DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

January 13, 2025

Ryan Moran, DrPH, MHSA
Deputy Secretary, Health Care Financing and Medicaid Director
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Dr. Moran:

The Centers for Medicare & Medicaid Services (CMS) is approving Maryland's (the "state") request to amend its Medicaid section 1115(a) demonstration entitled, "Maryland HealthChoice" (Project Number 11-W-00099/3), which is effective on the date of approval through the end of demonstration approval period. The demonstration is set to expire on December 31, 2026. Approval of this demonstration amendment will provide expenditure authority for limited coverage for certain services furnished to certain incarcerated individuals for up to 90 days immediately prior to the individual's expected date of release.

Approval of this amendment will also provide an expansion of the existing Assistance in Community Integration Services (ACIS) pilot program by increasing the number of participant spaces within the program and updating the program's budget neutrality model to a hypothetical model.

Pre-Release Services under the Reentry Demonstration Initiative

Expenditure authority is being provided to Maryland to provide limited coverage for a targeted set of services furnished to certain incarcerated individuals for 90 days immediately prior to the individual's expected date of release. The state's proposed approach closely aligns with CMS' "Reentry Demonstration Opportunity" as described in the State Medicaid Director Letter (SMDL) released on April 17, 2023.

Eligible Individuals

Maryland will cover a set of pre-release benefits for certain individuals who are inmates residing in a state managed prison or jail (herein after referred to as "correctional facilities"). To qualify for services covered under this demonstration approval, individuals residing in a correctional facility have been determined eligible for Medicaid pursuant to an application filed before or during incarceration, be 18 years of age or older, have been diagnosed with substance use disorder (SUD) and/or serious mental illness (SMI), and have an expected release date within 90 days.

Medicaid Eligibility and Enrollment

CMS is requiring, as a condition of approval of this demonstration amendment, that Maryland make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the correctional facilities listed above and outlined in the special terms and conditions (STCs).

For a Medicaid covered individual entering a correctional facility, Maryland will not terminate Medicaid coverage, but will suspend the individual's coverage. For individuals not enrolled in Medicaid upon entering a correctional facility, Maryland will ensure the individual receives assistance with completing and submitting a Medicaid application sufficiently prior to their anticipated release date such that the individual can receive the full duration of pre-release services, unless the individual voluntarily refuses such assistance or chooses to decline enrollment.

Scope of Pre-Release Benefit Package

The pre-release benefit package is designed to improve care transitions of such eligible individuals back to the community, including by promoting continuity of coverage, service receipt, and quality of care, as well as the proactive identification of both physical and behavioral health needs and health-related social needs (HRSNs). It is designed to address these overarching demonstration goals, while aiming to ensure that participating correctional facilities can feasibly provide all pre-release benefits to qualifying incarcerated individuals.

CMS is authorizing Maryland to provide coverage for the following services to be detailed in an attachment to the demonstration's STCs:

- Case management to assess and address physical and behavioral health needs and health-related social needs;
- Medication assisted treatment (MAT) for all types of substance use disorders (SUDs) as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;
- A 30-day supply of all prescription medications provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy.

CMS recognizes that many individuals exiting correctional facilities may not have received sufficient health care to address all of their physical or behavioral health care needs while incarcerated. This demonstration initiative will provide individuals leaving correctional facilities the opportunity to receive short-term Medicaid pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, while providing the state the opportunity to test whether these pre-release services improve uptake and continuity of MAT, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, and overdose-related death. Therefore, CMS is approving a demonstration benefit package in Maryland that is designed to improve identification of physical and behavioral health needs and HRSNs to facilitate connections to

providers with the capacity to meet those needs in the community during the period immediately before an individual's expected release from a correctional facility. Once an individual is released, the coverage for which the individual is otherwise eligible must be provided consistent with all requirements applicable to such coverage.

Eligible Juveniles and This Reentry Demonstration Initiative

Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) amends the Social Security Act (the Act) and describes a mandatory population (eligible juveniles and targeted low-income children) and set of pre-release and post-release services, while section 5122 of the CAA, 2023 amends the Act and gives a state the option to receive federal financial participation for the full range of coverable services for eligible juveniles and targeted low-income children while pending disposition of charges. Every state is required to submit Medicaid and CHIP State Plan Amendments (SPAs) attesting to meeting the requirements in Section 5121 effective January 1, 2025.[1]

To the extent there is overlap between the services required to be covered under sections 1902(a)(84)(D) of the Act and coverage under this demonstration, we understand that it would be administratively burdensome for states to identify whether each individual service is furnished to a beneficiary under the state plan or demonstration authority. Accordingly, to eliminate unnecessary administrative burden and ease implementation of statutorily required coverage and this demonstration, we are approving a waiver of the otherwise mandatory state plan coverage requirements to permit the state instead to cover at least the same services for the same beneficiaries under this demonstration. This approach will ease implementation, administration, and claiming, and provide a more coherent approach to monitoring, and evaluation of the state's reentry coverage under the demonstration. The state will provide coverage under the reentry demonstration to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act, at a level equal to or greater than otherwise would be covered under the state plan. Compliance and state plan submission requirements under section 5121 of the CAA, 2023 will remain unchanged. Coverage of the population and benefits identified in section 1902(a)(84)(D) of the Act, as applicable, will automatically revert to state plan coverage in the event that this demonstration ends or eliminates coverage of beneficiaries and/or services specified in that provision.

Implementation and Reinvestment Plans

As described in the demonstration STCs, Maryland will be required to submit to CMS a Reentry Initiative Implementation Plan (Implementation Plan) and Reinvestment Plan documenting how the state will operationalize coverage and provision of pre-release services and how existing funding for correctional facility health services will continue to support access to necessary care and achievement of positive health outcomes for the justice-involved population.

[1] SHO# 24-004, RE: Provision of Medicaid and CHIP Services to Incarcerated Youth. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf

The Implementation Plan must be submitted to CMS consistent with the STCs and must describe the milestones and associated actions being addressed under this demonstration amendment and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities and describe the state's strategic approach for making significant improvements on the milestones and actions, as well as associated timelines for meeting them, for both program policy implementation and investments in transitional nonservice elements, as applicable. The Implementation Plan will also outline any potential operational challenges that the state anticipates and the state's intended approach to resolving these and other challenges the state may encounter in implementing the reentry demonstration initiative. The operational plan requirement in section 1902(a)(84)(D) of the Act is satisfied by the state's Implementation Plan. The state is still required to provide coverage and otherwise meet state plan requirements with respect to any population or service specified in section 1902(a)(84)(D) of the Act that is not covered under this demonstration.

The reentry demonstration initiative is not intended to shift current correctional facility health care costs to the Medicaid program. Section 5032(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 155-271) makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of title XIX, which includes the inmate payment exclusion, in recognition that the correctional authority bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve correctional authorities in Maryland of their Constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a tribal, state, or local correctional authority to the Medicaid program.

Maryland agrees to reinvest the total amount of new federal matching funds for the reentry demonstration initiative received under this demonstration amendment into activities or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for physical and behavioral health needs that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement, Maryland will develop and submit a Reinvestment Plan to CMS outlining how the federal matching funds under the demonstration will be reinvested. The Reinvestment Plan should align with the goals of the state's reentry demonstration initiative. It should detail the state's plans to increase access to or improve the quality of health care services for those who have recently been released, and those who may be at higher risk of future criminal justice system involvement, particularly due to untreated behavioral health conditions. The Reinvestment Plan should describe the activities or initiatives selected by Maryland for investment and a timeline for implementation. Any investment in carceral health care must add to and/or improve the quality of health care services and resources for individuals who are incarcerated and those who are soon to be released from carceral settings, and not supplant existing state or local spending on such

services and resources. The reinvestment plan may include the services provided to eligible juveniles under section 1902(nn)(2) of the Act, who are covered under this demonstration.

Assistance in Community Integration Services (ACIS) Pilot Program

The ACIS pilot program provides housing and tenancy-based case management services to eligible Medicaid participants to assist them in obtaining the services of state and local housing programs. With this amendment approval, the program will expand from serving four counties to operating statewide and will increase its program participant space allocation from 900 participant spaces to 2,140 annually.

Budget Neutrality

CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration.[2] The demonstration amendment is projected to be budget neutral to the federal government, meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 demonstration approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and reporting requirements as outlined in the STCs.

Hypothetical Budget Neutrality Treatment

Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as "hypothetical" for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's "with waiver" (WW) hypothetical spending exceeds the supplemental

[2]https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS.

For each of these Medicaid Expenditure Groups (MEGs), discussed below in this section, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each of these MEGs MEG in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

The Medicaid expenditures for pre-release services furnished to incarcerated beneficiaries under the reentry demonstration initiative include coverage of services that states can and do cover through Medicaid state plan or other title XIX authority, for beneficiaries who are not subject to the inmate payment exclusion. CMS considers these expenditures to be "hypothetical" because the pre-release services would be coverable under the Medicaid state plan or other title XIX authority if furnished to a beneficiary outside a carceral setting, similar to how CMS treats expenditures for services furnished to certain beneficiaries who are short-term residents in an institution for mental diseases primarily to receive treatment for SUD, or SMI or serious emotional disturbance (SED), under the SUD and SMI/SED section 1115 demonstration opportunities. Any population identified in section 1902(a)(84)(D) of the Act and covered instead under this demonstration will be included in the reentry MEG.
As part of this amendment, CMS converted the ACIS program's budget neutrality model to a hypothetical model. The revised budget neutrality will apply as described in the STCs.

Monitoring and Evaluation

The state is required to conduct systematic monitoring and robust evaluation of the demonstration amendment in accordance with the STCs. The state must develop a Monitoring Protocol to incorporate how it will monitor the demonstration amendment components, including relevant metrics data as well as narrative details describing progress with implementing the demonstration amendment. In addition, the state is also required to conduct an independent Mid-Point Assessment of the reentry demonstration initiative, as provided in the STCs, to support identifying risks and vulnerabilities and subsequent mitigation strategies.

The state is required to incorporate the demonstration amendment into its evaluation activities to support a comprehensive assessment of whether the initiatives approved under the demonstration are effective in producing the desired outcomes for the individuals and the state's overall Medicaid program. Evaluation of the reentry demonstration initiative must align with the requirements detailed in the STCs, including examining impacts on Medicaid coverage, continuity of care, access to and quality and efficiency of care, utilization of services, health outcomes, and carceral and community coordination in service provision, among others. The state's monitoring and evaluation efforts must facilitate understanding the extent to which the demonstration amendment might support reducing existing disparities in access to and quality of care and health outcomes.

Eligible juveniles eligible under section 1902(nn)(2) of the Act are included under this reentry demonstration initiative and must be included in applicable monitoring and evaluation activities.

Consideration of Public Comments

The federal comment period for the reentry demonstration initiative application was open from March 22, 2024, through April 21, 2024, and CMS received seven comments. All seven comments were supportive of Maryland's request to provide reentry services. Several commentors advised that the state expand eligibility to include all individuals who qualify for Medicaid coverage 90 days prior to release, regardless of their medical history, and services for the demonstration, with recommendations including 12 months of continuous eligibility after release, the use of a statewide platform to track HRSN needs, and HIV services.

The federal comment period for the ACIS pilot program expansion application was open from November 25, 2024, through December 25, 2024. CMS received two relevant comments. Both comments stated their strong support for the state's request to expand the state's ACIS pilot program. One comment encouraged the state to consider the unique needs of pregnant and postpartum people in the design and implementation of the ACIS benefit.

After careful consideration of the public comments submitted during the federal public comment period and the information received from the state public comment period, CMS has concluded that the demonstration is likely to assist in promoting the objectives of Medicaid.

Other Information

CMS' approval of this demonstration amendment is conditioned upon compliance with the enclosed amended set of waiver and expenditure authorities and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. Your project officer, Laura Gray, is available to answer any questions concerning this demonstration amendment, and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: laura.gray@cms.hhs.gov

If you have any questions regarding this approval, please contact Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Chiquita Brooks-LaSure

Enclosure

cc: Nicole Guess, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES WAIVER LIST

NUMBER: 11-W-00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health (MDH)

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project January 1, 2022 through December 31, 2026. 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.

1. 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.

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

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

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

3. 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).

4. Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release. **Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES EXPENDITURE AUTHORITY

NUMBER: 11-W-00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health (MDH)

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Maryland for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XIX plan from January 1, 2022 through December 31, 2026, unless otherwise stated.

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

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

    a. Individuals must have resided in a nursing facility for at least six months, and been eligible for Medicaid for at least 30 consecutive days immediately prior to being enrolled in this program; and

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

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

    d. Pursuant to STC 4.4, the state may not enroll more than 100 participants into the ICS program at any one time.

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

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

3. **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.

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

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

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

   b. Enforce the requirement that an enrollee's verbal appeal be confirmed in writing as specified in sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 42 CFR 438.402(b)(3)(ii) and 42 CFR 438.406(b)(1). As of July 1, 2017, the regulations cite changes to 42 CFR 438.402(c)(3)(ii) and 42 CFR 438.406(b)(3). When a beneficiary's oral request for an appeal is not followed up in writing, the plan will send written confirmation of the appeal request to the beneficiary or the beneficiary's authorized representative.

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

6. **Residential Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment for SUD and withdrawal management in facilities that meet the definition of an institution for mental disease (IMD).

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

8. **Evidence Based Home Visiting Services Pilot.** Expenditures for evidence-based home visiting services by licensed practitioners to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children up to age 3.

9. **Assistance in Community Integration Services Pilot.** Expenditures for home and community-based services (HCBS) and related services as described in STC 4.9.

10. **HealthChoice Diabetes Prevention Program (DPP).** Expenditures for a diabetes prevention program for Medicaid eligible individuals 18-64 who have pre-diabetes or who are at high risk for developing type 2-diabetes as set forth in STC 4.12, effective July 1, 2019.

11. **Adult Dental Pilot Program.** Expenditures to offer dental services to dually eligible adults 21 through 64 years as set forth in STC 4.13, effective April 1, 2019.

12. **Collaborative Care Model Pilot Program.** Expenditures to implement a Collaborative Care Model (CoCM) pilot program as set forth in STC 4.14, no earlier than July 1, 2020.

13. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI)/ Serious Emotional Disturbance**: Expenditures for otherwise covered Medicaid services furnished to otherwise eligible individuals, who are primarily receiving treatment for an SMI/SED who are short-term residents in facilities that meet the definition of an institution for mental diseases as specified in STC 4.17.

