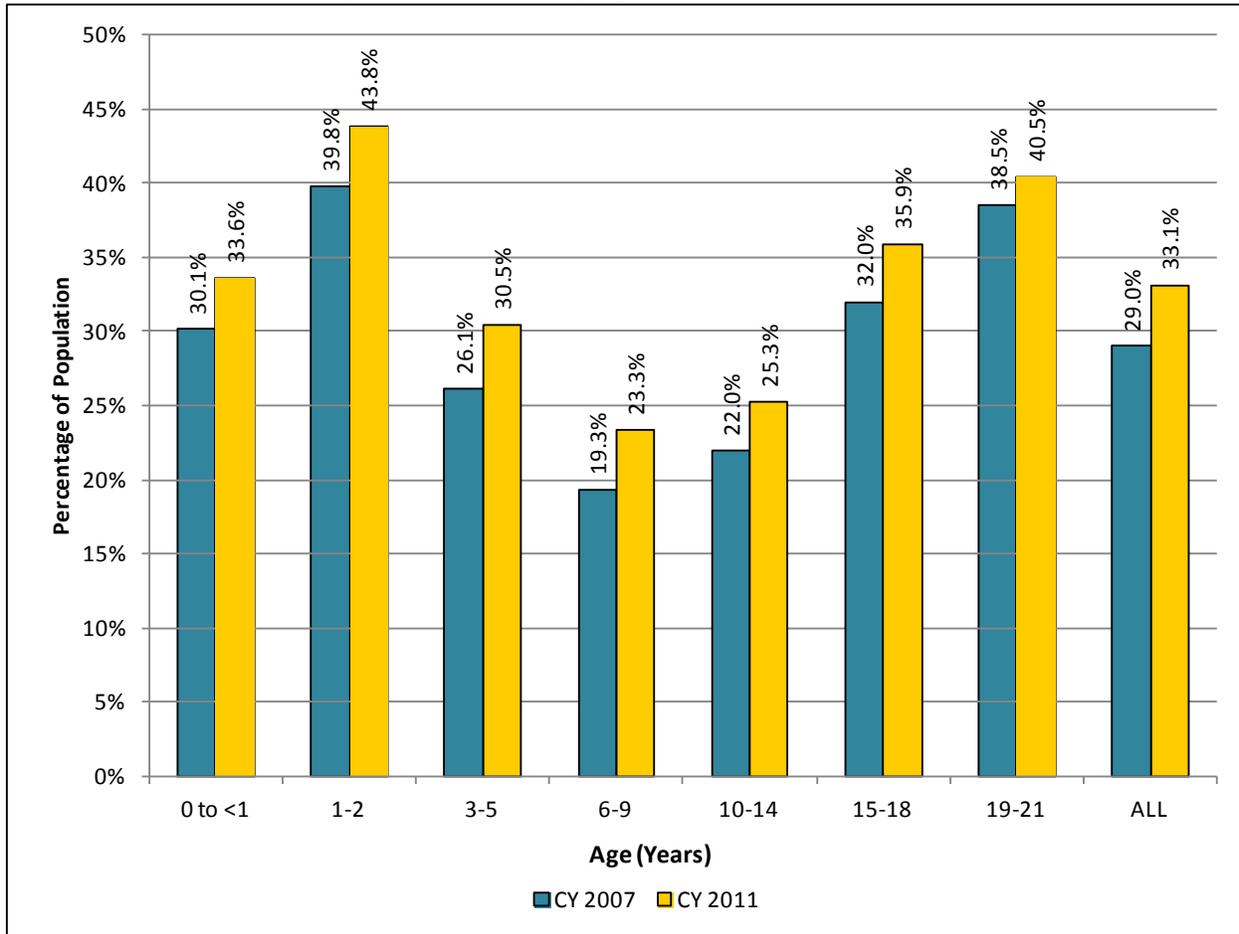


Figure 13 compares the MCO outpatient ED visit rate in CY 2011 for children in foster care to the rate of other children enrolled in HealthChoice. Overall, children in foster care visited the ED at a higher rate than other children in HealthChoice. Children aged 1 through 2 years had the highest ED visit rate across both groups of children. Please note that children often enter the foster care system through cases of abuse, which may account for their higher rate of ED utilization.

Figure 13. Percentage of Children in Foster Care vs. HealthChoice (Non-Foster) Children Receiving at Least One MCO Outpatient ED Visit by Age Group, CY 2011

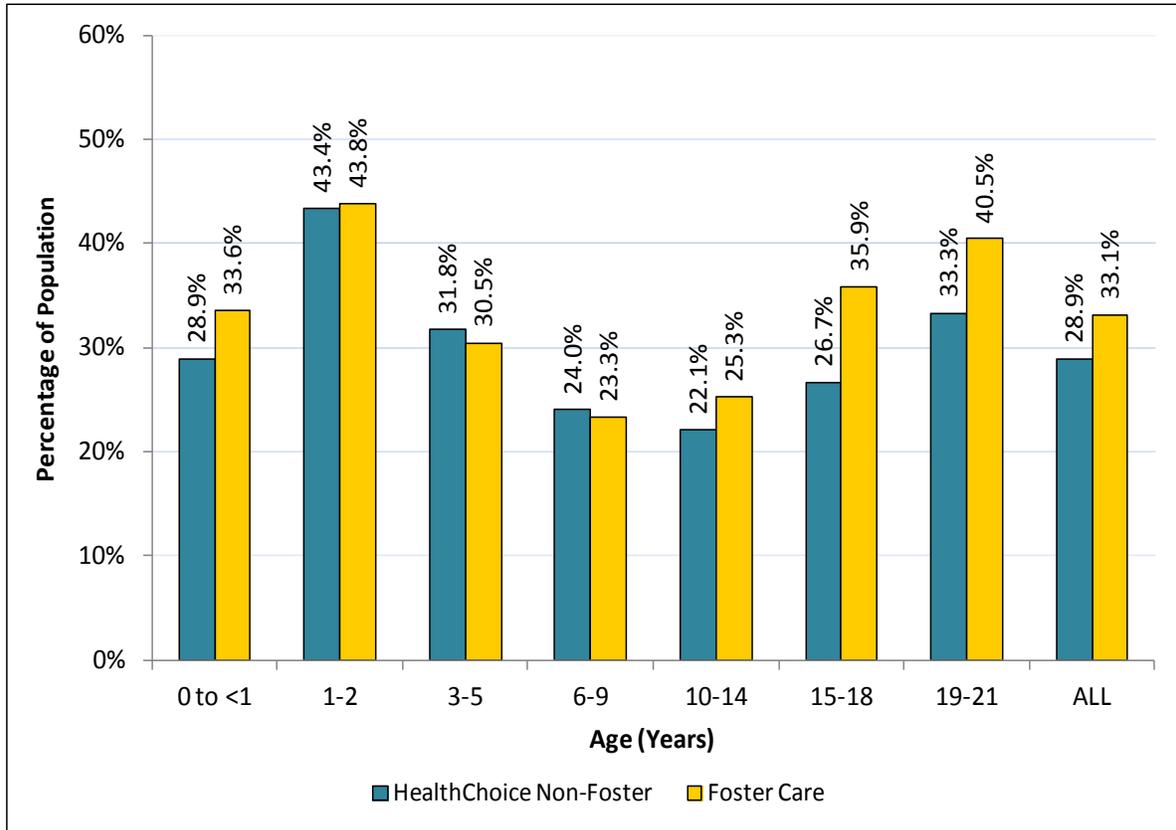


Figure 14 compares the dental utilization rate of children in foster care aged 4 to 20 years with any period of enrollment in Medicaid to the rate of other children in Medicaid in CY 2011. Overall, children in foster care had a higher dental visit rate (64.7 percent) than other Medicaid children (57.9 percent).

Figure 14. Percentage of Children Aged 4-20 Years (Any Period of Enrollment) in Foster Care in Medicaid vs. Children in Medicaid (Non-Foster) Receiving at Least One Dental Visit by Age Group, CY 2011

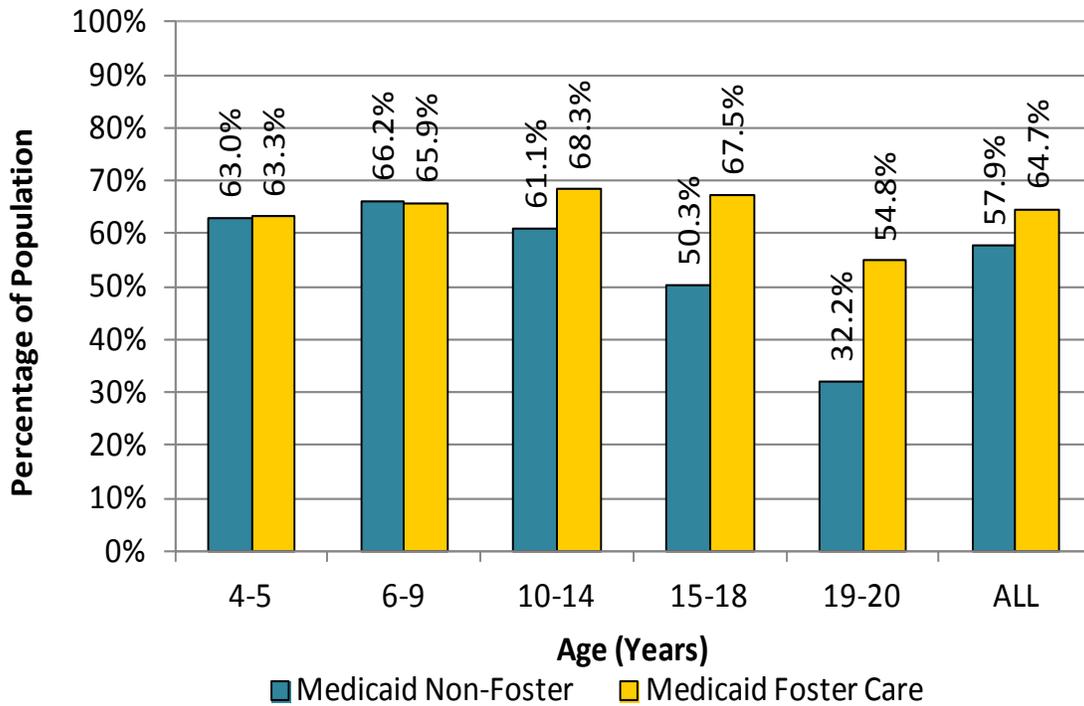
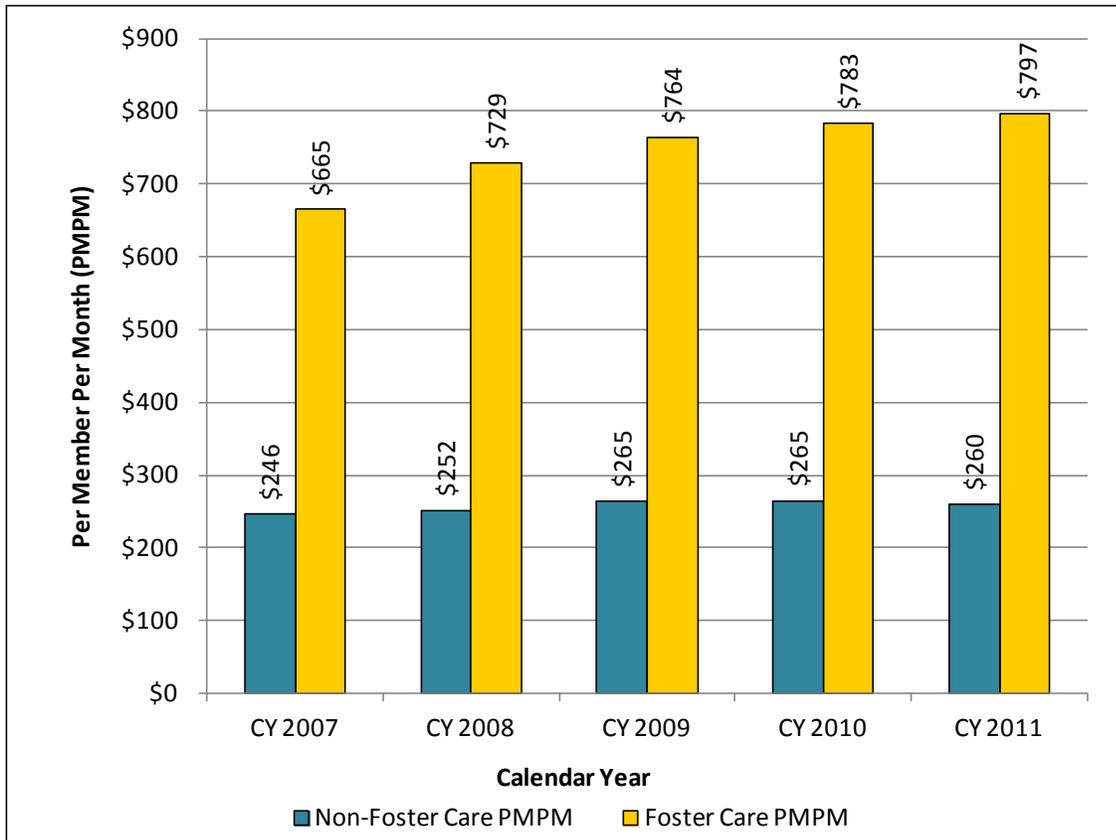


Figure 15 compares the per member per month (PMPM) cost for children in foster care with other children in Health Choice. The PMPM includes carve-out specialty mental health services and dental services. The PMPM for foster children rose considerably between 2007 and 2011, while the PMPM for non-foster children remained at a similar level. The PMPM for foster children is approximately three times greater than it is for non-foster children.