14. **Maternal Opioid Misuse (MOM) Model Pilot Program**: Expenditures to provide services under the MOM Model Pilot Program, including enhanced case management services, standardized social determinants of health screenings, and care coordination, as specified in STC 4.15.

15. **Medicaid Alternative Destination Transport Pilot Program**: Expenditures to allow ambulances in 4 jurisdictions of the state to transport beneficiaries to an alternative destination as specified in STC 4.16.

16. **Expenditures for Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the reentry demonstration initiative.

17. **Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 5.12, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the reentry demonstration initiative.

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 the above named Demonstration Populations.

Title XIX Requirements Not Applicable to Demonstration Population 12 (Increased Community Services)

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

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

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

Pilot Program

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

To the extent necessary, to permit the state to selectively contract with a single entity for the provision of the Rare and Expensive Case Management (REM) benefit as authorized under this demonstration through Expenditure Authority 3 and the CoCM pilot authorized under this demonstration through Expenditure Authority 12. The operation of this selective contracting authority does not affect a beneficiary's ability to select between two or more qualified case managers employed by the selected vendor for the REM benefit.

Title XIX Requirements Not Applicable to the Population in the CoCM Pilot Program, Evidence Based Home Visiting Services Pilot, Assistance in Community Integration Services Pilot, MOM Model Pilot Program, and the Medicaid Alternative Destination Transport Pilot Program

Statewideness Section 1902(a)(1)

To the extent necessary, to allow the state to offer the CoCM Pilot Program, Evidence Based Home Visiting Services Pilot, Assistance in Community Integration Services Pilot, MOM Model Pilot Program, and the Medicaid Alternative Destination Transport Pilot Program on less than a statewide basis.

Title XIX Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

Statewideness Section 1902(a)(1)

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B)

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

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

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health (MDH)

1. PREFACE

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

These STCs are effective January 1, 2022 through December 31, 2026, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Eligibility and Enrollment, Benefits, and Programs
5. Reentry Demonstration Initiative
6. Monitoring and Reporting Requirements
7. Evaluation of the Demonstration
8. General Financial Requirements Under Title XIX
9. Monitoring Budget Neutrality
10. Schedule of State Deliverables for the Demonstration Period

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

Attachment A:	Developing the Evaluation Design
Attachment B:	Preparing the Interim and Summative Evaluation Reports
Attachment C:	Evaluation Design
Attachment D:	Rare and Expensive Case Management (REM) Program and Increased Community Services (ICS) Benefits
Attachment E:	Evidence-Based Home Visiting Services (HVS) Pilot Program Protocol

Attachment F:	Assistance in Community Integration Services (ACIS) Pilot Program Protocol
Attachment G:	SUD Monitoring Protocol
Attachment H:	SMI Implementation Plan [Reserved]
Attachment I:	SMI Monitoring Protocol
Attachment J:	Maternal Opioid Misuse Model Pilot Program Protocol
Attachment K:	Reentry Monitoring Protocol [Reserved]
Attachment L:	Reentry Demonstration Initiative Services Definitions
Attachment M:	Reentry Demonstration Initiative Health-Related Criteria
Attachment N:	Reentry Demonstration Initiative Implementation Plan [Reserved]
Attachment O:	Reentry Demonstration Initiative Reinvestment Plan [Reserved]

PROGRAM DESCRIPTION AND OBJECTIVES

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

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

a. Improving access to health care for the Medicaid population;

b. Improving the quality of health services delivered;

c. Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies;

d. 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,

e. Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care.

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

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

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

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

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

The 2017 extension made the following changes to the demonstration:

a. Created a Residential Treatment for Individuals with Substance Use Disorder (SUD) Program as part of a comprehensive SUD strategy;

b. Created two Community Health Pilot programs:

    i. Evidence-based Home Visiting Services (HVS) Pilot for high-risk pregnant women and children up to two (2) years of age; and

    ii. Assistance in Community Integration Services (ACIS) Pilot;

    iii. Raised the enrollment cap for the Increased Community Services Program from 30 to 100; and,

iv. Expanded dental benefits for former foster youth.

On June 29, 2018, the Maryland Department of Health submitted an amendment to the HealthChoice section 1115 demonstration. The state requested authority to provide National Diabetes Prevention Program (National DPP) services, expand and extend medically managed intensive inpatient hospital services (ASAM 4.0) for Medicaid eligible individuals who reside in an in-state IMD and have a primary SUD diagnosis and a secondary mental health diagnosis for up to 15 days in a month, offer a limited adult dental pilot program for dually eligible adults 21-64, expand the annual enrollment cap of the Assistance in Community Integration Services (ACIS) pilot program, and modify the family planning program so that effective upon the approval date of MD SPA 18-0005 women of childbearing age who have a family income at or below 250 percent of the FPL and who are not otherwise eligible for Medicaid, CHIP, or Medicare, but had Medicaid pregnancy coverage, will be eligible for the HealthChoice family planning program for 12 months immediately following the 2-month post-partum period.

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

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

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

On June 30, 2021, MDH submitted a renewal application to extend the demonstration through December 31, 2026. The proposal modified three demonstration programs and added three new demonstration programs.

Program/Services Modifications:

1. Assistance in Community Integration Services Pilot Program: The state added 900 participants spaces for the ACIS pilot program to a total of 2,140 individuals annually.
2. Home Visiting Services Pilot Program: The state increased the age of the children the program will cover from 2 to 3 years old to align with the age limits associated with the

evidence-based models.

3. Expansion of SUD Residential and Inpatient Treatment Services: The state removed the caps on length of stays for SUD treatment in an IMD. The state will aim for a statewide average length of stay of 30 days or less.

New Programs:

1. Expansion of IMD Services for Beneficiaries with Serious Mental Illness (SMI);
2. Maternal Opioid Misuse (MOM) Model; and
3. Medicaid Alternative Destination Transport Pilot Program.

On March 6, 2024 Maryland submitted an application to amend the Maryland HealthChoice demonstration to include reentry services. Maryland's request aligns with CMS' State Medicaid Director Letter (SMDL) # 23-003, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated," issued April 17, 2023. In this demonstration, the state is seeking to improve care for adults and youth transitioning from correctional facilities into the community and strengthen connections across Medicaid, correctional settings, health and social services agencies, community-based providers, and other entities to promote the health and wellbeing of justice-involved individuals and support their successful reentry into the community. CMS approved this request to provide coverage of a targeted set of pre-release services for certain individuals for 90 days immediately prior to their expected date of release from a participating correctional facility. As part of this approval, CMS has authorized payments for allowable administrative costs related to implementation of these pre-release services.

On November 14, 2024, Maryland submitted an application to expand the state's existing Assistance in Community Integration Services (ACIS) pilot program by expanding the program statewide, increasing the number of participant spaces within the program and updating the program's budget neutrality model to a hypothetical model.

3. GENERAL PROGRAM REQUIREMENTS

3.1. Compliance with Federal Non-Discrimination Statutes. The state 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 (ADA), Title VI of Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. 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 federal law, regulation, 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), apply to the demonstration.

3.3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, **within** the timeframes specified in federal law, regulation, or written policy, come into compliance with a change in law, regulation, or policy affecting the Medicaid or CHIP

programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

a. To the extent that a change in federal law, regulation, 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, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

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

3.6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements 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 Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS

reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

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

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the Evaluation Design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS from the Governor's Office of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 3.9.

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

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase- out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received

when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will redetermine Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures: The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e) and 457.350. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last 6-months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to

withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. Adequacy of Infrastructure. The state will 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.

3.12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment

for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT, BENEFITS, AND PROGRAMS

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

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

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

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

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

Medicaid State Plan Mandatory Groups	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Expenditure and CMS–64 Eligibility Group Reporting**
New Adult Group	Childless adults and non-custodial parents ages 19- 64 with income up to 133 percent of the FPL as defined in section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, pursuant to the approved state plan.	New Adult Group
TANF adults, pregnant women, parents, and caretaker adults	Families with dependent children and foster children with incomes less than 123 percent of the FPL, including individuals with incomes below the pre- July 1, 2008, TANF income thresholds.	TANF Adults 0-123
Medicaid Child	Children up to 21 years of age.	Medicaid Child
SOBRA Adults	Pregnant women with incomes above the pre-July 1, 2008, standard up to and including 250 percent of the FPL who are not enrolled in the TANF group.	SOBRA Adults
Non-Dual Blind and Disabled	Individuals whose Medicaid eligibility derives from their status as blind or disabled and who are not entitled to Medicare.	SSI/BD Adults or SSI/BD Children
Medicaid State Plan Optional Group	**FPL and/or Other Qualifying Criteria**	**Expenditure and CMS–64 Eligibility Group Reporting**
Medically Needy Adults and Children	Families with dependent children, or foster children, whose gross income and resources exceed 116 percent of the FPL but who incur medical expenses such that their income is equal to or less than 116 percent FPL.	MN Adults or MN Children
Optional targeted low-income children through age 18.	Up to first birthday: Between 185 and 200 percent of the FPL; On first birthday through age 5: between 133 and 200 percent of the FPL; and Upon sixth birthday through age 18: between 100 and 200 percent of the FPL.	MCHP (Only during periods when title XXI funding is exhausted)

Medicaid State Plan Mandatory Groups	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Expenditure and CMS–64 Eligibility Group Reporting**
Optional targeted low-income children through age 18	Between 200 percent of the FPL and 300 percent of the FPL who pay a premium.	MCHP Premium (Only during periods when title XXI funding is exhausted)
Demonstration Eligible Groups	**FPL and/or Other Qualifying Criteria**	**Expenditures and CMS–64 Eligibility Group Reporting.**
Increased Community Services (ICS)	Medicaid eligible individuals over the age of 18 residing in a nursing home at the time initially determined eligible for ICS, with an income level at or below 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR).	ICS
Women with Breast and Cervical Cancer	Women diagnosed with breast or cervical cancer with incomes between 133-250 percent of the FPL and who were in active treatment under the Breast & Cervical Cancer Treatment program as of December 31, 2013.	WBCCHP
Presumptively Eligible Pregnant Women	Presumptively eligible pregnant women with incomes up to 250 percent of the FPL who receive full Medicaid state plan benefits through this demonstration.	PEPW
Demonstration Programs	**FPL and/or Other Qualifying Criteria**	**Expenditures and CMS–64 Eligibility Group Reporting.**
Residential Treatment for Individuals with Substance Use Disorder *Effective July 1, 2017	Effective July 1, 2017, expenditures for SUD treatment in IMDs.	SUD
Assistance in Community Integration Services (ACIS) Pilot *Effective July 1, 2017	Effective July 1, 2017, expenditures for the ACIS Pilot as described in STC 4.9.	ACIS

Medicaid State Plan Mandatory Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Expenditure and CMS–64 Eligibility Group Reporting
Evidence-Based Home Visiting Services (HVS) Pilot *Effective July 1, 2017	Effective July 1, 2017, expenditures for evidence- based home visiting services to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children.	HVS
Enhanced Dental Services for Former Foster Youth *January 1, 2017	Effective January 1, 2017, expenditures for enhanced dental services for former foster care youth up to 26 years old.	Former Foster Dental
HealthChoice National Diabetes Prevention Program *Effective July 1, 2019	Effective July 1, 2019, expenditures for a National Diabetes Prevention Program for individuals 18-64 who have prediabetes or are at high risk of developing type 2 diabetes as described in STC 4.12.	National Diabetes Prevention Program (National DPP)
Adult Dental Pilot Program *Effective April 1, 2019	Effective April 1, 2019, expenditures for a limited dental benefit for full dually eligible adults (21-64) as described in STC 4.13.	Adult Dental Pilot
Collaborative Care Model (CoCM) Pilot Program	Effective no earlier than July 1, 2020, expenditures to establish and implement a Collaborative Care Model (CoCM) pilot program that integrates primary and behavioral health services for a limited number of HealthChoice beneficiaries as describe in STC 4.14.	Collaborative Care Model (CoCM)
Maternal Opioid Misuse (MOM) Model Pilot Program	Effective no earlier than July 1, 2022, expenditures to establish a MOM care coordination model.	MOM Model
Medicaid Alternative Destination Transport Pilot Program	Effective no earlier than January 1, 2022, expenditures to implement an Alternative Destination Transport Pilot Program to allow ambulance providers to transport eligible Medicaid beneficiaries to an alternative destination in four jurisdictions.	AD Transport Pilot
Residential and Inpatient Treatment for Individuals with Serious Mental Illness	Effective no earlier than January 1, 2022, expenditures for SMI treatment in IMDs as specified in STC 4.17.	SMI IMD

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

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

   i. Copayments of $3.00 per prescription and refill for non-preferred drugs.

   ii. Copayments of $1.00 per prescription and refill for preferred brand name and generic drugs, and HIV/AIDs drugs.

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

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

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

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

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

a. Maryland HealthChoice participants including the New Adult Group, who have specified conditions that are expensive and require complex medical treatment may be enrolled in a special case management program operated by the state. The REM case management program includes certain optional services, not otherwise provided under the Medicaid program, to assist with the special needs of this population. To qualify, individuals must continue to meet eligibility diagnosis criteria for REM services. Should an individual no longer meet the diagnostic criteria for REM, that individual will be disenrolled from the REM program. The state may also enroll individuals who are not otherwise participating in the demonstration, who are under age 65 and receiving Medicare benefits in the REM program, if the individual was previously enrolled in the REM program and receiving private duty nursing services or home health aide services. REM services are reimbursed at the medical assistance rate. The state is allowed to contract with a single agency for the provision of the REM benefit as authorized under this demonstration through Expenditure Authority 4.

   The operation of this selective contracting authority does not affect a beneficiary's

ability to select between two or more qualified case managers.

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

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

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

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

4.4 Increased Community Services (ICS) Program

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

i. Individuals must meet one of the following criteria:

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

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

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

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

a. Benefits. This program provides Medicaid state plan benefits and home

and community- based services identical to those provided under the Community Options 1915(c) waiver. These services enable the participant to live at home with appropriate supports rather than in a nursing facility.

b. Enrollment Cap. The number of participants that may be enrolled in the ICS program at any one time is limited to 100. The state will create a registry that identifies all individuals eligible for the program who have indicated interest in receiving home and community-based services. The registry will be sorted based on date and time of interest. As slots become available, the state shall will notify individuals on the registry in numerical order of the opportunity to participate in the ICS program. Interested individuals will have fifteen (15) days to indicate whether or not they are still interested in participating. If after fifteen (15) days an individual fails to respond, a second letter will be mailed to the individual. If state receives no response in seven (7) days after the second letter is mailed, the state will remove the individual's name from the registry, and offer that slot to the next person on the registry.