Figure 15. PMPM for Foster Children vs. Health Choice (Non-Foster) Children, CY 2007 – CY 2011



Reproductive Health

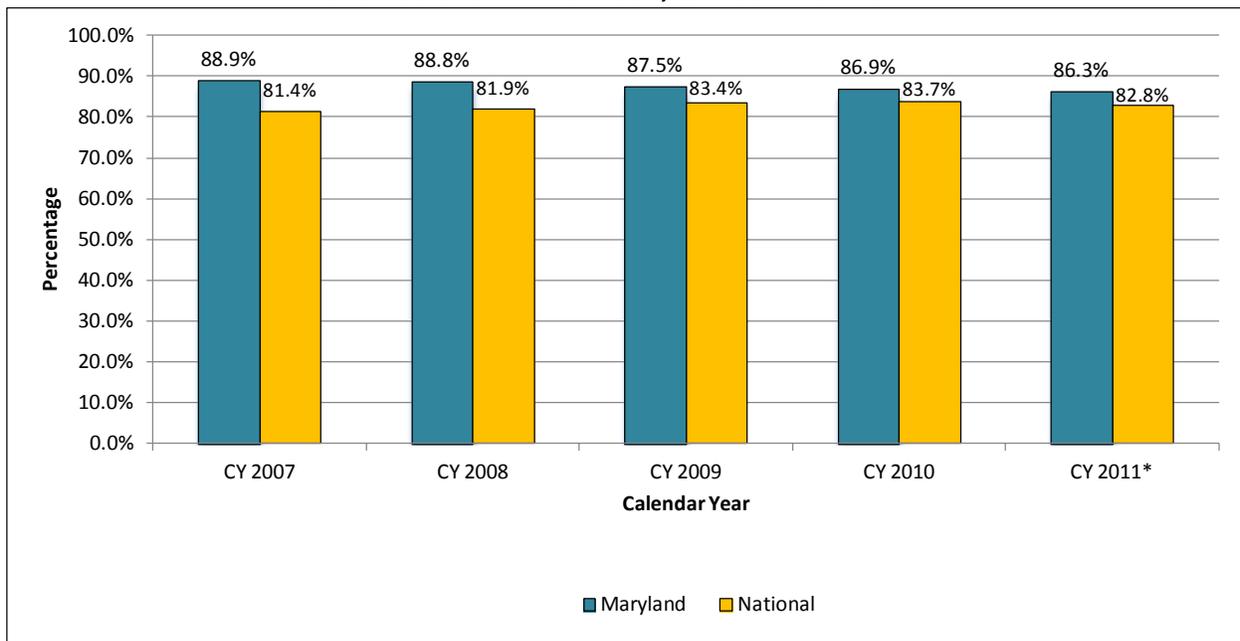
This section of the report focuses on reproductive health services provided under HealthChoice. HEDIS prenatal measures are presented first, followed by a discussion of the Family Planning Program.

Timeliness of Ongoing Prenatal Care

HEDIS measures the timeliness of prenatal care and the frequency of ongoing prenatal care to determine the adequacy of care during pregnancy. The earlier a woman receives prenatal care, the more likely health conditions that could affect her health or the health of the newborn will be identified and managed.

Timeliness of care considers the percentage of deliveries for which the mother received a prenatal care visit in the first trimester *or* within 42 days of HealthChoice enrollment.¹⁸ Figure 16 compares HealthChoice performance on this measure with the national HEDIS mean for CY 2007 through CY 2011 (HealthcareData Company, LLC, 2012). Utilization of prenatal care decreased by 2.6 percentage points during the study period, from 88.9 percent in CY 2007 to 86.3 percent in CY 2011. HealthChoice consistently outperformed the national HEDIS mean during the study period by 3 to 8 percentage points.

Figure 16. HEDIS Timeliness of Prenatal Care, Maryland Compared with the National HEDIS Mean, CY 2007 – CY 2011



¹⁸ HEDIS requires continuous enrollment 43 days prior to and 56 days after delivery.

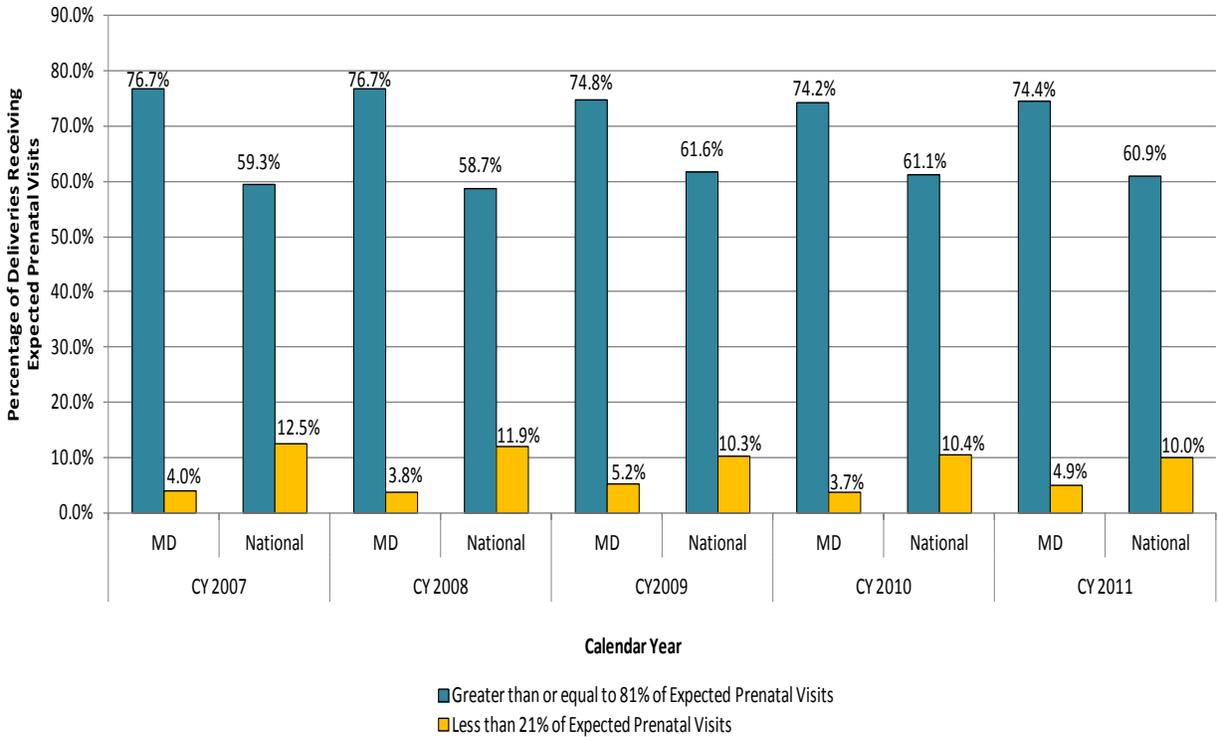
Frequency of Ongoing Prenatal Care

The frequency of ongoing prenatal care measure considers the percentage of recommended¹⁹ prenatal visits received. DHMH uses this measure to assess MCO performance in providing appropriate prenatal care. The measure calculates the percentage of deliveries that received the expected number of prenatal visits. This measure accounts for gestational age and time of enrollment, and women must be continuously enrolled 43 days prior to and 56 days after delivery.

The first aspect of this measure assesses the percentage of women that received more than 80 percent of expected visits; therefore, a higher score is preferable. This rate decreased by 2.3 percentage points during the study period, from 76.7 percent in CY 2007 to 74.4 percent in CY 2011 (Figure 17) (HealthcareData Company, LLC, 2012). The second aspect of this measure assesses the percentage of women who received less than 21 percent of expected visits; therefore, a lower score is preferable. Estimates of this measure for the study period increased slightly—by nearly a percentage point—from 4 percent in CY 2007 to 4.9 percent in CY 2011. In sum, Maryland consistently outperformed the national HEDIS means in both instances, although the performance over the study period declined slightly.

¹⁹ The American College of Obstetricians and Gynecologists recommends a visit once every 4 weeks during the first 28 weeks of pregnancy, once every 2 to 3 weeks during the next 7 weeks, and weekly for the remainder of the pregnancy, for a total of about 13 to 15 visits.

Figure 17. Percentage of Deliveries Receiving the Expected Number of Prenatal Visits \geq 81 Percent or $<$ 21 Percent of Recommended Visits, Maryland Compared with the National HEDIS Mean, CY 2007 – CY 2011



The Family Planning Program

The Family Planning Program provides family planning office visits—which include physical examinations, certain laboratory services, family planning supplies, reproductive education, counseling and referral, and permanent sterilization services—to women who are not eligible for Medicaid. During the study period, the Family Planning Program only enrolled postpartum women. Eligibility for the Program was expanded in 2012 to cover women younger than 51 years of age with household income below 200 percent of the FPL.

Tables 26 and 27 present the percentage of total Medicaid participants in the Family Planning Program and the percentage of Family Planning participants who received at least one service between CY 2007 and CY 2011. These data are presented for women who were enrolled in Family Planning for any period of time during the calendar year and women who were enrolled continuously for 12 months.

The number of women with any period of enrollment in the Family Planning Program decreased by 66.3 percent between CY 2007 and CY 2011 (Table 25). This decline in enrollment may be attributable to several significant changes made in CY 2008 in response to new CMS terms and conditions. CMS required the Program to perform annual active redeterminations in order to

reduce the upper income limit from 250 to 200 percent of the FPL and no longer enroll women with other third-party insurance that included family planning benefits. The July 2008 Medicaid expansion also increased the number of women who continue to be eligible for full Medicaid coverage after delivery, thus decreasing the number of women enrolled in the limited benefit Family Planning Program.

Table 26 shows that, during the evaluation period, the percentage of women with any period of enrollment in the Program who utilized at least one family planning service ranged between 14.2 and 19.4 percent. As Table 27 displays, the rate of women enrolled in the Program for the entire 12 months increased from 13 percent in CY 2007 to 23.9 percent in CY 2011.

Table 26. Percentage of Family Planning Participants (Any Period of Enrollment) with at least One Corresponding Service, CY 2007-CY 2011

| | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|------------------------------------|---------|---------|---------|---------|---------|
| Number of Participants | 62,469 | 52,094 | 38,132 | 25,920 | 21,070 |
| Number with at least 1 Service | 8,898 | 9,040 | 6,798 | 4,642 | 4,097 |
| Percentage with at least 1 Service | 14.2% | 17.4% | 17.8% | 17.9% | 19.4% |

Table 27. Percentage of Family Planning Participants (12-Month Enrollment) with at least One Corresponding Service, CY 2007-CY 2011

| | CY 2007 | CY 2008 | CY 2009 | CY 2010 | CY 2011 |
|------------------------------------|---------|---------|---------|---------|---------|
| Number of Participants | 21,216 | 14,731 | 7,433 | 1,886 | 1,737 |
| Number with at least 1 Service | 2,754 | 2,306 | 1,057 | 488 | 415 |
| Percentage with at least 1 Service | 13.0% | 15.7% | 14.2% | 25.9% | 23.9% |

Services for Individuals with HIV/AIDS

DHMH continuously monitors service utilization for HealthChoice participants with HIV/AIDS. This section of the report presents the enrollment distribution of HealthChoice participants with HIV/AIDS by race/ethnicity, as well as measures of ambulatory care service utilization, outpatient ED visits, CD4 testing, and viral load testing. CD4 testing is used to determine how well the immune system is functioning in individuals diagnosed with HIV. The viral load test monitors the progression of the HIV infection by measuring the level of immunodeficiency virus in the blood.

Table 28 presents the percentage of participants with HIV/AIDS by race/ethnicity for CY 2007 and CY 2011. Across the study period, Blacks and Whites composed about 95 percent of the HIV/AIDS population, and the Black-to-White ratio was about 8 to 1.

Table 28. Percentage of HealthChoice Participants (Any Period of Enrollment) with HIV/AIDS by Race/Ethnicity, CY 2007 and CY 2011

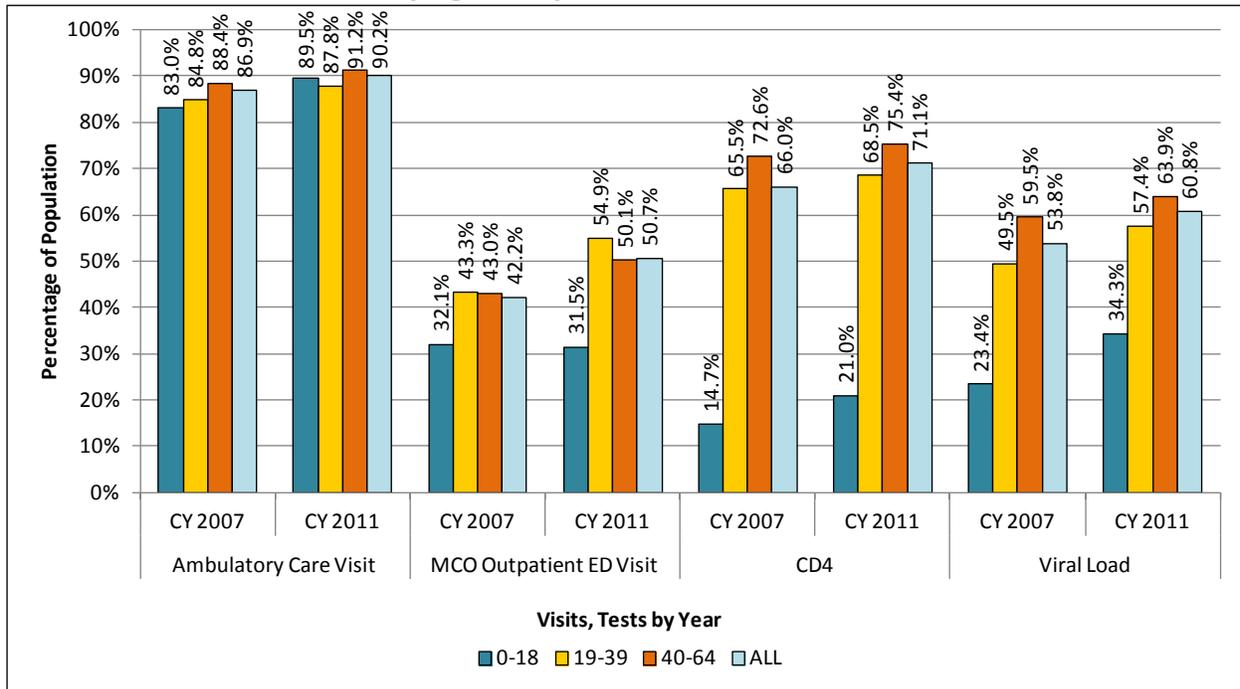
| Race/Ethnicity | CY 2007 | | CY 2011 | |
|----------------|------------------------|---------------------|------------------------|---------------------|
| | Number of Participants | Percentage of Total | Number of Participants | Percentage of Total |
| Asian | 8 | 0.2% | 18 | 0.4% |
| Black | 3,390 | 84.9% | 3,521 | 84.1% |
| White | 435 | 10.9% | 471 | 11.3% |
| Hispanic | 43 | 1.1% | 49 | 1.2% |
| Other | 117 | 2.9% | 126 | 3.0% |
| ALL | 3,993 | 100% | 4,185 | 100% |

Figure 18 shows service utilization by participants with HIV/AIDS in CY 2007 and CY 2011 by age group. The overall percentage of participants with HIV/AIDS with an ambulatory care visit increased from 86.9 percent in CY 2007 to 90.2 percent in CY 2011. This rate increased for all age groups. Similarly, the percentage of participants with an MCO outpatient ED visit increased by 8.5 percentage points during the study period. This rate increased for all age groups, except children aged 0 through 18 years, for which it reduced marginally.

Figure 18 also presents the percentage of individuals with HIV/AIDS who received CD4 testing in CY 2007 and CY 2011. The overall rate increased from 66 percent in CY 2007 to 71.1 percent in CY 2011. Individuals aged 40 through 64 years had the highest rates of CD4 testing during the study period. Individuals aged 0 to 18 years demonstrated the largest increase in CD4 testing rates: 6.3 percentage points.

Finally, Figure 18 presents the percentage of individuals with HIV/AIDS who received viral load testing during the study period. This measure increased from 53.8 percent in CY 2007 to 60.8 percent in CY 2011. Individuals aged 0 through 18 showed the largest increase in utilization, 10.9 percentage points.

Figure 18. Percentage of HealthChoice Participants with HIV/AIDS who Received an Ambulatory Care Visit, MCO Outpatient ED Visit, CD4 Testing, and Viral Load Testing by Age Group, CY 2007 and CY 2011



REM Program

The REM program provides case management services to Medicaid participants who have one of a specified list of rare and expensive medical conditions and require sub-specialty care. In order to be enrolled in REM, an individual must be eligible for HealthChoice, have a qualifying diagnosis, and be within the age limit for that diagnosis. Examples of qualifying diagnoses include: HIV/AIDS, cystic fibrosis, quadriplegia, muscular dystrophy, chronic renal failure, and spina bifida. REM participants do not receive services through an MCO. The REM program provides the standard FFS Medicaid benefit package and some expanded benefits, such as medically necessary private duty nursing, shift home health aide, and adult dental services. This section of the report presents data on REM enrollment and service utilization.

REM Enrollment

Table 29 presents REM enrollment by age group and sex for CY 2007 and CY 2011. In both years, the majority of REM participants were male children aged 0 through 18 years. The gender distribution differs from the HealthChoice population, which has a higher percentage of females (about 57 percent in CY 2011).

Table 29. REM Enrollments by Age Group and Sex, CY 2007 and CY 2011

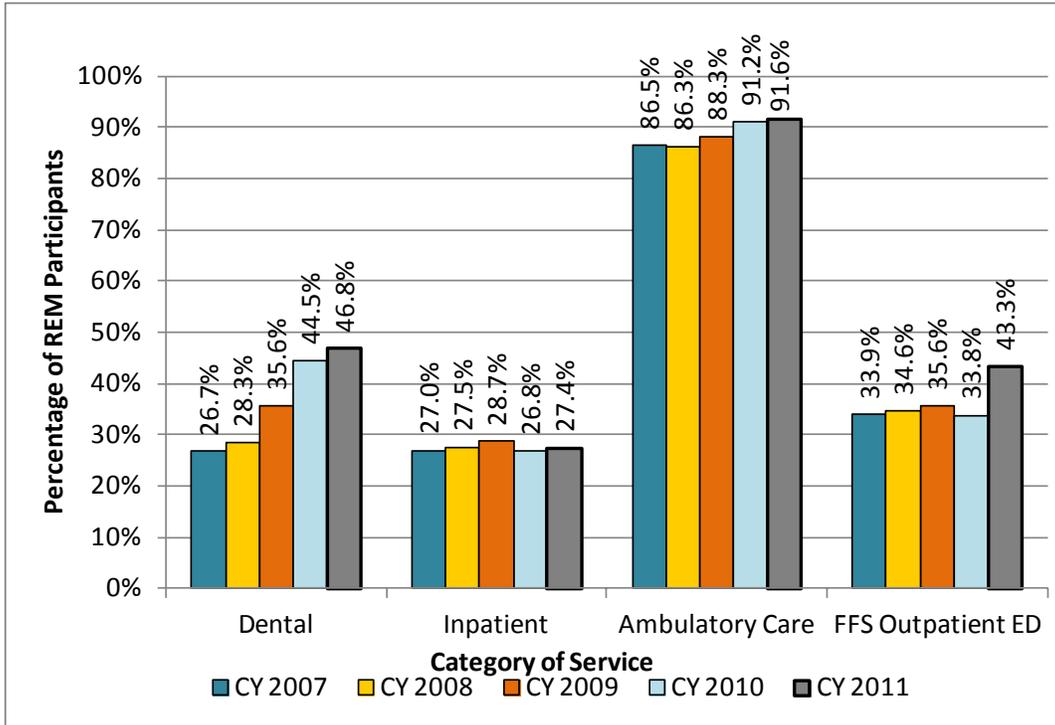
| Age Group (Years) | CY 2007 | | CY 2011 | |
|-------------------|------------------------|---------------------|------------------------|---------------------|
| | Number of Participants | Percentage of Total | Number of Participants | Percentage of Total |
| 0-18 | 2,961 | 74.5% | 3,139 | 70.3% |
| 19-64 | 1,013 | 25.5% | 1,327 | 29.7% |
| Total | 3,974 | 100.0% | 4,466 | 100.0% |
| Female | 1,778 | 44.7% | 1,977 | 44.3% |
| Male | 2,196 | 55.3% | 2,489 | 55.7% |
| Total | 3,974 | 100.0% | 4,466 | 100.0% |

REM Service Utilization

Figure 19 presents the percentage of REM participants who received at least one dental, inpatient, ambulatory care, and FFS outpatient ED visit between CY 2007 and CY 2011.²⁰ The dental, inpatient, and ambulatory care visits measures serve as indicators of access to care. The percentage of participants with a dental visit increased markedly during the study period, from 26.7 percent in CY 2007 to 46.8 percent in CY 2011. The ambulatory care utilization rate increased by 5.1 percentage points during the study period, and inpatient service utilization increased slightly. The percentage of participants who had a FFS outpatient ED visit was steady for four years before the sudden increase of 9.5 percentage points between CY 2010 and CY 2011.

²⁰ The analysis includes participants who were in the REM program for any period during the calendar year and received FFS dental, inpatient, ambulatory care, and outpatient ED services. Inpatient service includes services occurred in acute, chronic, hospice and rehab facilities.

Figure 19. Percentage of REM Participants (Any Period of Enrollment) with at least One Dental, Inpatient, Ambulatory Care, and FFS Outpatient ED Visit, CY 2007-CY2011



Racial/Ethnic Disparities

Racial and ethnic disparities in health care are nationally recognized issues. DHMH is committed to improving health services utilization among racial and ethnic groups through its managing-for-results program. This section of the report presents enrollment trends among racial and ethnic groups and assesses disparities within several measures of service utilization.

Enrollment

Table 30 displays HealthChoice enrollment by race/ethnicity. Enrollment increased within each racial/ethnic group between CY 2007 and CY 2011. However, this growth did not occur uniformly across all categories. The Hispanic and Other racial/ethnic categories increased by 43 percent and 59 percent, respectively. The Asian category experienced the most growth, increasing by 76 percent. The percentage of participants in the Black category decreased from 54 percent in CY 2007 to 50.3 percent in CY 2011, while the percentage of participants in the White category increased from 28 percent in CY 2007 to 29.3 percent in CY 2011.

Table 30. HealthChoice Enrollment by Race/Ethnicity, CY 2007 and CY 2011

| | CY 2007 | | CY 2011 | |
|--------------|------------------------|---------------|------------------------|---------------|
| | Number of Participants | Percentage | Number of Participants | Percentage |
| Asian | 14,600 | 2.3% | 25,694 | 3.1% |
| Black | 336,450 | 54.0% | 418,692 | 50.3% |
| White | 174,711 | 28.0% | 243,692 | 29.3% |
| Hispanic | 68,799 | 11.0% | 98,617 | 11.8% |
| Other | 28,739 | 4.6% | 45,803 | 5.5% |
| Total | 623,299 | 100.0% | 832,498 | 100.0% |

Ambulatory Care Visits

Figure 20 shows the percentage of children aged 0 through 20 years who received at least one ambulatory care visit across all racial/ethnic groups during the study period. This rate increased for all racial/ethnic groups during the evaluation period. Hispanics had the highest rate in both CY 2007 (83.8 percent) and CY 2011 (88.1 percent), and Blacks had the lowest rate across the study period.

Figure 20. Percentage of HealthChoice Participants Aged 0-20 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2007 and CY 2011

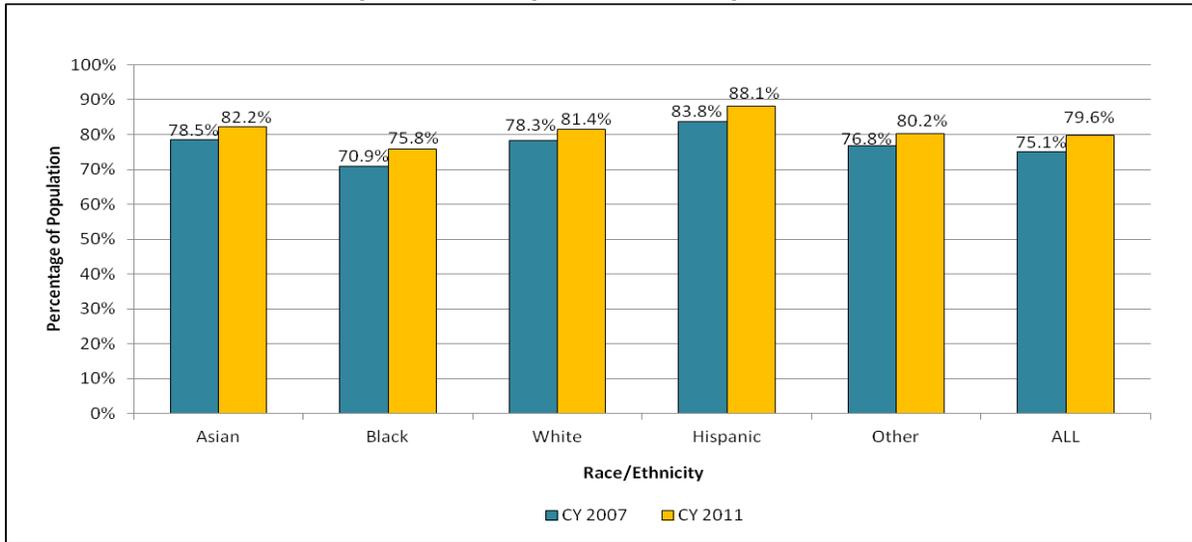
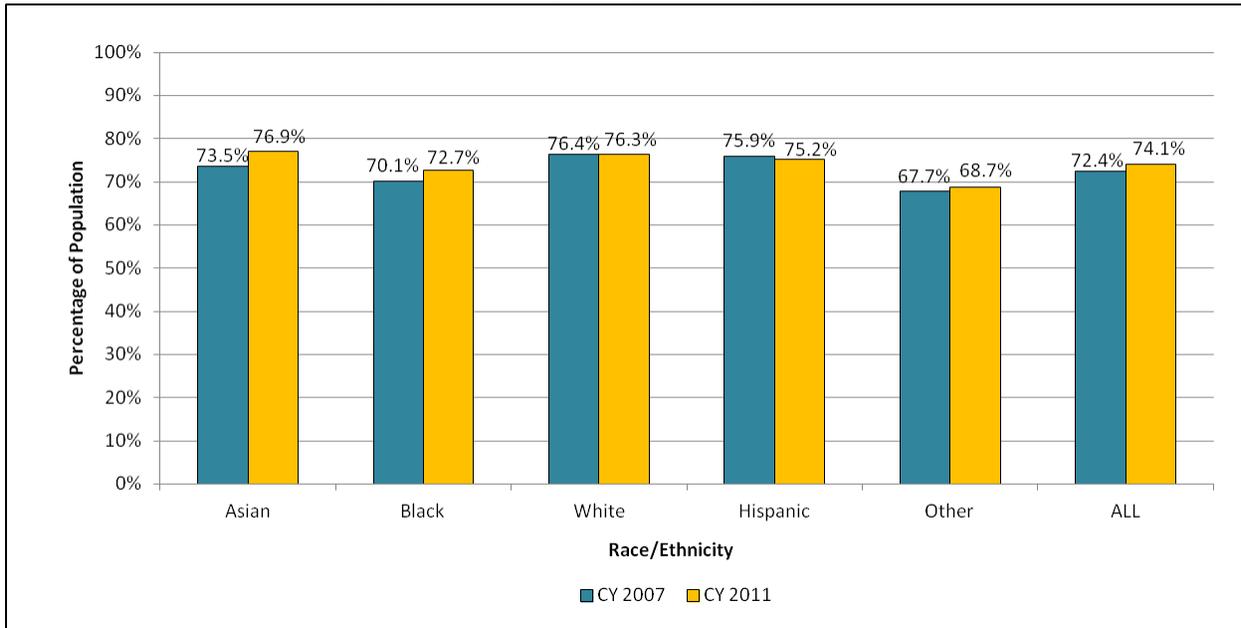


Figure 21 presents the percentage of adults aged 21 through 64 years who received at least one ambulatory care visit in CY 2007 and CY 2011. The ambulatory care visit rate improved for all racial/ethnic groups except Hispanics and Whites. The Asian racial/ethnic group experienced the greatest increase during the evaluation period (3.4 percentage points).