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

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

   i. Copayments of $3.00 per prescription and refill for non-preferred drugs; and

   ii. Copayments of $1.00 per prescription and refill for preferred brand name and, HIV/AIDs drugs.

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

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

4.5 Breast and Cervical Cancer Treatment Act Program (BCCTP)

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

effective January 1, 2014. The state submitted a conforming State Plan Amendment (SPA) to reflect this change.

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

a. Individuals with dual Medicare/Medicaid coverage with exception of those individuals who participate in the REM Program pursuant to STC 4.3.

b. Individuals over 65 years old.

c. Individuals determined Medically Needy under a spend-down.

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

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

f. Beneficiaries enrolled in the Breast and Cervical Cancer Treatment Program (BCCTP) until December 31, 2013. Beginning January 1, 2014 this population will be covered through the demonstration as described in STC 4.5.

g. Employed Individuals with Disabilities (EID) participants as of October 1, 2008.Certain foster care groups:

h. A child receiving an adoption subsidy who is covered under the parent's private insurance;

   i. A child under State supervision receiving an adoption subsidy who lives outside the state; and

   ii. A child under State supervision who is in an out-of-state placement.

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

Effective July 1, 2017, the demonstration benefit package for individuals age 21 through 64 will include SUD treatment in certain IMDs, which are not otherwise included as expenditures under section 1903 of the Act. Such services will be delivered by the ASO through the FFS delivery system. The SUD program will be available to all full-benefit Medicaid beneficiaries beginning July 1, 2017. The state began offering the SUD benefit to dual eligibles on January 1, 2020.

The state will aim for a statewide average length of stay of 30 days or less in residential and inpatient treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 4.8, to ensure short-term residential stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging from

residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

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

Table One: Maryland SUD Benefits (with Expenditure Authority)

ASAM Level of Care	Service	Service Definition	Expenditure Authority
0.5	Early Intervention		State plan
1	Outpatient Service	Counseling services are provided to recipients with a SUD diagnosis (up to 9 hours per week for adults, and less than 6 hours per week for adolescents) when determined to be medically necessary and in accordance with an individualized treatment plan.	State plan
2.1	Intensive Outpatient Service	Structured programming services provided to recipients with a SUD diagnosis (a minimum of 9 hours with a maximum of 19 hours per week for adults, and a minimum of 6 hours with a maximum of 19 hours per week for adolescents) when determined to be medically necessary and in accordance with an individualized treatment plan.	State plan
2.5	Partial Hospitalization	Structured programming services provided to recipients with a SUD diagnosis (20 or more hours of clinically intensive programming per week) when determined to be medically necessary and in accordance with an individualized treatment plan.	State plan
3.1	Clinically Managed Low-Intensity Residential Services	Supportive living environment with 24-hour staff that provides rehabilitation services to recipients with a SUD diagnosis (5 or more hours of low-intensity treatment per week) when determined to be medically necessary and in accordance with an individualized treatment plan.	Section 1115 demonstration (Covered for recipients aged 21 to 64)
3.3	Clinically	Clinically managed therapeutic rehabilitative	Section 1115

ASAM Level of Care	Service	Service Definition	Expenditure Authority
	Managed Population-Specific High Intensity Residential Services	facility for adults with cognitive impairment including developmental delay that provides rehabilitation services to recipients with a SUD when determined to be medically necessary and in accordance with an individualized treatment plan. Staffed by credentialed addiction professionals, physicians/physician extenders, and credentialed mental health professionals.	demonstration (Covered for recipients aged 21 to 64)
3.5	Clinically Managed High Intensity Residential Services	Clinically managed therapeutic community or residential treatment facility providing high intensity services for adults or medium intensity services for adolescents when determined to be medically necessary and in accordance with an individualized treatment plan. Staffed by licensed/credentialed clinical staff, including addiction counselors, licensed clinical social workers, licensed professional counselors, physicians/physician extenders, and credentialed mental health professionals.	Section 1115 demonstration (Covered for recipients aged 21 to 64)
3.7	Medically Monitored Intensive Inpatient Services	Medically monitored inpatient services in a freestanding residential facility or inpatient unit of an acute care hospital or psychiatric unit when determined to be medically necessary and in accordance with an individualized treatment plan. Includes 24-hour clinical supervision including physicians, nurses, addiction counselors and behavioral health specialists.	Section 1115 demonstration (Covered for recipients aged 21 to 64)
4.0	Medically Managed Intensive Inpatient Hospital Services	Acute care general or psychiatric hospital with 24/7 medical management and nursing supervision and counseling services (16 hours per day). Managed by addiction specialist physician with interdisciplinary team of credentialed clinical staff knowledgeable of biopsychosocial dimensions of addictions.	State plan
Opioid Treatment Services	Opioid Maintenance Therapy	Physician-supervised daily or several times weekly opioid agonist medication and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder in Maryland	State plan

ASAM Level of Care	Service	Service Definition	Expenditure Authority
		Department of Health (MDH) licensed methadone clinics in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of Maryland requirements.	
Opioid Treatment Services	Office Based Opioid Treatment	Physician-supervised medication and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder by primary care providers and other physician offices in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of Maryland requirements.	State plan
1 WM	Ambulatory Withdrawal Management Without Extended On-Site Monitoring	Ambulatory withdrawal management without extended on- site monitoring with specialized psychological and psychiatric consultation and supervision.	State plan
2 WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring	Ambulatory withdrawal management with extended on-site monitoring with clinical (medical) consultation and supervision.	State plan
3.7 WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary, unlikely to complete withdrawal management without medical, nursing monitoring.	Section 1115 demonstration (Covered for recipients aged 21 to 64)

SUD Goals:

a. Increased rates of identification, initiation, and engagement in treatment for SUD;

b. Increased adherence to and retention in treatment;

c. Reductions in overdose deaths, particularly those due to opioids;

d. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;

e. Fewer readmissions to the same or higher level of care where the readmission is

preventable or medically inappropriate; and

f. Improved access to care for physical health conditions among beneficiaries with SUD.

Residential Treatment Services

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

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

b. Residential services can be provided in settings of any size.

c. Effective July 1, 2017, services will be covered for ASAM Levels of Care 3.3, 3.5, 3.7 and

   3.7 WM. Effective January 1, 2019, services will be covered for ASAM Level of Care 3.1.

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

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

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

authorization request being submitted by the provider.

g. Room and board cost are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

4.8 SUD Monitoring Protocol. The state must submit a Monitoring Protocol for the SUD programs authorized by this demonstration within one hundred fifty (150) calendar days after approval of the demonstration. The Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment G. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the Monitoring Protocol include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in these STCs;

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the General Reporting Requirements described in Section V of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

4.9 Community Health Pilot Program: Assistance in Community Integration Services (ACIS) Pilot Program. Under this program, the state will provide a set of HCBS services under a pilot that is capped at 2,140 individuals annually.

Under this pilot program, the state will provide a set of Home and Community Based Services (HCBS) to a population that meets the eligibility criteria in Attachment F, capped at 2,140 individuals annually. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA). The protocol outlines the content that would otherwise be documented in a 1915(i) SPA, and includes service definitions and payment methodologies (See Attachment F).

a. **For 1915(i) HCBS**, the state must have an approved Quality Improvement Strategy and is required to develop performance measures to address the following requirements:

i. Service plans: a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers.

ii. Eligibility Requirements: a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; b) the processes and instruments described in the approved program for determining 1915(i) eligibility are applied appropriately; and c) the 1915(i) benefit eligibility of

enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved program.

iii. Providers meet required qualifications.

iv. Settings meet the home and community-based setting requirements as specified in the benefit and in accordance with 42 CFR 441.710(a)(1) and (2).

v. The State Medicaid Agency (SMA) retains authority and responsibility for program operations and oversight.

vi. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

vii. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.

viii. The state must also describe the process for systems improvement as a result of aggregated discovery and remediation activities.

b. The state must annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

c. The state will submit a report to CMS no later than 18 months prior to the end of the approved demonstration period on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers. (1915(c) and 1915(i) HCBS).

d. The Medicaid and CHIP Operations Group will evaluate each evidentiary report to determine whether the assurances have been met.

e. The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1) (1915(c)) or 42 CFR 441.725(c) (1915(i)), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2) (1915(c)) or 42 CFR 441.725(b) (1915(i)). The person-centered service plan is reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

f. Conflict of Interest: The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

g. Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these

options. (MLTSS with self- direction)

h. The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant. (MLTSS)

i. The state will assure compliance with the characteristics of HCBS settings as described in 1915(c) and 1915(i) regulations in accordance with implementation/effective dates as published in the Federal Register.

4.10 Community Health Pilot Program: Evidence-Based Home Visiting Services Pilot Program. Under this program, the state will provide evidence-based home visiting services by licensed practitioners to promote enhanced health outcomes, whole person care, and community-integration for high-risk pregnant women and children up to three

(3) years old (beginning January 1, 2022). The program is aligned with two evidence-based models focused on the health of pregnant women. Additional information regarding this pilot program can be found in Attachment E. The services available under the Home Visiting Services Pilot will be modified to be made available under a State Plan Amendment. The current expenditure authority will be in effect until the State Plan Amendment is approved, which is anticipated to be on or before December 31, 2022.

a. Nurse Family Partnership (NFP). The NFP is designed to reinforce maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. Lead Entities who elect to follow the NEP evidence-based model will adhere to the NFP national program standards.

b. The Healthy Families America (HFA). The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, SUD, mental health issues, and domestic violence. Lead Entities who elect to follow the HFA evidence-based model will adhere to the HFA national program standards.

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

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

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

DPP services.

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

a. Receive services through a HealthChoice MCO;

b. Between 18-64 years old;

c. Overweight or obese (Body Mass Index (BMI) of ≥ 25 kg/m2;; ≥ 23 kg/m2, if Asian); AND

d. Elevated blood glucose level OR History of gestational diabetes mellitus (GDM)[1]

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

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

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

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

Enrollment and Service Cap Limit:
The state has the discretion to set an annual per person cap at no less than $800. The state must include updates on the amount in the quarterly monitoring reports. There is no enrollment cap for this pilot program.

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

Adult Dental Pilot Program Services:
The services package for the Adult Dental Pilot Program includes coverage for diagnostic, preventive, and restorative services, in addition to extractions. The Adult Dental Pilot Program will cover, at a minimum, the benefits listed below:

Code	Description
	Diagnostic codes

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

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

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

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

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

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

a. Evidence Based Therapeutic Intervention Services:

   i. **Behavioral activation**: A therapeutic intervention that is often used to treat depression, which includes scheduled activities to change the environment of the beneficiary and improve the mood of the beneficiary.

   ii. **Motivational interviewing and problem-solving therapy**: A therapeutic intervention that helps beneficiaries establish and embrace behavioral changes that support better health outcomes.

b. Targeted Case Management Services:

   i. Care coordination;
   ii. Monitoring and treatment services using a validated clinical rating scale;

   iii. Caseload review and consultation for patients who do not show clinical improvement; and

   iv. Referrals

      a. In the case that a beneficiary requires additional psychiatric services outside the collaborative care intervention, the behavioral health care manager, under the direction of the psychiatric consultant, will schedule psychiatric or crisis services.

4.15 Maternal Opioid Misuse (MOM) Model Pilot Program

Effective no earlier than July 1, 2022, the state will implement the Maternal Opioid Misuse (MOM) model Pilot Program. From July 1, 2022 through December 31, 2022, the state will operate the program less than statewide, with statewide implementation expected for January 2023. The jurisdictions in which the MOM Model is operational are referenced in Attachment J. Under the MOM Model Pilot Program, the state will pay HealthChoice managed care organizations (MCOs) a per-member-per-month (PMPM) payment to provide a set of enhanced case management services, standardized social determinants of health screenings and care coordination. In addition to the care planning and social determinants of health screening activities conducted at intake, MCO case managers will also be responsible for a minimum of at least one monthly connection with MOM Model participants and for ensuring each participant receives at least one somatic or behavioral health service per month.

The MOM Model intervention provides services distinct from case management and care coordination services already available to Maryland Medicaid beneficiaries. Following is a description of the MOM model intervention to be funded via section 1115 authority.

a. **Intake**: Prior to MOM model intake, Maryland Medicaid MCOs will engage in a continuous 'no wrong door' approach to identifying potential MOM model participants.

b. **Assessment**: Once an individual consents to participate in the MOM model, they will respond to screening intended to inform the collaborative development of a care plan and will be revisited at various intervals during MOM model participation, such as health-related social needs. After delivery and during the postpartum period, reassessments will center on the infant-mother dyad, with a focus on parenting, managing stress and other activities that will contribute to a stable and healthy family environment for the infant and reduce the risk of recurrence of use or overdose.

c. **Creation of a Treatment Plan**: Each participant will work jointly with their MOM case manager during the intake session to develop an initial care plan, which will collect information on all providers who the participant sees for healthcare.

   Using participant engagement best practices such as motivational interviewing and shared decision-making, the MOM participant will work with their MOM case manager to identify two to three goals based on their identified needs, with time-based and achievable objectives for each goal. The MOM case manager will check in with the participant on their progress towards achieving each goal, addressing needs identified through the assessment and identifying any barriers to completing the goals.

d. **Coordination**: Each participant will be engaged in MOM model services from the time of intake up until 12-months postpartum or until they lose Medicaid eligibility, unless they opt out or become lost to follow-up (after substantial outreach, below) before that time. On a monthly basis, each participant will receive a minimum of one of the following five core components of care coordination: 1) comprehensive

case management; 2) care coordination; 3) health promotion; 4) individual and family supports; and 5) linkages to community and support services. Each participant will receive support from their case managers to ensure they are able to attend their appointments; this may include arranging for transportation, peer support or other supports that facilitate the keeping of scheduled medical appointments and thus remain engaged in the MOM model.

e. **Referral:** Each participant will work jointly with their case managers to develop an individualized plan when transitioning off of MOM model services. Participants will review the goals developed for their care plan, determine areas that may need continued support and work with their MCO case managers to perform warm handoffs to other programs if warranted**.**

f. **Outreach to Disengaged Beneficiaries**: Substantial outreach[2] is a specific protocol for re-engaging participants should they become disengaged from care (e.g., miss a doctor's appointment or miss a monthly case manager contact). Per month of substantial outreach, case managers will need to make and document at least three outreach attempts, two of which must be different types of follow-up (e.g., two phone calls and one letter in the mail).

4.16 Medicaid Alternative Destination Transport Pilot Program

Effective no earlier than January 1, 2022, the state will implement the Medicaid Alternative Destination Pilot Program. Under the pilot program, the state will provide emergency medical service (EMS) ground transportation for Medicaid beneficiaries to alternative destinations (AD) in four jurisdictions: Annapolis, Baltimore City, Charles County, and Montgomery County. The state will require that the participating EMS will evaluate whether the beneficiaries can be treated appropriately at the AD.

4.17 Services for Individuals with Serious Mental Illness (SMI)/ Serious Emotional Disturbance (SED) Residing in Institutions of Mental Diseases (IMD)s:

The goal of this demonstration component is for the state to maintain and enhance access to mental health services, and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment of Medicaid beneficiaries with serious mental illness (SMI) or serious emotional disturbance (SED). This demonstration component will provide the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SMI while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD. It will also support state efforts to enhance provider capacity and improve access to a continuum of SMI/SED evidence-based services at varied levels of intensity,

SMI/SED Goals:

[2] Substantial outreach means MOM case managers use a variety of means to contact the participant such as contacting participants' family members, friends, partners and emergency contacts via phone multiple times at different times of day; deploying assigned MOM case manager or other assigned care plan team members (i.e., certified peer recovery specialists or community health workers) to the participant's home and community, including on evenings or weekends; contacting participant's primary care provider and other providers to assist with reengagement; connecting with public agencies the participant is involved with; and monitoring the CRISP's Encounter Notification Service to check for inpatient admissions and emergency department visits.

During the demonstration period, the state seeks to achieve the following goals:

a. Reduced utilization and lengths of stay in EDs among beneficiaries with SMI while awaiting mental health treatment in specialized settings;

b. Reduced preventable readmissions to acute care hospitals and residential settings;

c. Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;

d. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and

e. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Effective no earlier than January 1, 2022, the state will implement the expansion of IMD services for adult with SMI. Under the SMI program, the state will cover short term stays or Medicaid adults 21-64 who reside in a private IMD with an SMI diagnosis. The authorization will be based on medical necessity and will be covered when services are delivered by facilities located within the State of Maryland, a contiguous state, or the District of Columbia.

Under this demonstration component, beneficiaries will have access to, the full range of otherwise covered Medicaid services, including SMI treatment services. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings.

The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days in IMD treatment settings for beneficiaries receiving coverage through this demonstration's SMI component, to be monitored pursuant to the SMI Monitoring Plan as outlined in STC 4.19 below.

4.18 SMI/SED Implementation Plan.

a. The state must submit the SMI/SED Implementation Plan within 90 calendar days after approval of the demonstration for CMS review and comment. If applicable, the state must submit a revised SMI Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI under expenditure authority #13 until CMS has approved the SMI implementation plan and the SMI financing plan described in STC 4.18(d). After approval of the required implementation plan and financing plan, FFP will be available prospectively, but not retrospectively.

b. Once approved, the SMI/SED Implementation Plan will be incorporated into the STCs as Attachment H, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI Implementation Plan, within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 6.3.

c. At a minimum, the SMI/SED Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

    i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.

        a. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS;

        b. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD;

        c. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

        d. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in

psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;

e. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

f. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitions to Community-Based Care.

a. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);

b. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available;

c. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to;

d. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

e. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

a. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;

b. Commitment to implementation of the SMI/SED financing plan described in STC 4.17(d);

c. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;

d. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment and Increased Integration

a. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;

b. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;

c. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

d. **SMI/SED Health Information Technology (Health IT) Plan.** The Health IT plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a sufficient

health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 4.17, to develop the infrastructure/capabilities of the state's health IT infrastructure.

The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them, and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

The state will include in its Monitoring Plans an approach to monitoring its SMI/SED Health IT Plan which will include performance metrics to be approved in advance by CMS.

The state will monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Monitoring Report (see STC 6.6).

As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

Components of the Health IT Plan include:

i. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of MI/SED care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

ii. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7)

Identity management.

iii. In developing the Health IT Plan, states should use the following resources:

a. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and *"Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information- exchange/)*.

b. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

c. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

e. **SMI Financing Plan.** As part of the SMI implementation plan referred to in STC 4.18, the state must submit, within 90 calendar days after approval of the demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment H and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Components of the financing plan must include:

i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers;

ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings; and

iii. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

4.19 SMI/SED Monitoring Protocol. The state must submit a Monitoring Protocol for the SMI program authorized by this demonstration within one hundred fifty (150) calendar days after approval of the demonstration. The Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments, if any. Once approved, the SMI Monitoring Protocol will be incorporated into the STCs, as Attachment I. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports (as required by STC 6.6 respectively). Components of the Monitoring Protocol must include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 4.18 information relevant to the state's SMI financing plan described in Attachment H and information relevant to the state's Health IT plans described in STC 4.18(d);

   i. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the General Reporting Requirements described in Section V of the demonstration; and

   ii. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

4.20 Availability of FFP for the SMI Services Under Expenditure Authority #13. Federal Financial Participation is only available for services provided to beneficiaries during short term stays for acute care in IMDs. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days—or 45 days, as relevant.

4.21 Unallowable Expenditures Under the SMI Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services furnished to beneficiaries who are involuntarily residing in a

psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G or the definition of a qualified residential treatment program in STC 4.22.

4.22 Qualified Residential Treatment Programs. The state may receive FFP for treatment provided to beneficiaries residing in Qualified Residential Treatment Programs (QRTP) with over 16 beds if the QRTPs meet the following requirements:

a. The QRTP meets all of the requirements of the Family First Prevention Services Act (FFPSA) that was signed into law on February 9, 2018, as part of the Bipartisan Budget Act of 2018.

b. The state performs a needs assessment for the beneficiary to assure the appropriateness of placement in the QRTP as specified in the FFPSA.

c. QRTP meets any guidance or regulations that may be issued by the Administration for Children and Families in these settings.

d. The billing provider is enrolled in Medicaid.

e. The practitioner who furnishes a service meets federal and state qualifications to provide the service.

f. QRTP complies with CMS regulations regarding seclusion and restraint found in 42 CFR Part 483 Subpart G.

g. FFP is not available for room and board costs in QRTPs.

h. QRTPs are not subject to the 30-day average length of stay requirement as described in STC 4.20 or the 60-day length of stay requirement as described in STC 4.21 for the first 2 years of the demonstration period.

5. REENTRY DEMONSTRATION INITIATIVE

5.1. Overview of Pre-Release Services and Program Objectives. This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to certain individuals who are inmates residing in state managed prisons and jails (hereinafter "correctional facilities"). To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid as determined pursuant to an application filed before or during incarceration and must have an expected release date no later than 90 days as further specified in the STCs below.

5.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish

relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The reentry demonstration initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other Substance Use Disorder (SUD) and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and health-related social needs;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medication for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release. This is an identified population health priority under the Maryland Total Cost of Care Model's Statewide Integrated Health Improvement Strategy;

5.3. Qualifying Criteria for Pre-Release Services. To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR

435.1010, and be incarcerated in a correctional facility specified in STC 5.1;

b. Have been determined eligible for Medicaid;

c. Have an expected release date within 90 days;

d. Be 18 years of age or older; and

e. Meet the health-related criteria, described below and further defined in Attachment M:

i. Have been assessed and determined to have SUD, are diagnosed with SMI, or both, based on specified criteria as defined in Attachment M.

5.4. Scope of Pre-Release Services. The pre-release services authorized under the reentry demonstration initiative include the following services, which are described in Attachment L, Reentry Demonstration Initiative Services

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and health-related social needs; and

ii. MAT for all of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies.

b. The state must also provide a 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy

c. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the Maryland Medicaid State Plan, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT treatment services for qualifying Medicaid beneficiaries under age 21) are not available to qualifying individuals through the reentry demonstration initiative.

5.5. Participating Correctional Facilities. The pre-release services will be provided at state managed prisons and jails, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to Maryland Department of Health's approval of a facility's readiness, according to the implementation timeline described in STC 5.9. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

Correctional facilities that are also IMDs are not allowed to participate in the reentry demonstration initiative.

5.6. Participating Providers.

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Maryland scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as a Medicaid provider.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

5.7. Suspension of Coverage. Upon entry of a Medicaid-enrolled individual into a correctional facility, Maryland Department of Health must not terminate and generally shall suspend their Medicaid coverage.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

5.8. Interaction with Mandatory State Plan Benefits for Eligible Juveniles. To the extent Maryland's reentry demonstration includes coverage otherwise required to be provided under section 1902(a)(84)(D) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality expenditure limit, the state will claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

5.9. Reentry Demonstration Initiative Implementation Timeline. Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). The Maryland Department of Health will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid application and enrollment processes for individuals who are not enrolled in Medicaid prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 5.2;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;

d. Maryland will require participating facilities to select a Service Level for implementation. Service Level One consists of the expected minimum set of pre-release services as indicated in the State Medicaid Director Letter (SMDL) (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated) and identified in STC 41(a) and (b), and must be the first Service Level category that is implemented. The state may define additional Service Level categories in its Implementation Plan. As applicable, additional service levels may be phased-in by facilities in any order, e.g., Service Level Two would not be a prerequisite for phasing-in Service Level Three, except that no facility may be a participating correctional facility that does not at least achieve and maintain provision of Service Level One. A facility must demonstrate to the state that it is prepared to implement all the services in Service Level One and within any chosen Service Level, if applicable;

e. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments, and managed care plans;

f. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 90-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

g. Operational approaches related to implementing certain Medicaid requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

h. A data exchange process to support the care coordination and transition activities described in (d), (e), (f), and (g) of this subsection subject to compliance with

applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

i. Reporting of data requested by the Maryland Department of Health to support program monitoring, evaluation, and oversight; and

j. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

5.10. Reentry Demonstration Initiative Implementation Plan. The state is required to submit a Reentry Demonstration Initiative Implementation Plan. As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. The finalized Implementation Plan will be incorporated into the STCs as Attachment N titled "Reentry Demonstration Initiative Implementation Plan."

CMS will provide the state with a template to support developing of the Implementation Plan.

5.11. Reentry Demonstration Initiative Reinvestment Plan. To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment O) and subject to CMS approval. The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the reentry demonstration initiative, defined as services not previously provided or paid by the correctional facility with custody of qualifying individuals prior to the facility's implementation of the reentry demonstration initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative, with respect to the relevant increase in expenditures, as described in Attachment O (the Reentry Demonstration Initiative Reinvestment Plan)) is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to

i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

iii. Improved access to or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment O) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment O titled "Reentry Demonstration Initiative Reinvestment Plan."

5.12. Reentry Demonstration Initiative Planning and Implementation.

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified

electronic health record (EHR) technology to support Medicaid pre-release applications. In addition, reentry demonstration initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the reentry demonstration initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among the Maryland Department of Health and Qualified Applicants listed in STC 5.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

b. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the reentry demonstration initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 5.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 5.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

    i. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 49(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

    ii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (**EHR**) technology and training for the staff that will use the EHR.

    iii. **Purchase of Billing Systems.** Expenditures for the purchase of billing systems for Qualified Applicants.

    iv. **Development of Protocols and Procedures.** Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid enrollment process, suspension/unsuspension process for eligible

individuals, and provision of care coordination and reentry planning for a period for up to 90 days immediately prior to the expected date of release for individuals qualifying for reentry demonstration initiative services.

v. **Additional Activities to Promote Collaboration.** Expenditures for additional activities that will advance collaboration among Maryland's Qualified Applicants in STC 5.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vi. **Planning. Expenditures** for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid application; (3) submitting the Medicaid application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

vii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

c. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 1. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 1. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 29	**DY 30**	**DY 31**
Total Computable Expenditures	$5,000,000	$10,000,000	$5,000,000

d. Reentry Demonstration Initiative Planning and Implementation funding will

receive the applicable administrative match for the expenditure.

e. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the state Medicaid Agency, correctional facilities, other state agencies supporting carceral health, Probation Offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the state Medicaid agency

6. MONITORING AND REPORTING REQUIREMENTS

6.1. **Monitoring Protocol**. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachments G, I, and K. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 6.6(b), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS, as applicable. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Disparities Sensitive Measure Set from CMS. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned

approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

For the qualitative elements (e.g., operational updates as described in STC 6.6(a)), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

6.2 Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission.

   Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a

corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

6.3 Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

6.4 Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

6.5 Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

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

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

6.6 Monitoring Reports. The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each demonstration year (DY). The fourth-quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the

fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The state must submit a revised Monitoring Report within sixty (60) calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key operation and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by individuals; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goal and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable. For example, these metrics will cover measures of enrollment, unpaid medical bills at application, and policy-specific measures of access to care, utilization of services, quality of care and health outcomes.

   Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on individuals' outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

   Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and

health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

i. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 5.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

   The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64 or CMS-21, as applicable. Administrative costs for this demonstration should be reported separately on the CMS-64 or CMS-21, as applicable.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SMI/SED Health IT and SUD Health IT. The state will include a summary of progress made in regards to SMI/SED and SUD Health IT requirements outlined in STC 4.18(d).

6.7 Reentry Demonstration Initiative Mid-Point Assessment. The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of the demonstration. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

6.8 SUD and SMI/SED Mid-Point Assessment(s). The state must conduct an independent Mid-Point Assessment by December 31, 2024. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In the design, planning and conduction of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of managed care organizations (MCO), SUD and SMI/SED treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the Mid-Point Assessment Report to CMS no later than sixty (60) days after December 31, 2024 and the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within sixty (60) calendar days after receipt of CMS's comments, if any.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SUD and SMI/SED Implementation Plans, the SMI Financing Plan, and the SUD and SMI/SED Monitoring Protocols for ameliorating these risks. Modifications to the applicable Implementation Plan, Financing Plan, and Monitoring Protocols are subject to CMS approval. Elements of the Mid-Point Assessment include:

a. An examination of progress toward meeting each milestone and timeframe approved in the SUD and SMI/SED Implementation Plans, the SMI/SED Financing Plan, and toward meeting the targets for performance measures as approved in the SUD and SMI/SED Monitoring Protocols;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SMI/SED Implementation Plan or SMI/SED Financing Plan or to pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements.

6.9 Corrective Action Plan Related to Demonstration Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial, sustained directional change,

inconsistent with state targets and goals, as applicable, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

6.10 Close-Out Report. Within one hundred twenty (120) calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The draft Close-Out Report must comply with the most current guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the Close-Out report.

c. The state must take into consideration CMS's comments for incorporation into the final Close-Out report.

d. The final Close-Out report is due to CMS no later than thirty (30) calendar days after receipt of CMS's comments.

e. A delay in submitting the draft or final version of the Close-Out report may subject the state to penalties described in STC 6.2.