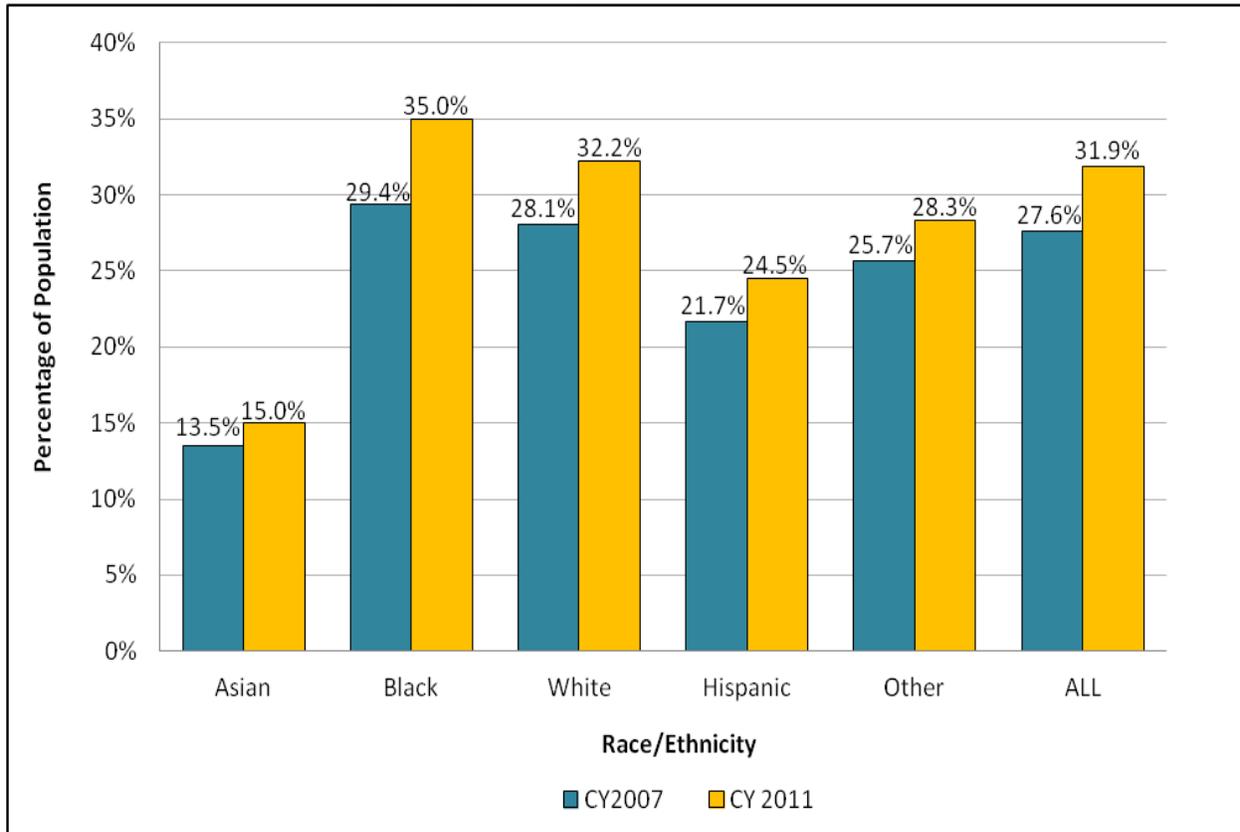
Figure 21. Percentage of HealthChoice Participants Aged 21-64 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2007 and CY 2011



ED Visits

Figure 22 displays the percentage of HealthChoice participants aged 0 through 64 years who had at least one ED visit by race/ethnicity in CY 2007 and CY 2011. Blacks had the highest ED visit rate, but each racial/ethnic group experienced an increase during the study period. Asians had the lowest rate across the study period.

Figure 22. Percentage of HealthChoice Participants Aged 0-64 Receiving an ED Visit by Race/Ethnicity, CY 2007 and CY 2011



Section IV Summary

This section of the report provided an overview of several special HealthChoice initiatives and programs. Some of the highlights of these special topics include:

- Dental services for children, pregnant women, and adults in the REM program were carved out of the MCO benefit package on July 1, 2009. These services are administered by an ASO. Maryland has made improvements in children’s dental service utilization and dental provider reimbursement.
- The percentage of participants with an MHD remained at approximately 25 percent between FY 2008 and FY 2011. The percentage of participants with an SUD ranged between 4.2 and 5 percent during the same time period. Both populations have similar rates of physician visits for somatic care, but participants with an SUD had a higher ED visit rate (67.6 percent) than participants with an MHD (46.2 percent) in FY 2011.
- In CY 2011, children in foster care had a lower rate of ambulatory care service utilization compared with other children in HealthChoice, as well as a higher rate of MCO outpatient ED visits.

- Measures of access to prenatal care services declined slightly during the study period, but Maryland outperformed the national HEDIS means in CY 2010.
- Due to program changes required by CMS, enrollment in the Family Planning Program decreased by 66 percent between CY 2007 and CY 2011 (using the any period of enrollment methodology).
- Ambulatory care service utilization, CD4 testing, and viral load testing improved for participants with HIV/AIDS during the study period. ED utilization by this population also increased during the study period.
- The REM program provides case management, medically necessary private duty nursing, and other expanded benefits to participants who have one of a specified list of rare and expensive medical conditions. The majority of REM participants are children (70 percent) and male (56 percent).
- Regarding racial and ethnic disparities in access to care, Black children have lower rates of ambulatory care visits than other children. Among the entire HealthChoice population, Blacks also have the highest ED utilization rates. DHMH will continue to monitor these measures to reduce disparities between racial/ethnic groups.

Section V. PAC Access and Quality

Implemented in July 2006, the PAC program offers limited benefits to childless adults aged 19 years and older who are not eligible for Medicare or Medicaid and whose incomes are at or below 116 percent of the FPL. The PAC program replaced the Maryland Pharmacy Assistance and Maryland Primary Care program. Participants must choose from one of five PAC MCOs and a participating PCP. Each MCO in the PAC program offers the following services:

- Primary care services, including visits to the doctor or clinic
- Family planning services
- Routine annual gynecological visits
- Prescriptions
- Certain over-the-counter medications with a doctor's order
- Some x-ray and laboratory services
- Diabetes-related services, including vision care and podiatry
- Mental health services provided by an enrollee's PCP
- Community-based substance abuse services (effective January 1, 2010)
- Outpatient ED facility services (effective January 1, 2010)

Additionally, participants may receive specialty mental health services through the FFS system. As a result of the Medicaid expansion option in the ACA, the PAC program will transition into a categorically eligible Medicaid population by January 2014. This section of the report analyzes a variety of PAC enrollment and service utilization performance measures.

PAC Enrollment

This section presents PAC enrollment from CY 2007 through CY 2011. The number of individuals with any period of enrollment in PAC increased by 164 percent during the study period: from 31,278 participants in CY 2007 to 82,647 participants in CY 2011.

Figure 23 presents the percentage of PAC participants with any period of enrollment by race/ethnicity for CY 2007 through CY 2011. Across the study period, Blacks and Whites composed around 95 percent of the PAC population, with the Black-to-White ratio almost 2 to 1 during the first two years of the study period. However, since CY 2009, this ratio has been decreasing.

Figure 23. PAC Enrollment (Any Period of Enrollment) by Race/Ethnicity, CY 2007-2011

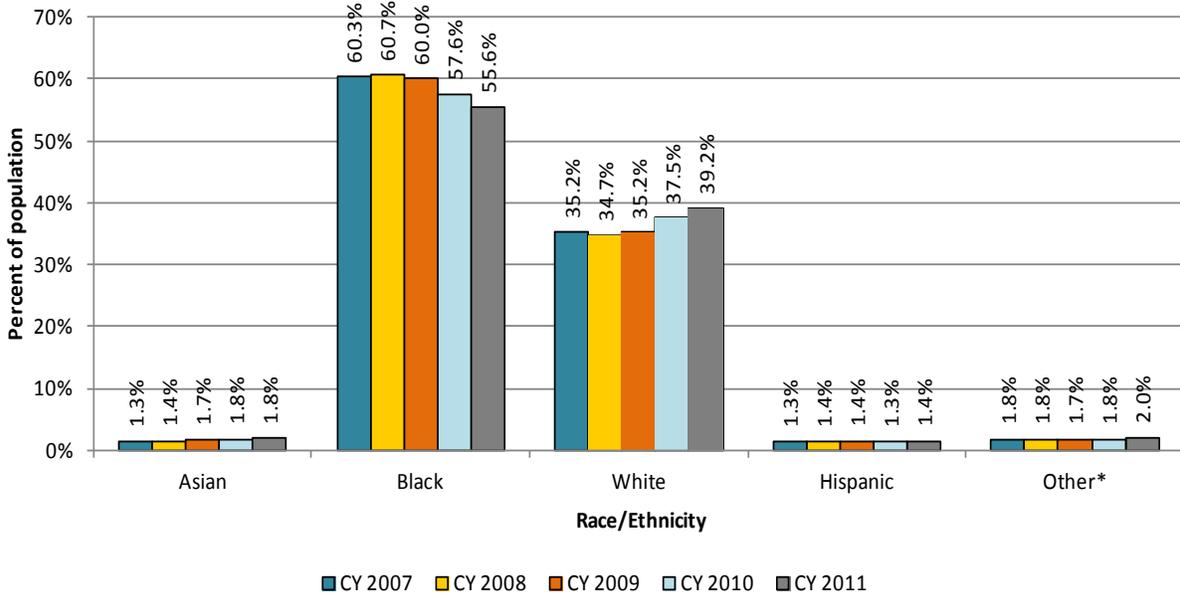
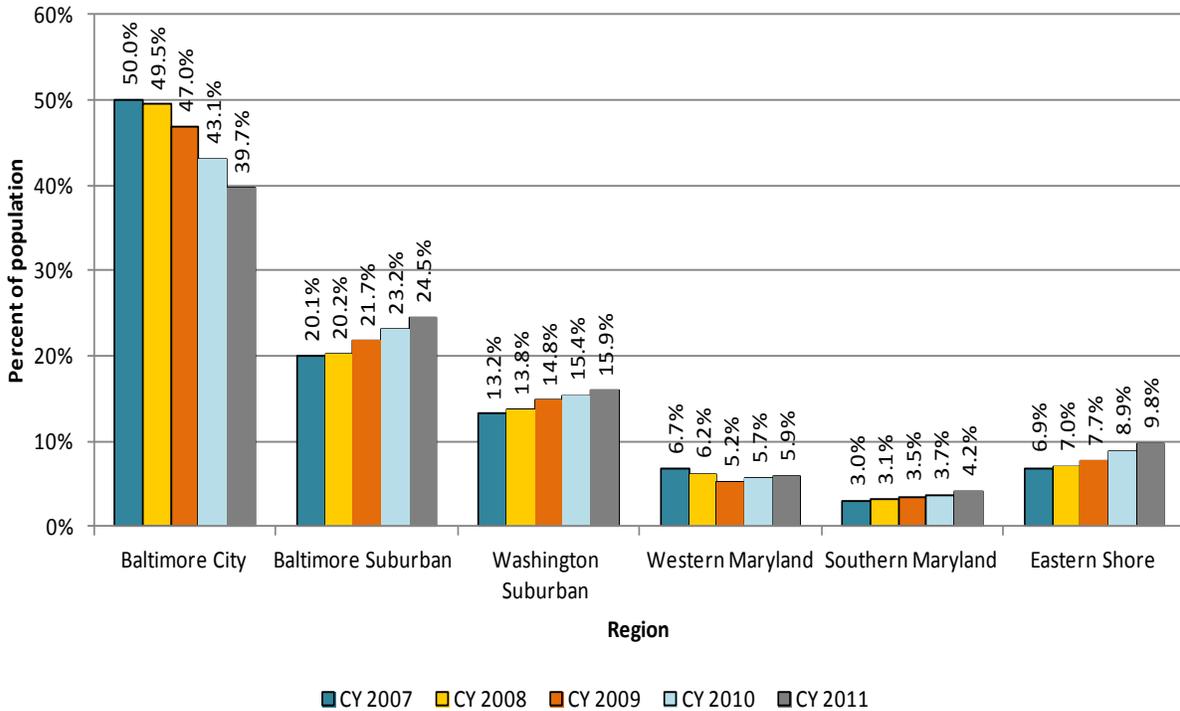


Figure 24 presents PAC enrollment by region from CY 2007 through CY 2011. Enrollment was concentrated in the densely populated areas of the State, with more than 80 percent residing in three regions: Baltimore City, Baltimore Suburban, and Washington Suburban.

Figure 24. PAC Enrollment (Any Period of Enrollment) by Region, CY 2007-2011



PAC Service Utilization

In order to provide a more accurate review of PAC enrollee service utilization, this section of the report includes only those who were enrolled in the PAC program for the entire year, except in the mental health and substance use disorder services sections.

Ambulatory Care Visits

Figure 25 presents the percentage of PAC participants who had at least one ambulatory care visit between CY 2007 and CY 2011 by race/ethnicity. The percentage of participants with an ambulatory care visit increased by 19.4 percentage points, from 55.0 percent in CY 2007 to 74.4 percent in CY 2011. Hispanic participants experienced the greatest increase (over 28 percentage points), followed by the Black, Asian, and Other categories, with increases around 20 percentage points. The number of Asians with an ambulatory care visit increased each year from CY 2007 to CY 2011, unlike the remaining racial/ethnic groups, which experienced a drop in CY 2011.