6.11 Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

6.12 Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

7. EVALUATION OF THE DEMONSTRATION

7.1. Assessment and Coordination Organization Process. Access to institutional and community-based supports and services will be through the Assessment and Coordination Organization (ACO) process. The purpose of the ACO is to streamline the intake and assessment processes and provide beneficiaries and their families with clear, concise, and accurate information about their care options. The ACO process will involve the beneficiary and involved family members, and treating practitioners and providers to ensure comprehensive assessments and care planning. The ACO is described more fully in Attachment C.

7.2 Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 6.2.

7.3 Independent Evaluator. Upon approval of the demonstration, the state must arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

7.4 Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design no later than one hundred eighty (180) days after the approval of the demonstration. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs, CMS's evaluation design guidance for SUD and SMI, and other applicable CMS technical assistance on the policy components, including post-partum coverage and waiver of retroactive eligibility, included in the HealthChoice demonstration. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, including establishing valid comparison groups and assuring causal inferences in demonstration evaluations. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 68 and 69.

7.5 Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS's comments.

Upon CMS approval of the draft Evaluation Design, the documents will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

7.6 Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and also its effectiveness in achieving the goals. For example, hypotheses for the SUD component of the demonstration must include an assessment of its objectives, to include (but are not limited to): initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes such as deaths due to overdose. Hypotheses for the SMI component of the demonstration must relate to (but are not limited to): utilization and length of stay in emergency departments, reductions in preventable readmissions to acute care hospitals and residential settings, availability of crisis stabilization services, and care coordination. Hypotheses for the waiver of retroactive eligibility must relate to (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, enrollment when people are healthy, and health status (as a result of greater enrollment continuity) and financial status. The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to: administrative costs of demonstration implementation and operation, Medicaid health service expenditures, and provider uncompensated care costs. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program. The evaluation should accommodate data collection and analyses stratified by key subpopulations of interest to inform a fuller understanding of existing disparities in access and health outcomes, and how the demonstration's various policies might support bridging any such inequities.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively

referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by National Quality Forum (NQF).

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the waiver of retroactive eligibility, beneficiary experiences with access to and quality of care, as well as changes in incidence of beneficiary medical debt. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including: utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support

developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

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

7.8 Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting an extension for the demonstration, the Interim Evaluation Report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised Interim Evaluation Report sixty (60) calendar days after receiving CMS's comments on the draft Interim Evaluation Report. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within thirty (30) calendar days.

e. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Reports) of these STCs.

7.9 Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs. The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

f. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.

g. The state must submit a revised Summative Evaluation Report sixty (60) calendar days after receiving CMS's comments on the draft Summative Evaluation Report. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within thirty (30) calendar days.

7.10 Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

7.11 State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

7.12 Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, the approved Evaluation Design, Interim Evaluation Reports, and Summative Evaluation Reports) on the state's Medicaid website within thirty (30) calendar days of approval by CMS.

7.13 Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment on or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

8. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

8.1. Accountable Entities. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so

long as they do not exceed the pre-defined limits as specified in these STCs.[3]

8.2. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit 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 thirty (30) days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on 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.

8.3. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that the non-federal share is obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that such funds must not be used to match any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, CMS reserves the right to prohibit the use of any sources of non-federal share funding that it determines impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to fund the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

8.4. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share funding of demonstration expenditures have been met:

[3] For a description of CMS's current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

a. Units of state or local government, including health care providers that are units of state or local government, certify that state or local monies have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, 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 expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot be used as the non-federal share needed to receive other federal matching funds under 42 CFR 433.51(c). 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 (IGT) to the extent that such funds are derived from state or local revenues and are transferred by units of government within the state. Any transfers from units of government must be made in an amount not to exceed the non-federal share of title XIX payments and any payment derived from a proper IGT is not contingent upon receipt of the IGT.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments to return and/or redirect to the state 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.

f. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

8.5. Financial Integrity for Managed Care and Other Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR §438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74.

b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR §447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

8.6. Requirements for health care related taxes and provider donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All health care-related taxes as defined by Section 1903 (w)(3)(A) of the Social Security Act and 42 CFR § 433.55 are broad-based as defined by Section 1903 (w)(3)(B) of the Social Security Act and 42 CFR § 433.68 (c)

b. All health care-related taxes are uniform as defined by Section 1903 (w)(3)(C) of the Social Security Act and 42 CFR § 433.68 (d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903 (w)(3)(E)(i) of the Social Security Act and 42 CFR § 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903 (w)(4) of the Social Security Act and 42 CFR § 433.68 (f).

e. All provider related-donations as defined by 42 CFR § 433.52 are bona fide as defined by Section 1903 (w)(2)(B) of the Social Security Act, 42 CFR § 433.66, and 42 CFR § 433.54.

8.7. State Monitoring of Non-federal Share. No later than 60-days after demonstration approval, the state must provide a report to CMS regarding payments under the demonstration specifying that payments under the demonstration are funded all or in part by a locality tax, if applicable. This report must include:

a. Any agreement written or otherwise regarding the arrangement among the providers with counties, the state or other entities for each locality tax;

b. Number of hospitals in each locality of the taxing entities for each locality tax;

c. Whether or not all hospitals will be paying the assessment for each locality tax;

d. The assessment rate that the hospitals will be paying for each locality tax;

e. Whether any hospitals that pay the assessment will not be receiving payments funded by the assessment;

f. Number of hospitals that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax comply

with section 1903(w)(4) of the Social Security Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under Section 1903(w) of the Act.

This deliverable is subject to the deferral as described in STC 6.2.

8.8. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section XIII:

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. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third- party liability.

8.9. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

8.10. Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
TANF Adults 0-123	Main	X		X	This MEG consists of families with dependent children and foster children with incomes less than 123 percent of the FPL, including individuals with incomes below the "pre- July 2008" TANF income threshold.

Table 2: Master MEG Chart					
Medicaid Children	Main	X		X	This MEG consists of children whose Medicaid eligibility derives from their status as a minor child up to 21 years of age.
Medically Needy Adults	Main	X		X	This MEG consists of adults whose income and resources exceed the categorically needy limits but are within Medicaid state plan limits.
Medically Needy Children	Main	X		X	This MEG consists of children whose income and resources exceed the categorically needy limits but are within Medicaid state plan limits.

Table 2: Master MEG Chart					
SOBRA Adults	Main	X		X	This MEG consists of income eligible pregnant women.
SSI/BD Adults	Main	X		X	This MEG consists of adults whose Medicaid eligibility derives from their status as blind or disabled.
SSI/BD Children	Main	X		X	This MEG consists of children whose Medicaid eligibility derives from their status as blind or disabled.
New Adult Group	HYPO 2	X		X	This MEG consists of childless adults, ages 19-64, with income up to 133 percent of the FPL, as defined in section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, pursuant to the approved state plan.
Residential Treatment for Individuals w/SUD	HYPO 3	X		X	This MEG consists of individuals ages 21-64 who are receive SUD services in a residential treatment facility.
Dental Expansion for Former Foster Care Youth	HYPO 4	X		X	This MEG consists of former foster care youth ages 21-26.
Residential Treatment for Individuals with Serious Mental Illness	HYPO 1	X		X	This MEG consists of adults 21-64 who reside in a private IMD with an SMI diagnosis.

Table 2: Master MEG Chart					
Assistance in Community Integration Services (ACIS) Pilot Program	HYPO 5			X	This MEG consists of individuals who meet the needs-based criteria for a set of HCBS services.
Home Visiting Services Pilot Program	Main			X	This MEG consists of individuals who high risk pregnant and children up to age 3.
HealthChoice Diabetes Prevention Program (DPP) Pilot Program	Main			X	This MEG consists of individuals 18-64 who are Medicaid eligible beneficiaries with elevated blood glucose and BMI levels.
Adult Dental Program	Main			X	This MEG consists of individuals 18-64 who are eligible for both Medicaid and Medicare services (dual eligible individuals).
Increased Community Services (ICS)	Main			X	This MEG consists of individuals over the age of 18 who reside in a nursing home with an income level at or below 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR).
Breast and Cervical Cancer Treatment Program (BCCTP)	Main			X	This MEG consists of women diagnosed with breast or cervical cancer with incomes between 133-250 percent of the FPL and who were in active treatment under the Breast & Cervical Cancer Treatment program as of December 31, 2013.
Presumptive Eligibility for Pregnant Women (PEPW)	Main			X	This MEG consists presumptively eligible pregnant women with incomes up to 250 percent of the FPL who receive full Medicaid state plan benefits.
Collaborative Care Model (CoCM)Pilot Program	Main			X	This MEG consists of individuals who are diagnosed with mild to moderate depression or another behavioral health condition.
Maternal Opioid Misuse (MOM) Model pilot program	Main			X	This MEG consists of Medicaid beneficiaries who are postpartum with an OUD.

Table 2: Master MEG Chart					
Medicaid Alternative Destination Transport Pilot Program	Main			X	This MEG consists of Medicaid beneficiaries who receive emergency ground transportation (EMS) to an alternative destination (AD).
Reentry	HYPO 6	X		X	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.
Reentry Non-Services	HYPO 6		X	X	Expenditures for allowable planning and non-services for the reentry demonstration initiative.

8.11. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11- W-00099/3). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's

compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. Administrative Costs. The state will 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. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in section V, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
TANF Adults 0-123	Families with dependent children and foster children with incomes less than 123 percent of the FPL, including	Exclude expenditures for services and populations listed in	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/1997	12/31/2026

Table 3: MEG Detail for Expenditure and Member Month Reporting								
	individuals with incomes below the pre-July 1, 2008, TANF income thresholds.	STC 4.6						
Medicaid Children	Children up to 21 years of age.	Exclude expenditures for services and populations listed in STC 4.6	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/1997	12/31/2026
Medically Needy Adults	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.	Exclude expenditures for services and populations listed in STC 4.6	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/1997	12/31/2026
Medically Needy 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.	Exclude expenditures for services and populations listed in STC 4.6	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/1997	12/31/2026
SOBRA Adults	Pregnant women with incomes above the pre-July 1, 2008, standard up to and including 250 percent of the FPL who are not enrolled in the TANF group.	Exclude expenditures for services and populations listed in STC 4.6	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/1997	12/31/2026
SSI/BD Adults	Individuals whose Medicaid eligibility derives from their status as blind or disabled and who are not entitled to Medicare.	Exclude expenditures for services and populations listed in STC 4.6	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/1997	12/31/2026
SSI/BD Children	Individuals whose Medicaid eligibility derives from their status as blind or disabled and who are not entitled to Medicare.	Exclude expenditures for services and populations listed in STC 4.6	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/1997	12/31/2026
New Adult Group	Childless adults and non-custodial parents ages 19-64 with income up to 133 percent of the	Exclude expenditures for services and populations	Follow standard CMS-64.9 category of service	Date of service	MAP	Y	07/01/1997	12/31/2026

Table 3: MEG Detail for Expenditure and Member Month Reporting								
	FPL as defined in section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, pursuant to the approved state plan.	listed in STC 4.6	definitions					
Residential Treatment for Individuals w/ SUD	Expenditures for SUD treatment in IMDs.	None	Follow standard CMS-64.9 category of service definitions; Line 2A – Mental Health Facility Services - Reg. Payments for IMD	Date of service	MAP	Y	07/01/2017	12/31/2026
Dental for Former Foster Care Youth	Expenditures for enhanced dental services for former foster care youth up to 26 years old.	None	Line 8 – Dental Services OR Line 18A – Medicaid-MCO	Date of service	MAP	Y	01/01/2017	12/31/2026
Residential Treatment For Individuals with Serious Mental Illness	Expenditures for SMI treatment in IMDs	None	Follow standard CMS-64.9 of service definitions; Line 2A – Mental Health Facility Services - Reg. Payments for IMD category	Date of service	MAP	Y	01/01/2022	12/31/2026
Assistance in Community Integration Services (ACIS) Pilot Program	Expenditures for the ACIS Pilot as described in STC 4.9.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	N	07/01/2017	12/31/2026
Home Visiting Services Pilot Program	Expenditures for evidence-based home visiting services to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children up to 3 years old.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/2017	12/31/2026
HealthChoice Diabetes Prevention Program (DPP) Pilot	Expenditures for a National Diabetes Prevention Program for individuals 18-64 who have	None	Follow standard CMS-64.9 category of service	Date of service	MAP	Y	07/01/2019	12/31/2026

Table 3: MEG Detail for Expenditure and Member Month Reporting								
Program	prediabetes or are at high risk of developing type 2 diabetes as described in STC 4.12.		definitions					
Adult Dental Program	Expenditures for a limited dental benefit for full dually eligible adults (21-64) as described in STC 4.13.	None	Line 8 – Dental Services OR Line 18A – Medicaid - MCO	Date of service	MAP	Y	04/01/2019	12/31/2026
Increased Community Services (ICS)	Medicaid eligible individuals over the age of 18 residing in a nursing home at the time initially determined eligible for ICS, with an income level at or below 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR).	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/2017	12/31/2026
Breast and Cervical Cancer Treatment Program (BCCTP)	Women diagnosed with breast or cervical cancer with incomes between 133-250 percent of the FPL and who were in active treatment under the Breast & Cervical Cancer Treatment program as of December 31, 2013.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	01/01/2014	12/31/2026
Presumptive Eligibility for Pregnant Women (PEPW)	Presumptively eligible pregnant women with incomes up to 250 percent of the FPL who receive full Medicaid state plan benefits through this demonstration.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/2017	12/31/2026
Collaborative Care Model (CoCM)Pilot Program	Expenditures to establish and implement a Collaborative Care Model (CoCM) pilot program that integrates primary and behavioral health services for a limited number of HealthChoice beneficiaries as describe in STC 4.15.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	N	07/01/2020	12/31/2026
Maternal Opioid	Expenditures to establish a MOM	None	Follow standard	Date of service	MAP	Y	07/01/2022	12/31/2026

Table 3: MEG Detail for Expenditure and Member Month Reporting								
Misuse (MOM) Model pilot program	care coordination model.		CMS-64.9 category of service definitions					
Medicaid Alternative Destination Transport Pilot Program ADM	Expenditures for SMI treatment in IMDs.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	01/01/2022	12/31/2026
Reentry	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.	None	Follow CMS-64.9 Based Category of Service Definition	Date of service	MAP	Y	01/13/2024	12/31/2026
Reentry Non-Services	Expenditures for allowable planning and non-services for the reentry demonstration initiative.	None	Follow CMS-64.10 Base Category of Service Definition	Date of payment	ADM	N	01/13/2024	12/31/2026

8.12. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 4: Demonstration Years		
Demonstration Year 26	January 1, 2022 to June 30, 2022	6-Months
Demonstration Year 27	July 1, 2022 to June 30, 2023	12-Months
Demonstration Year 28	July 1, 2023 to June 30, 2024	12-Months
Demonstration Year 29	July 1, 2024 to June 30, 2025	12-Months
Demonstration Year 30	July 1, 2025 to June 30, 2026	12-Months
Demonstration Year 31	July 1, 2026 to December 31, 2026	6-Months

8.13. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in section XI. CMS will provide technical assistance, upon request.[4]

[4] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between

8.14. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will 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.

8.15. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall 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 federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a

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the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

modified budget neutrality expenditure limit.

9. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

9.1 Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

9.2 Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

9.3 Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

9.4 Main Budget Neutrality Test. The Main Budget Neutrality Test allows the state to show that demonstration waivers granted have not resulted in increased costs to Medicaid, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are

counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 5:Main Budget Neutrality Test										
MEG	**PC or AG**	**WOW Only, WW Only or Both**	**Base Year**	**Trend Rate**	**DY26**	**DY26**	**DY27**	**DY28**	**DY29**	**DY30**
TANF Adults 0-123	PC	Both	$673.31	4.9%	$$697.91	$723.40	$758.85	$796.03	$835.04	$865.54
Medicaid Children	PC	Both	$301.77	1.6%	305.38	$316.54	$321.60	$326.75	$331.98	$335.96
Medically Needy Adults	PC	Both	$1,280.31	0%	$1,280.31	$1,327.08	$1,327.08	$1,327.08	$1,327.08	$1,327.08
Medically Needy Children	PC	Both	$1,540.86	5.9%	$1,608.55	$1,667.31	$1,765.68	$1,869.86	$1,980.18	$2,067.17
SOBRA Adults	PC	Both	$2,113.84	1.5%	$2,137.73	$2,215.82	$2,249.28	$2,283.24	$2,317.72	$2,343.92
SSI/BD Adults	PC	Both	$1,902.64	2.3%	$1,935.65	$2,006.36	$2,052.91	$2,100.54	$2,149.27	$2,186.56
SSI/BD Children	PC	Both	$1,631.86	0.8%	$1,641.64	$1,701.61	$1,715.22	$1,728.94	$1,742.78	$1,753.22
Home Visiting Services Pilot Program	PC	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
HealthChoice Diabetes Prevention Program (DPP) Pilot Program	PC	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Adult Dental Program	PC	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Increased Community Services (ICS)	PC	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Breast and Cervical Cancer Treatment Program (BCCTP)	PC	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Presumptive Eligibility for Pregnant Women (PEPW)	PC	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Collaborative Care Model (CoCM) Pilot Program	PC	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Maternal Opioid Misuse (MOM) Model Pilot	PC	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Program										
Medicaid Alternative Destination Transport Pilot Program	PC	WW Only	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

*PC – Per Capita, AG - Aggregate

9.5 Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration .

9.6 Hypothetical Budget Neutrality Test 1: The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

0										
MEG	**P C or A G**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend**	**DY26**	**DY26**	**DY27**	**DY28**	**DY29**	**DY30**
Residential and Inpatient Treatment for	P C	Both		5.2%	$15,370	$16,169	$17,010	$17,895	$18,825	$19,804

0										
MEG	**P C or A G**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend**	**DY26**	**DY26**	**DY27**	**DY28**	**DY29**	**DY30**
Individuals w/ Serious Mental Illness										

9.7 Hypothetical Budget Neutrality Test 2: The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 7: Hypothetical Budget Neutrality Test 2										
MEG	**P C or A G**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend**	**DY26**	**DY26**	**DY27**	**DY28**	**DY29**	**DY30**
New Adult Group	PC	Both	$716.56	5.8%	$747.51	$774.82	$819.76	$867.31	$917.61	$957.24

9.8 Hypothetical Budget Neutrality Test 3: The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 8: Hypothetical Budget Neutrality Test 3										
MEG	**P C or A G**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend**	**DY26**	**DY26**	**DY27**	**DY28**	**DY29**	**DY30**
Residential Treatment for Individuals w/ SUD	PC	Both	$7,137.11	5.2%	$7,413.69	$7,684.51	$8,084.10	$8,504.48	$8,946.71	$9,293.41

1. **Hypothetical Budget Neutrality Test 4:** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9: Hypothetical Budget Neutrality Test 4										
MEG	**P C or A G**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend**	**DY26**	**DY26**	**DY27**	**DY28**	**DY29**	**DY30**
Dental for Former Foster Care Youth	PC	Both	$28.36	5.2%	$29.46	$30.54	$32.13	$33.80	$35.56	$36.93

9.9 Hypothetical Budget Neutrality Test 5: The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit.

9.10 The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 10: Hypothetical Budget Neutrality Test 5							
MEG	**PC or AG**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend**	**DY29**	**DY30**	**DY31**
Assistance in Community Integration Services (ACIS) Pilot Program	PC	Both		4.7%	$503.67	$521.32	$539.59

9.11 Hypothetical Budget Neutrality Test 6: Reentry Demonstration Initiative Expenditures. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 6. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 6

are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11: Hypothetical Budget Neutrality Test 6							
MEG	**PC or AG**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend**	**DY29**	**DY30**	**DY31**
Reentry	PC	Both		7.7%	$1,921.65	$2,069.62	$2,188.03
Reentry Non-Services	AG	Both			$5,000,000	$10,000,000	$5,000,000

9.12 Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to 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 by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, 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 to method. Each Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

9.13 Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from January 1, 2022 to December 31, 2026. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

9.14 Mid-Course Correction. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 12: Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Years	**Cumulative Target Definition**	**Percentage**
DY 25 through DY 26	Cumulative budget neutrality limit plus	2.0 Percent
DY 25 through DY 27	Cumulative budget neutrality limit plus	1.5 Percent
DY 25 through DY 28	Cumulative budget neutrality limit plus	1.0 Percent
DY 25 through DY 29	Cumulative budget neutrality Limit plus	0.5 Percent
DY 25 through DY 30	Cumulative budget neutrality limit	0.0 Percent

10. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 13: Schedule of Deliverables for the Demonstration Period		
Date	**Deliverable**	**STC**
30 calendar days after demonstration approval	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 calendar days after demonstration approval	SMI Implementation Plan (including Health IT Plan)	STC 4.18
60 calendar days after receipt of CMS comments	Revised SMI Implementation Plan (including Health IT Plan)	STC 4.18
150 calendar days after demonstration approval	SUD Monitoring Protocol	STC 4.8
60 calendar days after receipt of CMS comments	Revised SUD Monitoring Protocol	STC 4.8
150 calendar days after demonstration approval	SMI Monitoring Protocol	STC 4.19
60 calendar days after receipt of CMS comments	Revised SMI Monitoring Protocol	STC 4.19

Table 14: Schedule of Deliverables for the Demonstration Period		
Date	**Deliverable**	**STC**
180 calendar days after demonstration approval	Draft Evaluation Design	STC 7.4
60 days after receipt of CMS comments	Revised Evaluation Design	STC 7.5
No later than 60 calendar days after December 31, 2024	SUD and SMI Mid-Point Assessment Report	STC 6.8
60 days after receipt of CMS comments	Revised SUD and SMI Mid-Point Assessment Report	STC 6.8
No later than the end of the third year of the demonstration	Reentry Mid-Point Assessment Report	STC 6.7
60 days after receipt of CMS comments	Revised Reentry Mid-Point Assessment Report	STC 6.7
June 30, 2024, or with renewal application	Draft Interim Evaluation Report	STC 7.8
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 7.8

Table 14: Schedule of Deliverables for the Demonstration Period		
Date	**Deliverable**	**STC**
Within 18 months after June 30, 2025	Draft Summative Evaluation Report	STC 7.9
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 7.9
Monthly Deliverables	Monitoring Calls	STC 6.11
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter.	Quarterly Monitoring Reports, including implementation updates	STC 6.6
	Quarterly Budget Neutrality Reports	STC 8.13
Annual Deliverables - Due 90 calendar days after end of each 4th quarter	Annual Monitoring Reports	STC 6.6

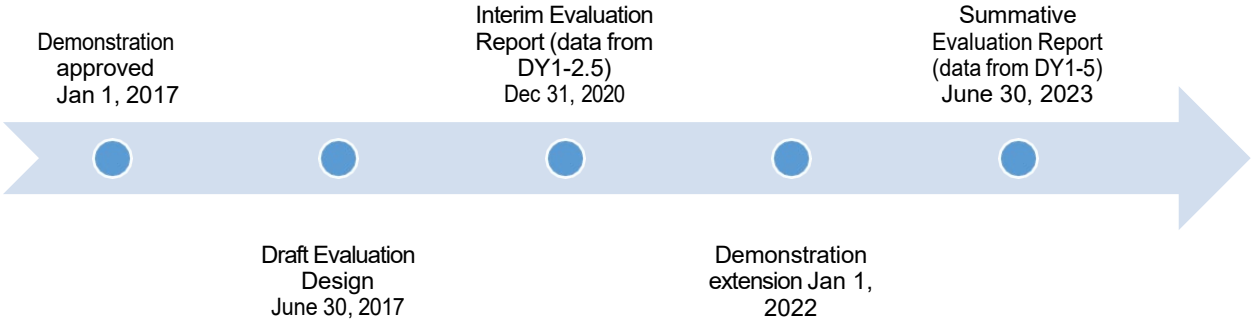
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If

the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
   b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
   c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
   d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

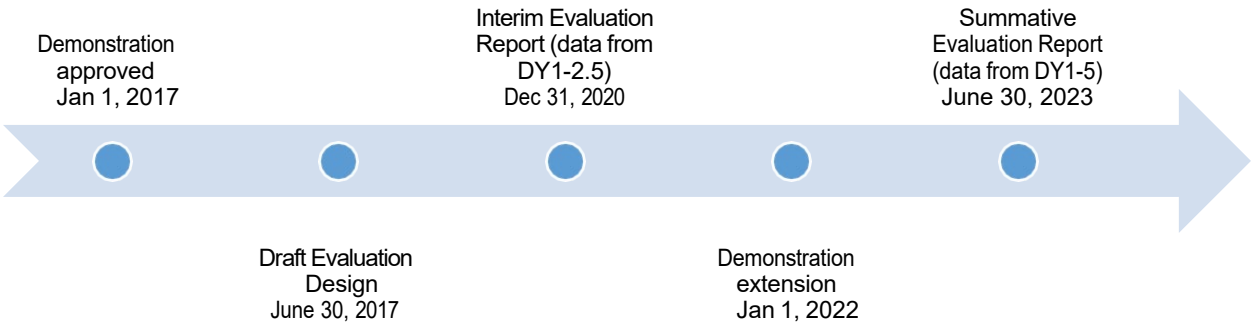
CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans for the demonstration.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for extension, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

E. E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.
2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

Attachment B:
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

A. The format for the Interim and Summative Evaluation reports is as follows: Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research,

(using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.

2) *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.

3) *Evaluation Period* – Describe the time periods for which data will be collected.

4) *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5) *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6) *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
    a. If the state did not fully achieve its intended goals, why not?
    b. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

a. **Attachment(s)**

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Maryland Department of Health

§1115 HealthChoice Demonstration Evaluation Design

August 24, 2023

Table of Contents

Acronyms

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

Background and History of Maryland's §1115 Demonstration

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

Subsequent to the initial grant, the Maryland Department of Health[2] (MDH) requested and received several program renewals—in 2002, 2005, 2008, 2011, 2013, 2016, and 2021. In June 2021, Maryland applied for its seventh extension of the HealthChoice demonstration, which CMS approved for the period of calendar years (CYs) 2022 to 2026. Approved effective January 1, 2022 through December 31, 2026, the current waiver period builds on the innovations of the previous extensions by focusing on developing cost-effective services that target the significant and complex health care needs of individuals enrolled in Maryland Medicaid. Specifically, the demonstration will implement initiatives to address the social determinants of health, such as those encountered by individuals with severe mental illness (SMI), substance use disorders (SUD), high-risk pregnant women and former foster care participants, among others.

As of May 2022, HealthChoice served over 1.75 million participants, constituting nearly 86 percent of Medicaid recipients in Maryland, over 452,000 of whom receive coverage under the ACA's Medicaid expansion.

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

1) Collaborative Care Model Pilot Program which integrates primary care and behavioral health services for HealthChoice participants who have experienced a behavioral health need (either a mental health condition or SUD).
2) Community Health Pilots: Assistance in Community Integration Services (ACIS) for individuals residing in institutions or at imminent risk of institutional placement.
3) Increased Community Services (ICS) for individuals over the age of 18 who were determined

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

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.

4) Diabetes Prevention Program (DPP) for individuals (18-64) who have prediabetes or are at high risk of developing type 2 diabetes.
5) Dental Services for Former Foster Care Individuals up to 26 years old.
6) Expansion of SUD Residential and Inpatient Treatment Services to remove caps on lengths of stays for SUD treatment in an IMD and aim for a statewide average length of stay of 30 days or less.