Figure 25. Percentage of PAC Participants (12 Months of PAC Enrollment) who Received an Ambulatory Care Visit by Race/ Ethnicity, CY 2007-CY 2011

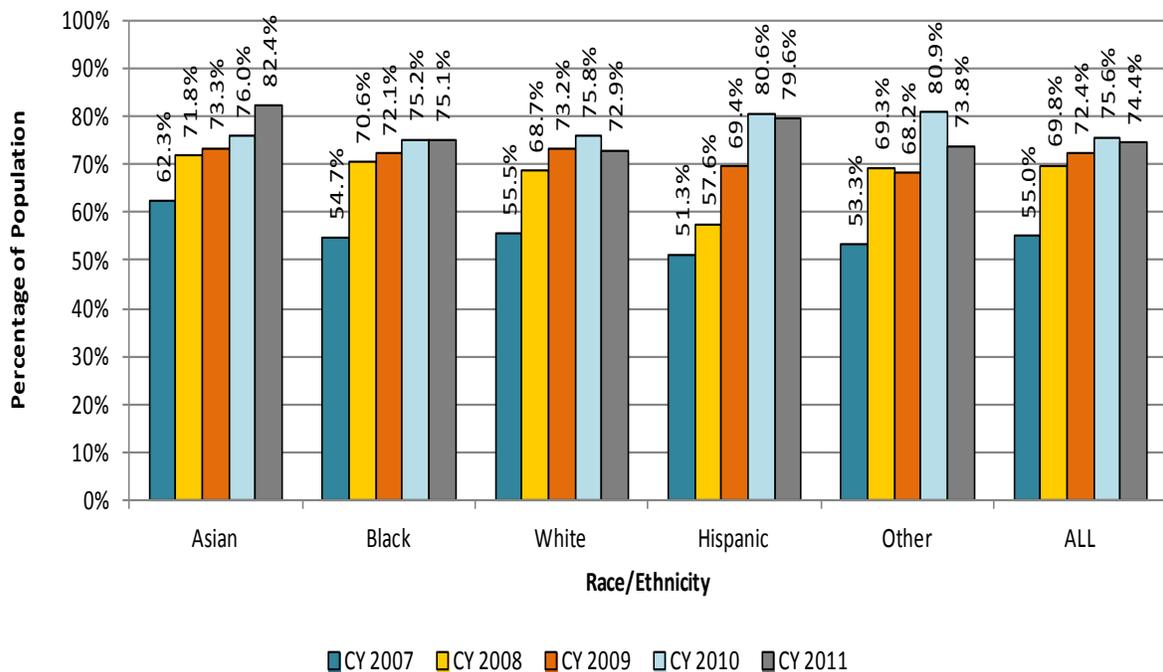
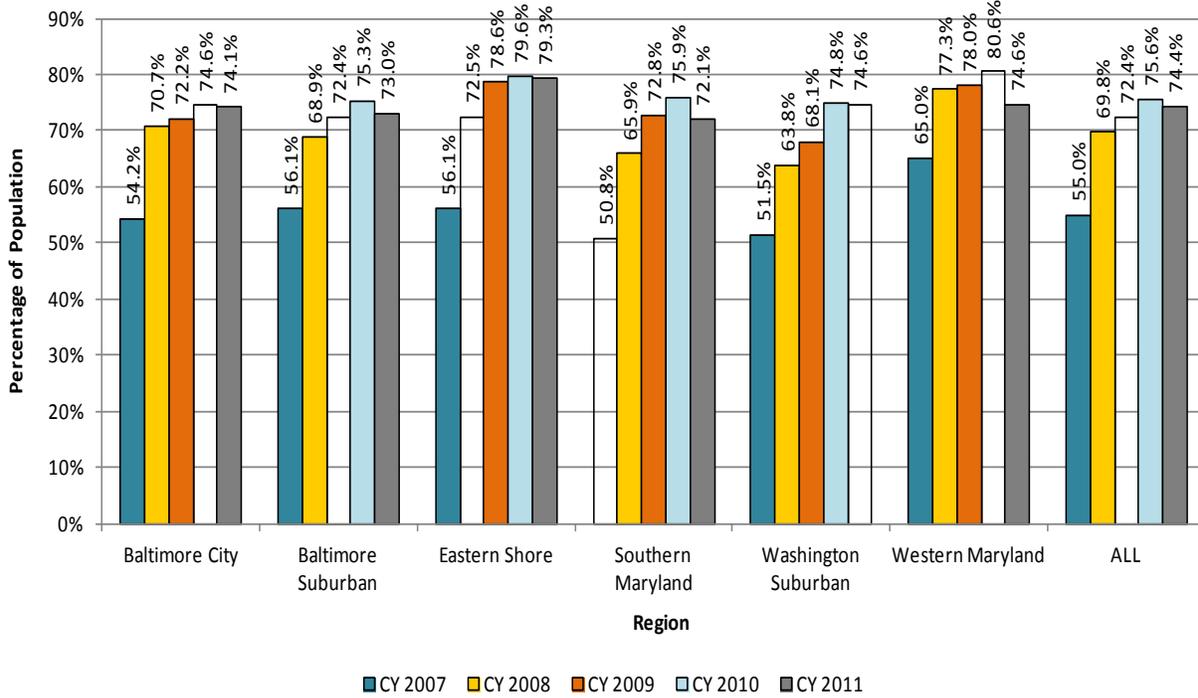


Figure 26 shows that the ambulatory care visit rate also increased within each region. The Eastern Shore and Washington Suburban regions experienced the greatest increase (23 percentage points), followed by Southern Maryland and Baltimore City (21.3 and 19.9 percentage points, respectively).

Figure 26. Percentage of PAC Participants (12 Months of PAC Enrollment) who Received an Ambulatory Care Visit by Region, CY 2007-CY 2011



Mental Health Services

Mental health services are carved out of the PAC MCO benefit package and are managed by an ASO. Table 31 shows the percentage of PAC participants with an MHD by region between FY 2008 and FY 2011. Overall, the percentage of PAC participants with an MHD decreased from 41.4 percent in FY 2008 to 38.3 percent in FY 2011.

Table 31. Percentage of PAC Participants (Any Period of Enrollment) with a Mental Health Disorder by Region, FY 2008 – FY 2011

| Region | FY 2008 | FY 2009 | FY 2010 | FY 2011 |
|---------------------|--------------|--------------|--------------|--------------|
| Baltimore City | 38.2% | 39.8% | 35.2% | 36.3% |
| Baltimore Suburban | 47.8% | 48.0% | 43.1% | 43.1% |
| Washington Suburban | 39.9% | 38.5% | 33.0% | 33.6% |
| Western Maryland | 41.8% | 41.3% | 43.5% | 43.4% |
| Eastern Maryland | 44.8% | 45.1% | 40.0% | 39.2% |
| Southern Maryland | 43.3% | 41.1% | 39.4% | 38.1% |
| Total | 41.4% | 41.9% | 37.8% | 38.3% |

Table 32 shows the percentage of PAC participants with an MHD who also accessed physician and ED somatic care services. The percentage of participants with at least one physician visit increased by 5.6 percentage points over the study period. The percentage of participants with an ED visit increased by nearly 33 percentage points, from 8.6 percent in FY 2008 to 41.3 percent in FY 2011.

Table 32. Service Utilization among PAC Participants (Any Period of Enrollment) with a Mental Health Disorder, FY 2008 – FY 2011

| Fiscal Year | PAC Participants with an MHD | Percentage with a Physician Visit for Somatic Care | Percentage with an ED Visit for Somatic Care |
|-------------|------------------------------|--|--|
| 2008 | 9,044 | 71.6% | 8.6% |
| 2009 | 10,003 | 73.7% | 9.6% |
| 2010 | 13,969 | 76.9% | 30.3% |
| 2011 | 19,133 | 77.2% | 41.3% |

Substance Use Disorder Services

Table 33 shows the percentage of PAC participants with an SUD by region between FY 2008 and FY 2011. Throughout the evaluation period, the Baltimore City region had the largest percentage of participants with an SUD. Overall, the percentage of PAC enrollees with an SUD increased steadily over the study period.

Table 33. Percentage of PAC Participants (Any Period of Enrollment) with a Substance Use Disorder by Region, FY 2008 – FY 2011

| Region | FY 2008 | FY 2009 | FY 2010 | FY 2011 |
|---------------------|--------------|--------------|--------------|--------------|
| Baltimore City | 22.9% | 22.6% | 33.9% | 38.1% |
| Baltimore Suburban | 10.8% | 11.0% | 26.8% | 32.4% |
| Washington Suburban | 5.2% | 6.3% | 11.8% | 16.3% |
| Western Maryland | 3.3% | 5.0% | 20.3% | 28.5% |
| Eastern Maryland | 4.9% | 6.5% | 19.8% | 25.0% |
| Southern Maryland | 7.2% | 5.6% | 15.0% | 25.1% |
| Total | 14.6% | 15.1% | 26.3% | 31.1% |

Table 34 shows the percentage of PAC participants with an SUD who also accessed somatic physician and ED services. The percentage of participants with at least one physician visit decreased from 87.2 percent in FY 2008 to 68.3 percent in FY 2011. The percentage of participants with an ED visit increased from 13.7 percent in FY 2008 to 43.5 percent in FY 2011. The number of participants with an SUD, the increase in ED visits for somatic care, and the decrease in the overall percentage of PAC participants with an SUD accessing somatic care can be attributed to the addition of outpatient substance abuse services and coverage for ED facility charges to the PAC benefit in January 2010.

Table 34. Service Utilization among PAC Participants (Any Period of Enrollment) with a Substance Use Disorder, FY 2008 – FY 2011

| Fiscal Year | PAC Participants with an SUD | Percentage with a Physician Visit for Somatic Care | Percentage with a ED Visit for Somatic Care |
|-------------|------------------------------|--|---|
| 2008 | 3,191 | 87.2% | 13.7% |
| 2009 | 3,595 | 89.0% | 15.4% |
| 2010 | 9,729 | 72.3% | 34.2% |
| 2011 | 15,519 | 68.3% | 43.5% |

Table 35 presents the number and percentage of PAC participants with an SUD and at least one methadone replacement therapy service. Between FY 2010 and FY 2011, the percentage of participants with at least one methadone replacement therapy increased from 3.3 percent to 29.4 percent.

Table 35. Number and Percentage of PAC Participants (Any Period of Enrollment) with a Substance Use Disorder and at least One Methadone Replacement Therapy, FY 2008 – FY 2011

| Fiscal Year | PAC Participants with an SUD | Number of Participants with an SUD and Methadone Replacement Therapy | Percentage of Total Participants with an SUD |
|-------------|------------------------------|--|--|
| 2008 | 3,191 | 37 | 1.2% |
| 2009 | 3,595 | 57 | 1.6% |
| 2010 | 9,729 | 321 | 3.3% |
| 2011 | 15,519 | 4,566 | 29.4% |

Prescription Drug Use

Table 36 presents the percentage of PAC participants who filled a prescription in CY 2007 and CY 2011 by the number of prescriptions filled per person. The percentage of participants who filled a prescription increased from 69.5 percent in CY 2007 to 83.2 percent in CY 2011.

Table 36. Percentage of PAC Participants (12 Months of Enrollment) with a Prescription by Number of Prescriptions, CY 2007 and CY 2011

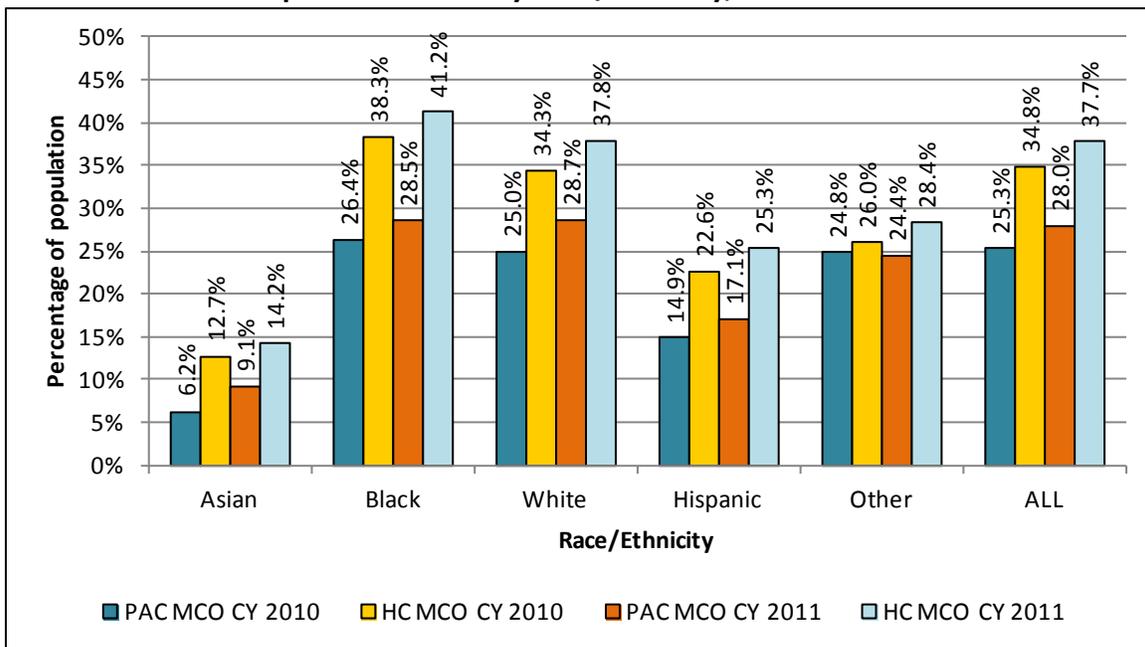
| Number of Prescriptions | CY 2007 | | CY 2011 | |
|-------------------------|------------------------|---------------------|------------------------|---------------------|
| | Number of Participants | % with Prescription | Number of Participants | % with Prescription |
| 0 | 5,002 | 30.5% | 3,627 | 16.8% |
| 1 | 624 | 3.8% | 864 | 4.0% |
| 2 | 702 | 4.3% | 1,024 | 4.7% |
| 3 | 486 | 3.0% | 810 | 3.7% |
| 4 | 503 | 3.1% | 699 | 3.2% |
| 5-10 | 1,926 | 11.8% | 3,027 | 14.0% |
| 11-20 | 2,160 | 13.2% | 3,720 | 17.2% |
| 21-30 | 1,406 | 8.6% | 2,424 | 11.2% |
| 31-40 | 1,020 | 6.2% | 1,660 | 7.7% |
| 41-50 | 756 | 4.6% | 1,195 | 5.5% |
| 51 or More | 1,803 | 11.0% | 2,566 | 11.9% |
| ALL | 16,388 | 100.0% | 21,616 | 100.0% |

ED Visits

On January 1, 2010, Maryland added outpatient ED visits to the PAC benefit package. Figure 27 compares the percentage of PAC participants who had at least one outpatient ED visit in CY 2010 and CY 2011 with the percentage of HealthChoice participants aged 19 to 64 years with an ED visit in those years. These data are presented by race/ethnicity.