Two additional programs have been approved for the demonstration period:

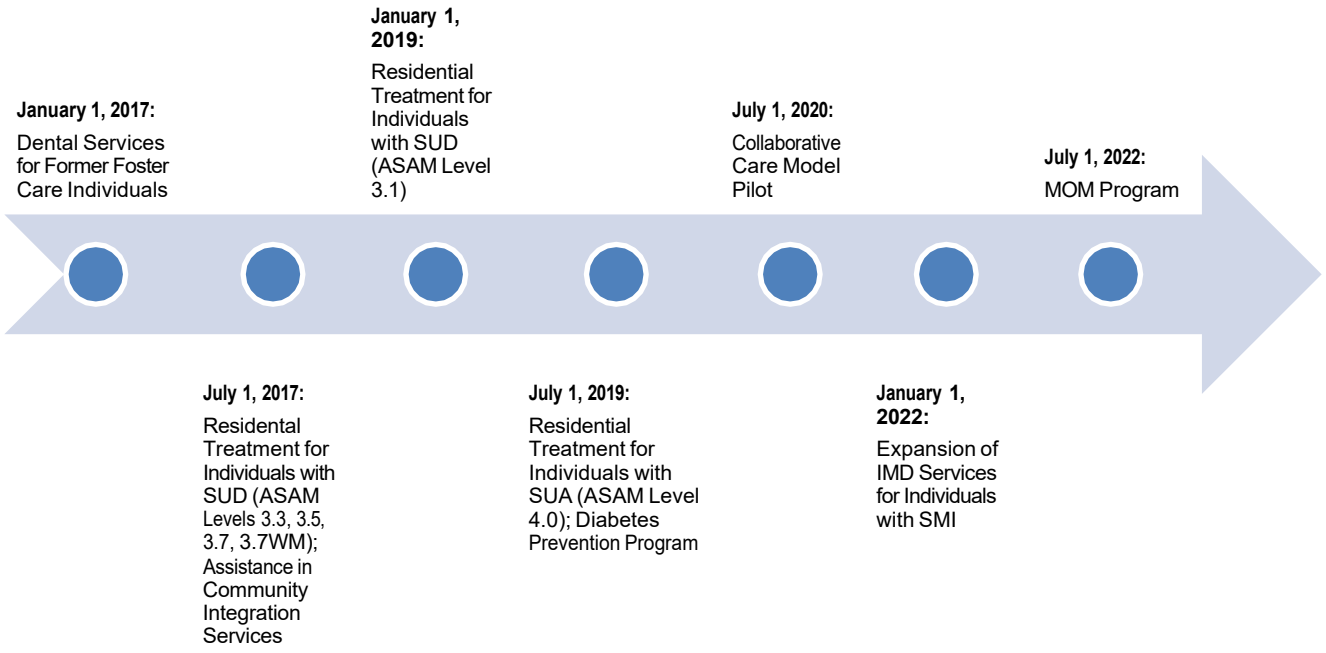
1) Expansion of IMD Services for Beneficiaries with SMI to cover short term stays of adults (21-64) who reside in a private IMD with an SMI diagnosis.
2) Maternal Opioid Misuse (MOM) program to provide a set of enhanced case management services, standardized social determinants of health screenings and care coordination to pregnant and postpartum beneficiaries with opioid use disorder (OUD).

Due to being expanded statewide and incorporated into Maryland's state plan, the following programs are no longer included in the demonstration and will not be included in the evaluation:

1) Medicaid Alternative Destination Transport Pilot Program.
2) Evidence-Based Home Visiting Services Pilot Program.
3) Adult Dental Pilot Program.

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

Figure 1. Implementation Timeline for HealthChoice Demonstration Components



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

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

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

MDH aims to meet the following goals related to SUD:

1) Increased rates of identification, initiation, and engagement in treatment for SUD;
2) Increased adherence to and retention in treatment;
3) Reductions in overdose deaths, particularly those due to opioids;
4) Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5) Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6) Improved access to care for physical health conditions among beneficiaries with SUD.

MDH also aims to meet the following goals related to SMI/serious emotional disturbance (SED):

1) Reduced utilization and lengths of stay in EDs among beneficiaries with SMI while awaiting mental health treatment in specialized settings;
2) Reduced preventable readmissions to acute care hospitals and residential settings;
3) Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
4) Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
5) Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Evaluation Questions and Hypotheses

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

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

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

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

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

- Do changes to the population health incentive program (formerly known as the value-based purchasing program) to an incentive only program result in higher rates of achievement of the program goals, without reducing the outcomes achieved by previously existing goals? Changes to the Value-Based Purchasing program went into effect starting in CY 2022.
- Do programs incentivizing greater attention to problems of particular concern among children (*e.g.*, asthma and lead exposure) help to reduce the incidence of those problems? Maryland's Health Services Initiative (HSI) went into effect on July 1, 2017.
- Do programs restricting access to prescription drugs that may be subject to misuse control the rates of such misuse? The policy change commenced on March 1, 2016.

Hypothesis 3 involves the largest number of policy initiatives, although many are currently being implemented as pilot programs and so will have relatively limited enrollment. Therefore, the research

questions around pilot programs will benefit from the ability to compare participants' results with the results of a control group. This hypothesis will produce the following policy questions:

- Does the opportunity to treat acute cases of SUD and SMI in residential treatment in institutions for mental disease (IMDs) improve the control of SUDs? The SUD benefit was phased into effect beginning in July 2017, covering ASAM Levels 3.3, 3.5, 3.7 and 3.7WM.[3] ASAM Levels 3.1 and 4.0 were phased in beginning in January and July 2019, respectively. The SMI benefit began January 2022.
- Does the ACIS pilot improve the living situations and reduce potentially unnecessary health care utilization for persons at risk of institutionalization or homelessness? This program went into effect in July 2017, with awards to local Lead Entities first granted in November 2017.
- If dental benefits are extended young adults aged out of foster care would these benefits also result in reduced incidence and costs of conditions related to dental disease? This program went into effect in January 2017.
- Does the Increased Community Services program increase transitions to the community? This program is a continuation from previous waiver periods and has been operating since 2009; the current waiver increased the program's cap to 100 slots.
- Does implementation of the National Diabetes Prevention Program (National DPP), proven to be sufficiently-effective to become a covered service under Medicare, work equally well with preventing diabetes diagnoses for a Medicaid population? The HealthChoice DPP was approved effective April 2019.
- Does a service model that integrates primary and behavioral health care and provides evidence-based therapeutic intervention and case management services for individuals with behavioral health conditions through the Collaborative Care Model result in improved outcomes for the target population? This pilot program went into effect on July 1, 2020 and will be transitioned out of the 1115 waiver to operate statewide on October 1, 2023.
- Does a service model that provides a set of enhanced case management services, standardized social determinants of health screenings and care coordination through the MOM program result in improved outcomes for the target population? This program went into effect on July 1, 2022.

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

Driver Diagram

Table 1 provides a driver diagram, offering a visual representation of the aims of the 2022-2026 waiver period, along with a closer look at the measures that MDH intends to employ to assess HealthChoice's performance against the stated hypotheses. In addition to the proposed measures, MDH will continue to

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

monitor the development and release of new sources of information—such as upcoming surveys or HEDIS® measures—that may serve to evaluate the demonstration.

Table 1. Driver Diagram for Maryland §1115 Waiver Evaluation

Aims	Goals	Primary Drivers	Secondary Drivers
Eligibility and enrollment changes implemented during the current HealthChoice waiver period increase coverage and access to care for HealthChoice participants.	Improve access to health care for the Medicaid population; Expand coverage to additional low-income Marylanders with resources generated through managed care efficiencies	Auto-renewal process	Health status at enrollment
			Financial status of beneficiaries
			Periods of continuous enrollment without interruption
			Decreases in the frequency of disenrollment and reenrollment (churn)
		MCO auto-assignment after one day policy	Improved service utilization of new participants (>120 day six-month enrollment gap)
Payment approaches implemented during the current HealthChoice waiver period improve quality of care for HealthChoice participants	Improve access to health care for the Medicaid population; Improve the quality of health services delivered; Emphasize health promotion and disease prevention;	Value-Based Purchasing (VBP) Program/Population Health Incentive Program (PHIP)	Improved VBP/PHIP measures, such as diabetes management
			Increased preventive care visits, such as ambulatory care for children and adults with disabilities
		CHIP Health Services Initiative addressing lead and asthma	Healthy Homes for Healthy Kids (Program 1)
			Childhood Lead Poisoning Prevention and Environmental Case Management Program (Program 2)
		Statewide health IT solutions	Streamlined Corrective Managed Care (CMC) targeting prescription drug abuse
Innovative programs address the social determinants of health and improve the health and wellbeing of the Maryland population	Increased rates of identification, initiation, and engagement in treatment for SUD	Residential Treatment of Adults with SUD	Improving rates of initiation and engagement of alcohol and other drug dependence treatment among members with SUD

Aims	Goals	Primary Drivers	Secondary Drivers
			Improved rates of members receiving any addiction treatment for SUD
	Increased adherence to and retention in treatment		Better follow-up care after ED visit for alcohol and other drug abuse or dependence
			Increased rates of medication-assisted treatment (MAT) among participants with OUD
	Reductions in overdose deaths, particularly those due to opioids		Reduction in opioid-related mortality
	Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services		Lower rates of acute inpatient stays that had any SUD/opioid use disorder (OUD) diagnosis
			Reduced lengths of stay in acute inpatient and residential settings for treatment for SUD
	Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate		Decreased rates of readmission to the same level of care or higher among members discharged from residential treatment facilities.
	Improved access to care for physical health conditions among beneficiaries with SUD		Decreased cost of care for individuals with SUD including co-morbid physical and mental health conditions
	Reduced utilization and lengths of stay in EDs among beneficiaries with	IMD Services for Adults with SMI	Lower rates of ED visits and reduced ED lengths of stay for adults with SMI

Aims	Goals	Primary Drivers	Secondary Drivers
	SMI while awaiting mental health treatment in specialized settings Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care		
	Reduced preventable readmissions to acute care hospitals and residential settings Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities		Reduced preventable readmissions to acute care hospitals among adults with an SMI
	Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric		Increased number of call centers and mobile crisis units

Aims	Goals	Primary Drivers	Secondary Drivers
	hospitals, and residential treatment settings throughout the state		
	Improve access to health care for the Medicaid population; Improve the quality of health services delivered; and Emphasize health promotion and disease prevention	Assistance in Community Integration Services Pilot	Decreased ED visits (incl. potentially avoidable utilization)
			Decreased inpatient admissions
			Better follow-up care after hospitalization
			Reduced admissions to CFR 578.3 facilities
	Improve access to health care for the Medicaid population; Improve the quality of health services delivered	Increased Community Services Program	Reduction in nursing facility admissions and lengths of stay
	Provide patient-focused, comprehensive and coordinated care by providing Medicaid participants with a single case manager; Emphasize health promotion and disease prevention; Increased rates of identification, initiation, and engagement in treatment for SUD; Improved access to care for physical health conditions	MOM Program	Improved care coordination including comprehensive case management, care coordination, health promotion, individual and family supports, and linkages to community and support services

Aims	Goals	Primary Drivers	Secondary Drivers
	among beneficiaries with SUD.		
	Improve access to health care for the Medicaid population; Expand coverage to additional low-income Marylanders with resources generated through managed care efficiencies	Dental benefits for former foster care children	Increased use of dental services, including preventive/diagnostic, and restorative visits
			Reduction in ED use for dental-related conditions
	Improve access to health care for the Medicaid population; Improve the quality of health services delivered; and Emphasize health promotion and disease prevention	HealthChoice Diabetes Prevention Program	Reduction in total cost of care for prediabetic patients
			Decreased diabetes incidence
			Reduction in ED admissions for prediabetic patients.
			Reduction in hospital admissions where diabetes is the primary diagnosis
	Improve access to health care for the Medicaid population; Provide patient-focused, comprehensive and coordinated care by providing Medicaid participants with a single medical home; Expand coverage to	Collaborative Care Model Pilot Program	Increased rate of depression screening
			Increased monthly contact with enrolled pilot participants
			Improvement in depression diagnostic scores
			Increased case and treatment plan review
			Increased proportion of enrolled pilot participants in remission

Aims	Goals	Primary Drivers	Secondary Drivers
	additional low-income Marylanders with resources generated through managed care efficiencies.		Increased referral to and utilization of specialty behavioral health services by participants identified with high levels of acuity that cannot be appropriately addressed through the Collaborative Care Model

Methodology

Evaluation Design

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

Target and Comparison Populations

Because Medicaid is fluid in its enrollment of individuals, it is not always possible to maintain the programs' focus on particular participants or participant groups. Some of these programs evaluated apply to the HealthChoice populations as a whole, or a subpopulation which intrinsically cannot be divided into intervention and comparison groups, such as new participants. In this case, the best way to measure effects is to compare trends before and after the implementation of the program, using statistical methodologies such as pooled cross-section time series that separate between fixed effects and time-varying effects to control for exogenous changes outside of the program implementation.

On the other hand, a number of the programs are pilot studies with limited enrollment or implementation in specific geographic areas, for example, the Childhood Lead Poisoning Prevention and Environmental Case Management Program and the HealthChoice Diabetes Prevention Program components. Such programs can identify non-participants to serve as a comparison group. Specific decisions about which approach might be used to create a comparison group may need to await the availability of sufficient data on the number of program participants and their clinical, demographic, and geographic characteristics.

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

Evaluation Period

The evaluation period covers outcomes measured during the renewal period of Maryland Medicaid's §1115 waiver. The time periods of analysis for most outcomes will be the years of the demonstration, CYs 2022-2026. In some cases (*i.e.*, for certain measures), it may be necessary to look at data from before the renewal period to better identify trends in the measure in question, such as with policies that were implemented before the start of the demonstration extension period and are continuing under the extension (such as the Diabetes Prevention Program). The pre-implementation period for these policies may extend 1-2 years prior to implementation. Because The Hilltop Institute at the

University of Maryland, Baltimore County is the repository for Maryland Medicaid's MMIS, it would require little additional effort to incorporate these additional data to improve the validity of an analysis relying on trends over time, such as pooled cross-section time series.

Data Sources

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

Due to the distinct attributes of the HealthChoice population, the evaluation will not take into consideration any additional populations for purposes of comparison. MDH believes that year-to-year trend comparisons of the enrolled population provide a more meaningful analysis. Over 86 percent of Maryland Medicaid participants are enrolled in managed care. The remaining 14 percent consists largely of much smaller populations with greater health complexities: dual eligibles, spend-down recipients and participants in other partial benefit programs. Hence, the evaluation will not compare participants in the HealthChoice program with either the non-HealthChoice FFS population, Medicare beneficiaries or the commercially-insured.

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

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

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

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

Because 86 percent of Maryland Medicaid recipients participate in HealthChoice and are enrolled with

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

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

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

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

Vital Statistics Administration

One of the key requirements of the HealthChoice demonstration's Residential Treatment for Individuals with SUD is to monitor the incidence of opioid-related mortality. Maryland's MMIS2 does not contain information regarding cause of death. MDH will collaborate with Maryland's Vital Statistics Administration to obtain the data necessary to populate this measure. Hilltop has data available from CY 2015 onwards to use for evaluation.

Department of Human Services

Hilltop, while able to identify foster care participants by their coverage group in MMIS2, does not maintain access to foster care participants in the subsidized adoption program. Subsidized adoption

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

[5] COMAR 10.09.70.02(L).

participants are excluded from MDH's analysis of foster care in the HealthChoice evaluation; therefore, MDH coordinates with the Maryland Department of Human Services to obtain updated foster care subsidized adoption lists on an annual basis, which will be available for all years of the demonstration period.

Maryland Department of the Environment

While Medicaid claims and encounters contain information regarding blood lead testing, they do not include information on the results of those tests. To report on the number of HealthChoice children with elevated blood lead levels, MDH will utilize the statewide Childhood Lead Registry (CLR). Maintained by the Maryland Department of the Environment, the CLR performs childhood blood lead surveillance for Maryland and provides results to MDH, including to Medicaid and local health departments as needed for case management. Hilltop has data from FY 2008 onwards to use for evaluation.