In both years, outpatient ED utilization rates among HealthChoice participants were nearly 10 percentage points higher than PAC participants. Among all racial/ethnic groups, Blacks had a higher rate of ED use for both the PAC and HealthChoice populations, except in CY 2011 when Whites in the PAC population had a slightly higher utilization rate (28.7 percent) than Blacks (28.5 percent).

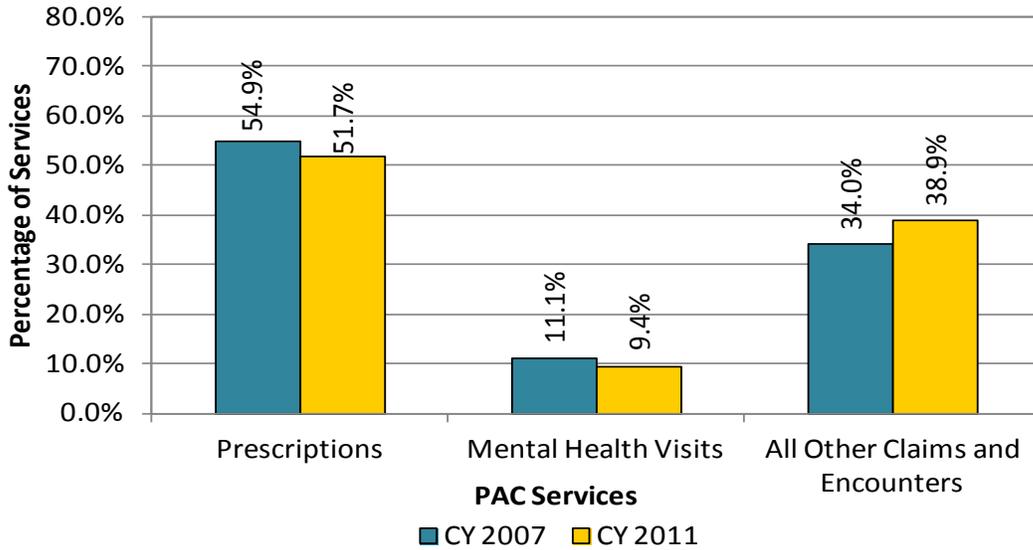
Figure 27. PAC Population vs. HealthChoice Population (Any Period of Enrollment) Receiving an Outpatient ED Visit by Race/Ethnicity, CY 2010–CY 2011



Composition of Total PAC Services

Figure 28 presents the overall composition of services (categorized as prescriptions, mental health, and all other services) provided under the PAC program in CY 2007 and CY 2011. Across the study period, prescriptions accounted for over half of all PAC services. Mental health visits accounted for 9.4 percent of the services in CY 2011, a 1.7 percentage point decrease from CY 2007. The “all other services” category increased by about 5 percentage points between CY 2007 and CY 2011.

Figure 28. Comparison of Total Services Provided in PAC, CY 2007 and CY 2011



PAC HEDIS Measures

In CY 2008, DHMH began using HEDIS to assess quality and service utilization in the PAC program. The PAC HEDIS measures include breast cancer screening, cervical cancer screening, and comprehensive diabetes care. Table 37 compares the PAC HEDIS measures with the national HEDIS means for CY 2008 through CY 2011 (HealthcareData Company LLC, 2012).

The breast cancer screening measure assesses the percentage of women aged 40 through 69 years who received at least one mammogram for breast cancer screening within a two-year period. Overall, about 41 percent of women enrolled in PAC received a mammogram in CY 2011, an increase of 8.7 percentage points over CY 2008.

The cervical cancer screening measure is reported for women aged 21 through 64 years who received a PAP test within a three-year period. The rate increased by 5.4 percentage points between CY 2008 and CY 2011. It should be noted that this measure examines participants’ experiences during the measurement year and the two years prior to the measurement year. PAC was not in existence for three years when these measures were conducted, which may explain why the PAC scores are lower than the national HEDIS means.

The CDC measure assesses the percentage of participants with diabetes (types 1 and 2) who received HbA1c testing, eye exams, and LDL-C screening. Between CY 2008 and CY 2011, the HbA1c testing rate, the eye exam rate, and the LDL-C screening rates increased. PAC CDC rates are below national averages, but CY 2011 was the first year in the measurement period when the LDL-C screening rate surpassed the national HEDIS mean.

**Table 37. PAC HEDIS Measures Compared with the National HEDIS Means,
CY 2008–CY 2011**

| HEDIS Measures | CY 2008 | | CY 2009 | | CY 2010 | | CY 2011 | |
|---------------------------|---------|---------------------|---------|---------------------|---------|---------------------|---------|---------------------|
| | PAC | National HEDIS Mean |
| Breast Cancer Screening | 32.1% | 50.8% | 38.4% | 52.4% | 41.7% | 51.3% | 40.8% | 50.4% |
| Cervical Cancer Screening | 39.1% | 66.0% | 42.0% | 65.8% | 42.7% | 67.2% | 44.5% | 66.7% |
| CDC – HbA1c Testing | 75.2% | 80.5% | 77.0% | 80.6% | 76.7% | 82.0% | 81.6% | 82.5% |
| CDC – Eye Exam | 35.1% | 52.8% | 44.8% | 52.7% | 40.5% | 53.1% | 40.7% | 53.4% |
| CDC – LDL-C Screening | 73.0% | 74.1% | 72.6% | 74.2% | 72.8% | 74.7% | 76.2% | 75.0% |

Section V Summary

PAC is a limited benefit program for adults with low income who are not eligible for Medicare or the full Medicaid benefit package. Overall, PAC enrollment increased 164 percent during the study period. DHMH measured PAC ambulatory care, MHD and SUD services, and prescription drug utilization between CY 2007 and CY 2011. During the study period, ambulatory care and prescription utilization increased, as did the use of physician visits and ED visits for somatic care by PAC participants with an MHD. The percentage of PAC participants with an SUD and an ED visit for somatic care increased over the study period, while the percentage with a physician visit decreased. On January 1, 2010, Maryland added outpatient ED visits to the PAC benefit package. In CY 2011, 28 percent of PAC participants had at least one ED visit, which is a 2.7 percentage point increase from CY 2010. DHMH began using PAC HEDIS measures in CY 2008. PAC performance on these measures improved during the study period but remained lower than the national HEDIS means except for the LDL-C screening rate in CY 2011.

Conclusion

HealthChoice is a mature managed care program that provides services to 15 percent of Marylanders. The information presented in this renewal application provides strong evidence that HealthChoice has been successful in achieving its stated goals related to coverage and access to care, providing a medical home to participants, and improving quality of care. As with any program, there are areas that need improvement to ensure that the growing number of participants have access to quality care. DHMH is committed to working with CMS and other stakeholders to identify and address necessary programmatic changes upon renewal of this waiver.

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Appendix A. Summary of Public Comments

Public Hearings

The public did not provide any formal comments during the first hearing. Several individuals asked clarifying questions about DHMH's proposals to continue to cover pregnant women with income up to 250 percent of the FPL and to phase out new enrollment in the Breast and Cervical Cancer Program after January 1, 2014.

During the second hearing, DHMH received two comments related to the waiver application. The first comment raised the concern that DHMH requesting a waiver from implementing the alternative benefit package would result in limiting substance abuse and mental health services for the population of childless adults and higher income parents newly eligible under the Medicaid expansion. DHMH requested a list of services that the alternative benefit package would cover that are presently unavailable under HealthChoice, and further explained the administrative burden and disparities created by offering different benefit packages to different populations in HealthChoice.

In the second comment, a stakeholder recommended that DHMH adopt a collaborative care model in providing primary care to individuals with mental health and substance use disorders. To address this comment, DHMH advised the commenter to take part in ongoing stakeholder meetings involving the behavioral health integration process, as that environment may be a more appropriate vehicle for introducing care models.

Written Comments

DHMH received three sets of written comments after the 30-day notification period. These comments addressed the following topics:

ICS Program

One stakeholder recommended that DHMH increase the enrollment cap for the ICS program (the current cap is 30) and make the eligibility criteria less restrictive through methods such as excluding cost-of-living adjustment (COLA) increases from the income limit. To address this comment, DHMH decided to modify the waiver renewal application to permit individuals receiving services through the Living at Home or Older Adults waiver (or a successor waiver to these two waivers) with a 300 percent of SSI income limit to transition directly into the ICS program if their income exceeds the 300 percent of SSI by no more than 5 percent (such as due to a COLA). Any excess income above 300 percent of SSI would be collected by the DHMH and used to offset the individual's Medicaid expenses.

Pregnant Women

One stakeholder suggested that DHMH implement a case management function to assist pregnant women who transition eligibility between Medicaid and the Exchange. To address this comment, DHMH will work closely with the Public Health Administration to ensure that pregnant women with incomes between 138 and 250 percent of the FPL are transitioned back into qualified health plans offered in the Exchange. As part of this effort, DHMH will continue to fund Administrative Care Coordination Units (ACCUs) located in health departments. The ACCUs provide administrative case management services to pregnant and postpartum women, as well as other special populations. DHMH will work with the ACCUs to help pregnant women with both the Medicaid intake process, as well as the transition back into QHPs.

Breast and Cervical Cancer Program

One stakeholder recommended that DHMH implement case management and other activities to identify women with breast and cervical cancer who remain uninsured after 2014. To address this comment, DHMH proposed to grandfather women currently enrolled in the program and will work with local health departments to ensure that new women screened for breast and cervical cancer through the public health program enroll in the Medicaid program or a qualified health plan offered in the Exchange, depending on the woman's income.

Substance Abuse Services

One stakeholder group recommended DHMH adopt the EHB alternative benefit package to expand substance abuse services. DHMH responded to this comment with a letter explaining its concerns about the proposed requirement for states to offer EHBs to the newly eligible expansion population. The key concern is that this proposed rule only would apply to the newly eligible category of adults. This would create a situation where the higher income adult Medicaid enrollees would receive a more generous benefit package than accorded to existing, lower income Medicaid populations, unless Medicaid expanded the benefit package for all adults, at significant cost to the State for those populations covered under the usual 50/50 match rate. Offering the enhanced benefits only to the expansion population would be inequitable treatment of lower-income beneficiaries, and it would create a churn point in covered services within Medicaid as adults move across differing Medicaid benefit packages. This would result in higher administrative costs and coverage disparities, and it likely could not be implemented with our current claims system.

DHMH also noted that the Secretary decided to move forward with a behavioral health integration initiative that will establish a performance-based carve-out for substance abuse and mental health services. DHMH encouraged this stakeholder group to participate in the planning activities for this initiative and provided them with stakeholder meeting dates.

PCMH

One stakeholder requested that DHMH allow federally qualified health centers to receive fixed transformation payments in the PCMH pilot. DHMH responded to this comment with a letter indicating that it increased its budget for the pilot, enabling DHMH to begin providing federally qualified health centers with fixed per member per month payments.

Maryland HealthChoice Program
§1115 Waiver Renewal Application

**Attachment 2. MEG Crosswalk
and Capitation Rates**

| Crosswalk for HealthChoice 1115 Waiver Renewal | | | |
|--|--|---|--|
| New MEGS and Coding | Current MEGS | Proposed Blended CAP RATE 1st (start) year of renewal, DY 17 | Trend Rate Forward for each of DY 18, DY 19 & DY 20 |
| TANF Parent 0-116 | TANF LT 30 ADULT TANF 30-116 ADULT | \$809.25 | 5.3 |
| NEW:Parent 116-138 | | \$809.25 | 5.3 |
| Medicaid Child (0-21) | TANF LT 30 CHILD TANF 30-116 CHILD SOBRA CHILD | \$445.05 | 4.9 |
| MCHP | MCHP | | N/A |
| MCHP Premium | MCHP Premium | | N/A |
| SSI-BD ADULT | SSI-BD ADULT | \$1,948.31 | 6 |
| SSI-BD CHILD | SSI-BD CHILD | \$1,765.73 | 6 |
| MEDICALLY NEEDY ADULT | MEDICALLY NEEDY ADULT | \$4,734.49 | 5.3 |
| MEDICALLY NEEDY CHILD | MEDICALLY NEEDY CHILD | \$2,165.30 | 4.9 |
| SOBRA ADULT | SOBRA ADULT | \$3,652.20 | 5.3 |
| FAMILY PLANNING | FAMILY PLANNING | | Pass Through |
| Childless Adult | PAC | \$892.00 | 5.3 |
| ICS | ICS | | N/A |
| Breast and Cervical Cancer | New | | N/A |

Maryland HealthChoice Program
§1115 Waiver Renewal Application

Attachment 3. Public Notice Documentation

**DEPARTMENT OF HEALTH AND
MENTAL
HYGIENE/LABORATORIES
ADMINISTRATION**

Subject: Call for Pharmacist Nominations for Drug Utilization Review (DUR) Board
Add'l. Info: The Maryland Department of Health and Mental Hygiene Drug Utilization Review (DUR) Board is currently recruiting for two pharmacists to serve on the Maryland DUR Board beginning in September 2013.

The implementation of the Omnibus Budget Reconciliation Act of 1990 requires that the Maryland Department of Health and Mental Hygiene establish a DUR Board. The DUR Board is comprised of both physicians and pharmacists and has been in operation since November 1992. The activities of the DUR Board include:

- Overseeing retrospective and prospective DUR within the Maryland Medicaid Program.
- Approving DUR criteria and standards.
- Making recommendations concerning education and other types of interventions based on prospective and retrospective DUR findings.
- Preparing an annual report for submission to the Centers for Medicare and Medicaid (CMS) describing the nature and scope of the DUR program, summarizing educational/interventional strategies used, and estimating cost savings generated.
- Reviewing individual recipient profiles and make recommendations to restrict patients who might be abusing Medicaid prescription drugs.

The DUR Board has quarterly 3-hour meetings in the Baltimore area. Meetings are normally scheduled on a Thursday morning during the months of March, June, September, and December.

The membership of the Maryland DUR Board includes health care professionals who have recognized knowledge and expertise in one of the following areas:

- (1) The clinically appropriate prescribing of outpatient drugs.
- (2) The clinically appropriate dispensing and monitoring of outpatient drugs.
- (3) Drug use review, evaluation and intervention.
- (4) Medical quality assurance.

For an application packet, please contact Gina Homer at The Maryland Medicaid Pharmacy Program at 410-767-1749 or via email at Gina.Homer@Maryland.gov. The application deadline is June 14, 2013.
Contact: Gina Homer (410) 767-1749

[13-09-41]

**DEPARTMENT OF HEALTH AND
MENTAL HYGIENE/OFFICE OF
HEALTH SERVICES**

Subject: HealthChoice Waiver Renewal Notice

Add'l. Info: The Secretary of Health and Mental Hygiene is proposing to renew its §1115 demonstration waiver known as HealthChoice for a period of 3 years. HealthChoice, first implemented in 1997 under the authority of Section 1115 of the Social Security Act, is Maryland's Statewide mandatory managed care program for Medicaid enrollees. Under HealthChoice, eligible families and individuals are required to enroll into a managed care organization that has been approved by the Maryland Department of Health and Mental Hygiene. Each MCO is responsible for ensuring that HealthChoice enrollees have access to a network of medical providers that can meet the health needs of each enrollee.

This renewal period will focus primarily on changes to HealthChoice and Medicaid required by implementing the Affordable Care Act (ACA). A major revision to the 1115 waiver proposes shifting current and future Primary Adult Care (PAC) eligible individuals to HealthChoice, permitting them to receive full Medicaid benefits in lieu of a limited benefit package.

Electronic copies of the draft application may be downloaded from the following website:

<https://mmcp.dhnh.maryland.gov/healthchoice/SitePages/HealthChoice%20Renewal%202013.aspx>

Hard copies of the application may be obtained by calling (410) 767-5806.

Interested parties may send written comments concerning the waiver renewal to Tricia Roddy, Director of Planning, Maryland Medicaid Program, DHMH, 201 W. Preston St., Room 224, Baltimore, MD 21201, emailed to tricia.rodny@maryland.gov, or faxed to (410) 333-7505. Written comments will be accepted until Monday, June 3, 2013.

The following public hearings will discuss the content of the waiver renewal and solicit feedback and input from public stakeholders:

Baltimore City: Thursday, April 25, 2013; 3 — 5 p.m.; Maryland Department of Health and Mental Hygiene, 201 West Preston Street, Room L-3, Baltimore, MD 21201

Webinar Access: To participate in the public hearing remotely, please visit <https://mmcp.dhnh.maryland.gov/healthchoice/SitePages/HealthChoice%20Renewal%202013.aspx> for the webinar link.

Audio Conference Line: (410) 225-5300; Meeting ID: 4913; Health Dept. VOIP: 5300

Annapolis: Thursday, May 9, 2013; 1 — 3 p.m.; House Office Building, 6 Bladen Street, Health and Government Operations Committee Hearing Room 240, Annapolis, MD 21401

Contact: Michael Cimmino (410) 767-0579

[13-09-47]

**BOARD OF HEATING,
VENTILATION, AIR-
CONDITIONING, AND
REFRIGERATION CONTRACTORS
(HVACR)**

Subject: Public Meeting

Date and Time: May 8, 2013, 9:30 a.m. — 12 p.m.

Place: 500 N. Calvert St., 3rd Fl. Conf. Rm., Baltimore, MD

Contact: Steve Smitson (410) 230-6169

[13-09-06]

**MARYLAND STATEWIDE
INDEPENDENT LIVING COUNCIL
(MSILC) AND MARYLAND DIVISION
OF REHABILITATION SERVICES
(DORS)**

Subject: Public Meeting

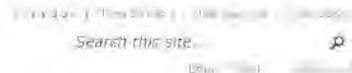
Date and Time: May 9, 2013, 4 — 6:30 p.m.

Place: Workforce & Technology Center, 2301 Argonne Dr., Baltimore, MD 21218; 410-554-9442; Free Parking

Add'l. Info: The Maryland Statewide Independent Living Council (MSILC) and the Maryland Division of Rehabilitation Services (DORS) invite people with disabilities, parents, advocates and others to public meetings to comment on the draft 2014—2016 Maryland State Plan for Independent Living (SPIL).

The mission of Maryland's Independent Living (IL) programs and services is to maximize the independence and productivity of people with disabilities and promote meaningful integration into the community. All programs and services have, at their core, the ideals of consumer control based on the concept of consumer direction and choice.

The State Plan assures that the IL Programs in Maryland are operated in accordance with the federal Rehabilitation Act, as amended. The public can read in advance and comment about the State Plan by visiting www.dors.state.md.us by calling 240-638-0074 or emailing marylandsilc@gmail.com. Comments provided in writing, by phone or email are due no later than April 30, 2013.



MMA CHILDREN'S HEALTH PAC PROGRAM PHARMACY PROGRAM LONG TERM CARE

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HealthChoice • HealthChoice Renewal 2013

Maryland HealthChoice §1115 Waiver Renewal Notice of Public Hearings and Public Comment Submission Process

To download the current draft of the HealthChoice §1115 Waiver Renewal Application, please click the following link:

[Draft HealthChoice 1115 Waiver Renewal 4.19.13.pdf](#)

About the HealthChoice §1115 Waiver Renewal Application

HealthChoice is Maryland's statewide mandatory Medicaid managed care program. The 2013 submission of the §1115 Waiver Renewal Application marks the fourth renewal since 1997, when the Department of Health and Mental Hygiene (DHMH) first implemented the HealthChoice program. DHMH submitted previous renewals in 2005, 2007, and 2010. The 2013 renewal application primarily focuses on changes to Maryland Medicaid required under the Affordable Care Act (ACA), and is organized into the following sections:

- Recent changes to the waiver (pgs. 1-3).
- Special initiatives in the next renewal period (pgs. 3-7).
- Requested changes in the next renewal period (pgs. 7-9).
- A list and description of the requested waiver and expenditure authorities (pgs. 10-12).
- A description of the public input process (pgs. 12-13), and
- An evaluation report of the demonstration from calendar years 2007 to 2011 (pgs. 14-73).

A significant change resulting from the implementation of the ACA stems from Maryland's ability to extend full Medicaid coverage to individuals with incomes up to 138 percent of the federal poverty level. DHMH anticipates the result of this provision will result in approximately 108,000 new individuals receiving health care coverage through Medicaid and the new health benefits exchange (the Exchange) in fiscal year 2014. In this renewal, DHMH is requesting the extension of full Medicaid benefits under HealthChoice to childless adults under the age of 65. This population traditionally would be eligible for a limited benefit package in the Primary Adult Care (PAC) program. Because current and future participants in PAC will be eligible for full Medicaid benefits as a result of the ACA, DHMH plans to shift these individuals into HealthChoice and cease operation of PAC, effective January 1, 2014. The Department estimates approximately 88,000 of new enrollees into Medicaid will originate from the PAC expansion.

Public Hearing Notice

The following public hearings will discuss the content of the HealthChoice §1115 Waiver Renewal Application and solicit feedback and input from public stakeholders:

Baltimore City
Thursday, April 25, 2013
3:00 PM - 5:00 PM
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Room L-3
Baltimore, MD 21201

This hearing will be web and audio conference accessible.
Webinar Link (No registration required, only guest sign-in): [Join Webinar](#)
Audio Conference Information: (410) 225-5300; Meeting ID - 4913

Annapolis
Thursday, May 9, 2013
1:00 PM - 3:00 PM
House Office Building
6 Bladen Street
Health and Government Operations Committee Hearing Room 240
Annapolis, MD 21401

Public Comment Submission Process

Interested parties may also send written comments concerning the HealthChoice §1115 Waiver Renewal Application to Tricia Roddy, Director of Planning, Maryland Medicaid Program, DHMH, 201 West Preston Street, Room 224, Baltimore, MD 21201. Comments may also be emailed to tricia.rodody@maryland.gov or faxed to (410) 333-7505 with the subject "2013 HealthChoice 1115 Waiver Application -- Comment."

Written comments will be accepted until Monday, June 3, 2013.

To view information on Maryland's current waivers filed with CMS, please visit Medicaid.gov.

[Contact the Department](#) |
 [Accounting](#) |
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 [Forms](#) |
 [Home](#)

201 West Preston Street - Baltimore, MD 21201 - (410) (410) 225-5300 ext. 2714

Telephone: 410-841-3770
301-858-3770

HABILITATIVE SERVICES BENEFITS, WORKGROUP ON ACCESS TO
Senator Richard S. Madaleno, Jr., Co-Chair
Delegate Ariana B. Kelly, Co-Chair

Wednesday May 22, 2013

9:30 A.M. Hearing Room
to
11:30 A.M. Maryland Insurance
Administration
St. Paul Plaza
200 St. Paul Place
Baltimore, MD

Subject: Meeting information and meeting notes are available on the MIA
Web site at
[http://www.mdinsurance.state.md.us/sa/news-center/legislative-
information.html](http://www.mdinsurance.state.md.us/sa/news-center/legislative-information.html)

FOR FURTHER INFORMATION, CONTACT: Tinna Damaso Quigley, Maryland Insurance
Administration
Telephone: 410-468-2202

HEALTH AND MENTAL HYGIENE, DEPARTMENT OF
Tricia Roddy, Chair

Thursday May 9, 2013

1:00 P.M. Room 240
to
3:00 P.M. House Office Building
6 Bladen Street
Annapolis, MD

Subject: Public Hearing, Healthchoice 1115 Waiver Renewal

FOR FURTHER INFORMATION, CONTACT: Monchel Pridget, Dept. of Health and Mental Hygiene
Telephone: 410-767-5946

Addendum Issued: April 19, 2013

Thursday April 25, 2013

3:00 P.M. Lobby Level, L-3
to Department of Health and
5:00 P.M. Mental Hygiene
201 West Preston Street
Baltimore, MD

Subject: Public Hearing, Healthchoice 1115 Waiver Renewal

FOR FURTHER INFORMATION, CONTACT: Monchel Pridget, Dept. of Health and Mental Hygiene
Telephone: 410-767-5946

MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION
John A. Hurson, Chair

FOR FURTHER INFORMATION, CONTACT: Mark Luckner, Executive Director MD
Community Health Resources Commission
Telephone: 410-260-7046

Addendum Issued: April 19, 2013

Friday April 26, 2013

1:00 P.M. Conference Call

Subject: Discussion and approval of the CHRC Local Health Improvement Coalitions (LHIC) RFP
This call is open to the public, but participation is open only to Members of the Commission
Dial in number: 866.247.6034; Conference code: 4102607046



HealthChoice 1115 Waiver Renewal Application

Carrol Barnes -DHMH- <carrol.barnes@maryland.gov>

Fri, Apr 19, 2013 at 2:39 PM

To: "Barnes, Carrol" <Carrol.Barnes@maryland.gov>

Bcc: "Alborn, Salliann" <salborn@chipmd.org>, "Barnes, Carrol" <barnesc@dhmh.state.md.us>, "Barnes, Carrol" <Carrol.Barnes@maryland.gov>, "Booker, D.D.S, Winifred" <wbcohi@aol.com>, "Charles Shubin, MD" <cshubin@umaryland.edu>, "Demattos, Joseph" <jdemattos@hfam.org>, "Douglas, Michele" <mdouglas@marylandadvocacy.com>, "Doyle, Lori" <lori.doyle@mosaicinc.org>, "Hammen, Del. Peter" <peter.hammen@house.state.md.us>, "Hartley, Floyd" <hartleyfloyd_ssf@yahoo.com>, "Keane, M.D., Virginia" <vkeane@peds.umaryland.edu>, "Kelley, Delores" <delores.kelley@senate.state.md.us>, "Kipke, Delegate Nic" <kipke@kipke.com>, "Lessard, Kerry" <kerrylessard@me.com>, "Lindamood, Kevin" <klindamood@hchmd.org>, "Malone, Rosemary" <rmalone@dhr.state.md.us>, "Middleton, Sen. Thomas" <thomas.mclain.middleton@senate.state.md.us>, "Mizeur, Heather" <heather.mizeur@house.state.md.us>, "Muse, C. Anthony" <anthony.muse@senate.state.md.us>, "Nathan-Pulliam, Shirley" <shirley.nathan.pulliam@house.state.md.us>, "Phelps, Sue" <sphelps@jhhc.com>, "Rasenberger, Ann" <annras@verizon.net>, "Robinson, Norbert" <nrobinson@kernan.umm.edu>, "Ross, Samuel" <samuel_ross@bshsi.org>, "Shubin, Charles" <cshubin@hcb.org>, "Steffen, Ben" <ben.steffen@maryland.gov>, "Tillman, MD, Ulder" <ulder.tillman@montgomerycountymd.gov>, Vincent DeMarco <demarco@mdinitiative.org>, "Wallace, Lesley" <lesley.wallace@medstar.net>, "Ward, David" <cwardward@aol.com>

----- Forwarded message -----

From: Tricia Roddy -DHMH- <tricia.rodde@maryland.gov>

Date: Fri, Apr 19, 2013 at 2:35 PM

Subject: HealthChoice 1115 Waiver Renewal Application

To: Carrol Barnes -DHMH- <carrol.barnes@maryland.gov>

Cc: Alice Middleton -DHMH- <alice.middleton@maryland.gov>

Dear Maryland Medicaid Advisory Committee,

As discussed in recent meetings, the Department must renew its HealthChoice 1115 Waiver Demonstration program. Our current waiver period expires on December 31, 2013. The waiver renewal application must be submitted to the Centers for Medicare and Medicaid Services no later than June 30, 2013.

We are soliciting public comments prior to submission of the waiver application. At our next meeting, we plan to discuss the attached draft renewal application. Following the meeting, we will hold a public hearing from 3 pm to 5 pm. The public meeting will be held in the same room (L-3) at DHMH. A second public hearing will be held May 9th in Annapolis. The hearing details are attached below.

Because the last MMAC meeting was cancelled due to weather conditions, the MMAC agenda for Thursday is quite full. If additional time is needed to discuss the waiver application or the HealthChoice evaluation, we can continue the discussion at our meeting in May. Of course, we hope that you will stay for the public meeting.

Look forward to seeing you next week –

Tricia

--

Tricia Roddy

4/22/13

Maryland.gov Mail - HealthChoice 1115 Waiver Renewal Application

Director, Planning Administration
Health Care Financing
Tricia.Roddy@maryland.gov
410-767-5809

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2 attachments

 **Draft HealthChoice 1115 Waiver Renewal 4.19.13.pdf**
714K

 **HealthChoice Waiver Renewal Public Hearings.doc**
27K



1115 Waiver Application Renewal Hearings

Carrol Barnes -DHMH- <carrol.barnes@maryland.gov>

Mon, Apr 22, 2013 at 11:48 AM

To: "Barnes, Carrol" <Carrol.Barnes@maryland.gov>

Bcc: "A. Shelehdor" <a.shelehdor@magellanhealth.com>, "Alexander, Monique" <officemanager@machc.com>, Amanda Valentine <amanda.valentine@maryland.gov>, Andrew Corsig <acorsig@phrma.org>, "Ayensu, Sharen" <sturkson@yahoo.com>, Barbara Marx Brocato <barbara1@bmbassoc.com>, "Bayu, Tizita" <tizemuba@yahoo.com>, "Benson, Ryan" <ryan.benson@maryland.gov>, "Bernstein, Kathy" <bernsteink@medimmune.com>, "Boyle-King, Sharyn" <sking@coordinatingcenter.org>, Brenda Myrick <blmyrick@cvtv.com>, Brian Fischer <brianf@marylandphysicianscare.com>, Brian Frazee <bfrazee@macsonline.org>, "Brooks, Johanna" <johanna.brooks@marylandphysicianscare.com>, "Brooks, Selina" <selina.brooks@marylandphysicianscare.com>, Bryan Deegan <DeeganB@medimmune.com>, "Bryant, Eric" <ebryant@rlls.com>, "Burrus, Jan" <jan.l.burrus@gsk.com>, "Cameron, Patricia" <patricia.cameron@medstar.net>, "Camilla Roberson (robersonc@publicjustice.org)" <robersonc@publicjustice.org>, Carrie Maglich <carrie.maglich@astrazeneca.com>, Cathy S <cathys@mdlcbalto.org>, "Christner, Debra" <debra.christner@montgomerycountymd.gov>, "Christoffel, Pamela" <billpamela@hotmail.com>, "Ciekot, Ann" <aciekot@policypartners.net>, "Clavelle, Paul" <clavellep@aol.com>, "Coats, Christopher" <christopher.coats@maryland.gov>, "Cohen, June" <jcohen@msde.state.md.us>, "Cooper, Jordan" <keith.haynes@house.state.md.us>, "Coward, Antoinette" <antoinette.coward@maryland.gov>, "Creighton, Nancy" <nancy.creighton@peninsula.org>, "Cromwell, Herb" <mdcbh@verizon.net>, "Cunningham, Andrea" <andrea.cunningham@cms.hhs.gov>, "Cuozzo, Lisa" <lcuozzo@mhamd.org>, David Trimble <dtrimble@chs-corp.com>, "Davis, James" <jdavis@myriversidehealth.com>, Debbie Rivkin <drivkin@fblaw.com>, "Dietsch, Linda" <linda.dietsch@marylandphysicianscare.com>, Dina Smoot <dina.smoot@maryland.gov>, Donna Fortson <donna_fortson@bshsi.org>, "Dwyer, Diane" <diane.dwyer@maryland.gov>, "Ellick, Jennifer" <jennifer.ellick@mlis.state.md.us>, "Ellis, Adrienne" <aellis@mhamd.org>, "Engstrom, Fayette" <fengstro@goeaston.net>, "Epstein, Martin" <mepstein@cnmc.org>, "Everett, Anita" <aeveret4@jhmi.edu>, "Farinholt, Kate" <kfarinholt@namimd.org>, "Finch, Glendora" <glendora.finch@maryland.gov>, "Fisher, Josh" <jkf@stateside.com>, "Forsyth, Linda" <lforsyth@senate.state.md.us>, "Fox, Marlana" <marlana.fox@maryland.gov>, "Frasier, Bobbe" <bobbe.frasier@maryland.gov>, "Garner, Julie" <garnerj@medimmune.com>, "Garrity, Stephanie" <stephanie.garrity@maryland.gov>, "George Dover, MD" <gdover@jhmi.edu>, George Miller <george.r.miller@vivhealthcare.com>, "Gerard, Cheri" <cgerard@dbm.state.md.us>, "Gerrits, Diane" <diane.gerrits@cms.hhs.gov>, "Glotfely, Rodney" <rodney.glotfely@maryland.gov>, "Gold, Irina" <igold002@gmail.com>, "Goldberg, Jennifer" <jgoldberg@mdlab.org>, "Guerrieri, Sarah" <sguerrie@cnmc.org>, "Hafner, Gayle" <gayleh@mdlcbalto.org>, "Hamilton, Jeanne" <jeanne.hamilton@marylandphysicianscare.com>, "Harris, Rose" <rose.harris@maryland.gov>, "Harrison, Susan" <susan.harrison@maryland.gov>, "Healey, Chris" <chris.healey@us.grifols.com>, "Hemphill, Lisa" <lisa.hemphill@maryland.gov>, "Hepburn, Brian" <brian.hepburn@maryland.gov>, "Holcomb, Pat" <patricia.holcomb@maryland.gov>, "Hook, Greg" <ghook@ola.state.md.us>, "Horton, Ann" <ahorton@mncha.org>, "Hubbard, Anne" <ahubbard@mhaonline.org>, "Hubbard, James" <james.hubbard@house.state.md.us>, "Hummel, Kery" <khummel@mdpsych.org>, "Jackson, Alice" <ajac956@aol.com>, Jeff Singer <jsinger@hchmd.org>, Jenine Woodward <jwoodward@hilltop.umbc.edu>, Jennifer Witten <Jennifer.Witten@heart.org>, Jeremy Crandall <jeremy@heathermizeur.com>, Johnna Robinson <jjrobinson@att.net>, "Johnson, Bernadette" <bernadette@machc.com>, "Johnson, Carolyn" <cjohnson@hprplaw.org>, "Johnson, Kalena" <kpjohnson@cvtv.com>, "Jones, Antonio" <ajones@bhca.org>, "Jones, Timothy" <tjones@cnmc.org>, "Jordan-Randolph, Gayle" <gayle.jordan-randolph@maryland.gov>, Josh White <JWhite@rlls.com>, Judy Jenkins <judy.jenkins@otsuka-us.com>, "Kleiman, Judy" <judy.kleiman@verispan.com>, "Klein, Barbara" <bklein@umaryland.edu>, "Krampel, Doug" <doug.krampel@abbott.com>, "Lavin, Angel" <amlavin@venable.com>, Leah Hendrick <leah.hendrick@maryland.gov>, Lee McCabe <lmccabe@jhmi.edu>, "Legislative Svs, Mary" <marw@mlis.state.md.us>, "Lehnert, Ellen" <ellen.lehnert@maryland.gov>, Leigh Cobb <lcobb@acy.org>, "Lepore, Wendy" <wendy.lepore@bms.com>, "Lichtenstein, Karen Ann" <kalichtenstein@coordinatingcenter.org>, "Lisa A. Oelfke (DHMH)" <lisa.oelfke@maryland.gov>, "Loughran, Kathleen" <kloughr@amerigroupcorp.com>, "Lupo, John"

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The Department must renew its HealthChoice 1115 Waiver Demonstration program. Our current waiver period expires on December 31, 2013. The waiver renewal application must be submitted to the Centers for Medicare and Medicaid Services no later than June 30, 2013.

The Department is soliciting public comments prior to submission of the waiver application. Following the April 25, 2013 Medicaid Advisory Committee meeting, we will hold a public hearing from 3 pm to 5 pm. The public meeting will be held in the same room (L-3) at DHMH. A second public hearing will be held May 9th in Annapolis. The hearing details and draft renewal application are attached below.

2 attachments

 **HealthChoice Waiver Renewal Public Hearings Notice 4.22.13.doc**
27K

 **Draft HealthChoice 1115 Waiver Renewal 4.19.13 (1).pdf**
714K

**1115 WAIVER RENEWAL PUBLIC HEARING
APRIL 25, 2013**

| NAME | ORGANIZATION | CONTACT INFORMATION |
|------------|--------------|---------------------------------|
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**1115 WAIVER RENEWAL PUBLIC HEARING
MAY 9, 2013**

| NAME | ORGANIZATION | CONTACT INFORMATION |
|------------|--------------|----------------------------------|
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1115 WAIVER RENEWAL PUBLIC HEARING

TESTIMONY SIGN UP SHEET

DATE: May 9, 2013

PLEASE PRINT CLEARLY

| | NAME | ORGANIZATION | EMAIL |
|-----|------------|--------------|-----------------------------------|
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| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |
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| 7. | _____ | _____ | _____ |
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| 11. | _____ | _____ | _____ |
| 12. | _____ | _____ | _____ |



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

August 9, 2013

Cindy Mann
Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop S2-26-12
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Mann,

On behalf of the Maryland Medicaid program, I am writing to request two additional waiver authorities to be included in our §1115 HealthChoice renewal application.

Presumptive Eligibility

Starting January 1, 2014, regardless of whether a state has chosen to implement presumptive eligibility for certain eligible populations, participating Medicaid hospitals have the option to elect to become an entity that is qualified to make a presumptive eligibility determination. Maryland does not currently permit presumptive eligibility determinations in its Medicaid program. The Department is concerned about the number of system changes that is required to implement the presumptive eligibility requirements by hospitals. The federal statutory requirement -- 42 CFR § 435.1103(a) -- requires that states only determine pregnant women to be eligible for ambulatory prenatal care during the presumptive eligibility period. The system requirements to assure inpatient stays and other State Plan services are not provided for pregnant women during the presumptive eligibility period are significant. The Department, therefore, requests a waiver to this requirement and that it be allowed to provide the entire State Plan benefit package to pregnant woman.

Rare and Expensive Management Program

The Rare and Expensive Management (REM) program was created in 1997 in the original HealthChoice §1115 waiver. Under REM, individuals with delineated diagnoses may opt out of capitated managed care, and remain in fee-for-service. REM now includes approximately 4,000

Letter to Cindy Mann, Director

August 9, 2013

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recipients with complex needs. Individuals in the REM program also have a REM case manager to help them navigate across all of their medical providers, such as subspecialty pediatricians, DME, specialists, hospitals, etc. The Department has received strong recommendations from the State's physician association (MedCHI) and the State's chapter of the American Academy of Pediatrics that we should selectively contract with a single REM case management agency. We have been urged to select this single case management agency on the basis of quality, enhanced benefits, past performance, a strong work plan, and other factors. We have taken steps in this direction. At present, the Department currently claims these REM case management services as an administrative expense, not a medical service expense. We have two issues related to the renewal of the §1115 waiver. First, starting January 1, 2014, the Department intends to begin to claim REM case management as a medical service expenditure, rather than as an administrative expenditure. We want to make this switch to clarify that a REM case manager is a provider of services to a REM recipient, and is a patient-advocate for the recipient. The function, in other words, is not administrative case management akin to utilization review. The role properly is described as a service. Second, and related, the Department requests a waiver to 42 CFR § 431.51 which requires a choice of REM case management agency providers. Because we have been strongly urged by physicians and other providers who treat REM recipients to selectively contract with a high-quality REM case management agency that understands and can serve complex populations, the Department would like the authority to selectively contract with a case management agency (that includes many individual case managers) based on its evaluation of how best to assure efficiency and quality of care for REM participants. If the Department completes the award to only one contract, REM recipients would have a choice of case manager providers within that single agency.

I look forward to working with your Administration during the §1115 (HealthChoice) Demonstration Waiver renewal process. Should you have any questions or concerns, please contact our Director of the Planning Administration, Tricia Roddy, via email at tricia.rodny@maryland.gov or via telephone at (410) 767-5809.

Sincerely,

/s/

Charles J. Milligan, Jr.
Deputy Secretary
Health Care Financing

cc: Julie Sharp, CMS
Heather Hostetler, CMS
Andrea Cunningham, CMS