HealthCare Effectiveness Data and Information Set (HEDIS®)

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

Maryland Department of Health Sources

Several of the measures proposed for the HealthChoice evaluation will rely on systems and programs internal to MDH, including the *LTSSMaryland* system and internal program quality surveys. ACIS enrollment data are submitted by participating entities, and data are available for 2018 and all subsequent years. At present, MDH is actively investigating the possibility of obtaining and sharing with Hilltop quantitative data from other sources, such as state-only claims in support of evaluating the IMD exclusion waiver (residential SUD treatment). If this is not possible, MDH will make a note in the Methodological Limitations section. Residential SUD treatment may also be covered in commercial behavioral health claims, but the Maryland All-Payer Claims Database relies on submissions from fully-insured carriers and voluntary submission from self-funded plans. In addition to potential bias from the data excluded, before submission to Maryland's APCD system there is a lag at least 18 months from dates of service delivery. These factors will result in challenges for comparing to Medicaid claims. Data to support the evaluation of the CoCM Pilot Program will be sourced from the contracted CoCM vendor for the years of the demonstration period. The point of sale pharmacy system provides real-time claims processing continuity to providers and recipients, which includes the comprehensive prescription

pharmacy needs of the HealthChoice population, including data on patients in the CMC program as well as overdose information. Hilltop will have access to reports from the point-of-sale system to evaluate the CMC program for CYs 2022-2026. Hilltop will also use beneficiary surveys conducted as part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Member Experience Survey to evaluate the perceived health and financial status of beneficiaries. The State of Maryland Executive Summary Reports on the CAHPS Member Experience Survey include beneficiary ratings of overall health, overall mental/emotional health, and several CAHPS survey measures of beneficiary access, quality of care, and satisfaction for the HealthChoice population. Reports will be available for all years of the demonstration. To support evaluation of the MOM program, Hilltop will use newborn processing data (1184), a monthly dataset of newborns and their birthing parent that includes information on birth weight and other outcomes. Hilltop has access to these files from December 2017 onwards.

Analytic Methods

Where there are pilot interventions or benefits limited to certain populations, a sample of participants and non-participants may be selected based on demographic characteristics, such as age, race and ethnicity, sex, and county of residence, enrollment factors, like coverage duration and coverage group, and service utilization, such as diagnosis or procedure criteria. Cases and controls can then be analyzed to compare the effects of the interventions using descriptive analysis. For interventions that effect the entire HealthChoice population, or where a comparison group cannot be created, descriptive analysis and event count models will be used to analyze changes over the course of the demonstration. Subgroup analysis will be conducted for various demographic sub-populations to enrich the evaluation of certain programs.

To measure program effects for populations that cannot be separated into case and control groups, an interrupted time-series analysis is suitable for program measurements that are frequently repeated and can be measured prior to the initiation of the HealthChoice policy intervention. Policies evaluated using an interrupted time-series approach will utilize at least eight data points across the pre and post implementation periods, and outcomes will be measured monthly, quarterly, or annually depending on the timeframe of program implementation.

Sole reliance on quantitative techniques risks missing some critical aspects of the projects undertaken. Policy context will be included in the narrative portions of the evaluation for certain measures. For example, Maryland is unique in that the Health Services Cost Review Commission (HSCRC) builds uncompensated care costs into the hospital rates that are paid by all payers (including Medicaid). Additionally, Maryland is a Medicaid-expansion state that has recently taken legislative action to reduce medical debt. Policy context will be important to include in an assessment of the demonstration on measures such as provider uncompensated care and beneficiary medical debt. Data such as the reports of the qualitative impressions of key informants on implementation issues and program outcomes, program documents and literature or site visits by the evaluators, can be collected systematically and analyzed along with quantitative measures (although certain analyses are administrative and not suitable for qualitative approaches). MDH and its Independent Evaluator will use such mixed-methods as described in Table 2.

Methodological Limitations

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

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

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

Any external changes beyond the control of the HealthChoice program make isolating the effects of HealthChoice more difficult. MDH and the Independent Evaluator will consult with interest groups in communities of concern to define the counterfactual; *i.e.*, if measurable changes observed would have occurred without the HealthChoice program, and if those changes could be explained by the causes suggested in a systematic survey of alternatives. If not, then the analysis can conclude that the HealthChoice program had an impact.

The effects of the COVID-19 pandemic pose methodological challenges for evaluation. The public health emergency (PHE) led to increased enrollment in HealthChoice, as participants werenot disenrolled from the program during the PHE. Enrollment measures, such as spans of coverage without interruptions and persons disenrolling and reenrolling within six months, are likely to be most affected by the PHE and subsequent unwinding. Hilltop will describe the overall effects of the PHE and unwinding periods on HealthChoice eligibility trends during the evaluation period. To account for potential confounding effects of the PHE and unwinding periods, Hilltop will use sensitivity analyses to analyze policies with implementation periods during these timeframes. Hilltop may exclude time periods most affected by the PHE and unwinding or adjust time periods for evaluation purposes.

Special Methodological Considerations

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

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

Table 2. Measurement Framework

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Hypothesis 1: Eligibility and enrollment changes implemented during the current HealthChoice waiver period increase coverage and access to care for HealthChoice participants.							
Did the initiation of automated renewals of coverage—based on data indicating no substantial changes in participants' financial position—reduce the amount of time Medicaid-eligible individuals were without Medicaid coverage?	Spans of coverage without interruptions	All HealthChoice participants are subject to autorenewal. Separate analysis will be performed for the ACA expansion coverage groups Subgroup analysis can be performed by gender, age, race, ethnicity and geographic location.	Uninterrupted Coverage Spans	All coverage spans coming due during a specific measurement year	N/A	MMIS	Descriptive analysis Multiple linear regression to analyze effects by subgroup
	Persons disenrolling and reenrolling within six months	All HealthChoice participants are subject to autorenewal. Separate analysis will be performed for the ACA expansion coverage groups Subgroup analysis can be performed by gender, race, ethnicity, age and	Persons disenrolling and reenrolling within six months	All Persons disenrolling within a specific measurement year	N/A	MMIS	Descriptive analysis Multiple linear regression to analyze effects by subgroup

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
		geographic location.					
	Process Measures Total cost of care for all Medicaid beneficiaries under the demonstration over time Total health expenditures and administrative costs over time Provider uncompensated care: policy context/narrative Incidence of beneficiary medical debt: policy context/narrative Perceived health and financial status of beneficiaries over time: use of CAHPS survey reports						
Does automated selection of an MCO after one day for new participants, who in the past were permitted up to twenty-eight days to select an MCO, speed new participants' ability to access services?	Mean duration until services first used by new participants	New participants (>120 day six-month enrollment gap)	Duration Data	N/A	N/A	MMIS	Descriptive analysis of trends over the demonstration period

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Hypothesis 2: Payment approaches implemented during the current HealthChoice waiver period improve quality of care for HealthChoice participants.							
Do changes to the population health incentive program (formerly known as the value-based purchasing program) to an incentive only program result in higher rates of achievement of the program goals, without reducing the outcomes achieved by previously existing goals?	HPC-AD: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Population eligible for measure, with possible sub analysis by MCO	Persons in denominator with HbA1c >9.0%	Persons identified with diabetes ages 18 to 64 based on NCQA's Comprehensive Diabetes Care measure	NCQA	MMIS, HEDIS	Descriptive quantitative analysis of trends over time during the demonstration
	Ambulatory Care Visits for SSI Adults and Children	Participants with SSI, with possible subanalysis by MCO	Persons in the denominator with ambulatory care visits	Participants with SSI	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Do programs incentivizing greater attention to problems of particular concern among children (*e.g.*, asthma and lead exposure) help to reduce the incidence of those problems?	Percentage of children with elevated blood lead levels (BLL) who have received a follow-up lead test	Participants in Healthy Homes for Healthy Kids versus non- participants (Program 1)	Children receiving lead remediation	Children with elevated blood lead >=5µg/dL	N/A	MMIS using ICD-10 coding of BLL, Blood Lead matching, Local Health Departments, Childhood Lead Registry	Descriptive quantitative analysis of trends over time during the demonstration
	Among those will elevated BLL, the proportion whose follow up blood lead test was below 5µg/dL	Expansion of the Childhood Lead Poisoning Prevention and Environmental Case Management Program versus non-participants (Program 2). Non-participant comparison group will be selected from counties not participating in the program. Subgroup analysis can be performed by gender, age and geographic location.	Children in the denominator with a follow up blood test below 5µg/dL	Children with elevated blood lead >=5µg/dL	N/A	MMIS using ICD-10 coding of BLL, Blood Lead matching, Local Health Departments, Childhood Lead Registry	Descriptive quantitative analysis of trends over time during the demonstration

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	Asthma: Fewer nights awakened; fewer days with shortness of breath; fewer days of rescue inhaler use; Reduced asthma- related ED and inpatient use	Expansion of the Childhood Lead Poisoning Prevention and Environmental Case Management Program versus non-participants (Program 2). Non-participant comparison group will be selected from counties not participating in the program. Subgroup analysis can be performed by gender, age and geographic location.	Children in the denominator with asthma-related ED visits Children in the denominator with asthma-related inpatient use Children in the denominator with fewer nights awakened, fewer days with shortness of breath, and fewer days of rescue inhaler use	Children with asthma	N/A	Local Health Departments; MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Process Measures ***Program 1 (Lead Remediation)*** • IA and DUA signed between DHCD and MDH • DHCD procurement of abatement companies to work on program • DHCD procurement of lead inspector company to perform work for Program 1 • Successful completion of invoicing and billing payment • No. of lead remediation contractors procured for task order according to National HUD and local MDE guidelines • New provider type established in Maryland Medicaid's provider enrollment system: Lead Risk Assessor						

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	Program 2 (Environmental Case Management) • IA and DUA IRD to EHB • No. of IAs and DUAs established between IRD, EHB and LHDs • Successful completion of billing and payment mechanism, i.e. through IGT • No. of LHDs with MMIS and EVS access to screen for current Medicaid enrollment • No. of LHDs with staff onboarded based on quotas established by MDH • No. of LHDs with staff that have been trained						
Do programs restricting access to prescription drugs that may be subject to misuse control the rates of such misuse?	No. of persons on CMC	Subgroup analysis can be performed by gender, age and geographic location.	N/A	N/A	N/A	Point of Sale Pharmacy System	Descriptive quantitative analysis of trends over time during the demonstration
	No. of overdoses	Subgroup analysis can be performed by gender, age and geographic location.	N/A	N/A	N/A	Point of Sale Pharmacy System	Descriptive quantitative analysis of trends over time during the demonstration
Hypothesis 3: Innovative programs address the social determinants of health and improve the health and wellbeing of the Maryland population.							
Does the opportunity to treat acute cases of SUD and SMI in residential treatment in institutions for mental disease (IMDs) improve the control of SUDs?	Probability of initiation and engagement in SUD treatment following IMD discharge	IMD users with a primary diagnosis of SUD in each year Subgroup analysis can be performed by level of care in the IMD as well as gender, age and geographic location.	Number of IMD users in the year with claims for non-emergency department, non-inpatient SUD treatment within 45 days of discharge from IMD where SUD was	All IMD users with primary diagnosis of SUD	N/A	MMIS, HEDIS	Descriptive analysis of percentage, reported annually

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
			primary diagnosis				
	ED visit for SUD	Newly enrolled or first time IMD users with primary diagnosis of SUD pre/post participation Subgroup analysis can be performed by gender, age and geographic location.	Number of ED visits for SUD for IMD users	All newly enrolled or first time IMD users with a primary diagnosis of SUD	N/A	MMIS or HEDIS	Event count models with interrupted time series, controlling for level of care in the IMD
	Probability of initiation and engagement in SMI treatment following IMD discharge	IMD users in each year with primary SMI diagnosis Subgroup analysis can be performed by level of care in the IMD as well as gender, age and geographic location.	Number of IMD users with primary SMI diagnosis in the year with claims for non-emergent, non-inpatient SMI treatment within 45 days of discharge from IMD where SMI was primary diagnosis	All IMD users in the year with primary diagnosis of SMI	N/A	MMIS, HEDIS	Descriptive analysis of percentage, reported annually

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	ED visits for SMI	Newly enrolled or first time IMD users with SMI primary diagnosis pre/post participation Subgroup analysis can be performed by gender, age and geographic location.	Number of ED visits for SMI	All newly enrolled or first time IMD users with a primary diagnosis of SMI	N/A	MMIS or HEDIS	Event count models with interrupted time series, controlling for level of care in IMD
	ED visits and ED length of stay for SMI immediately following IMD	IMD users in each year with SMI primary diagnosis Subgroup analysis can be performed by level of care in the IMD as well as gender, age and geographic location.	Persons in denominator who are admitted or transferred from an IMD for ED visit with	IMD users in the year	N/A	MMIS or HEDIS	Descriptive analysis of percentage, reported annually
	Use of MAT services among persons with OUD and IMD placement	IMD users with primary diagnosis of SUD Subgroup analysis can be performed by gender, age and geographic location.	Persons in denominator receiving MAT	IMD users with opioid SUD diagnoses before and after IMD placement	N/A	MMIS or HEDIS	Descriptive quantitative analysis of trends over time during the demonstration

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	Use of Intensive Outpatient and Partial Hospitalization Mental Health Services	IMD users with MH diagnosis Subgroup analysis can be performed by gender, age and geographic location.	Persons in denominator with IOP utilization	IMD users with MH diagnoses before and after IMD placement	N/A	MMIS or HEDIS	Descriptive quantitative analysis of trends over time during the demonstration
	Readmission frequency to the same level of care or higher	IMD users	IMD users having readmissions	IMD users	N/A	MMIS or HEDIS	Descriptive quantitative analysis of trends over time during the demonstration.
	Overall cost of care for individuals with SMI/SUD including co- morbid physical and mental health conditions Tabulations of spending inclusive of IMD and outpatient treatment	Persons with SMI/SUD, users of IMD Subgroup analysis can be performed by gender, age and geographic location.	N/A	N/A	N/A	MMIS or HEDIS	Summary statistics of spending inclusive of IMD and outpatient treatment, reported annually
	Death by OUD	Deaths by OUD among IMD users with SUD diagnoses Subgroup analysis can be performed by gender, age and geographic location.	Deaths of individuals in the denominator	All IMD users with SUD diagnoses		Vital Statistics	Summary statistics of incidence of OUD death, reported annually

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	Number of crisis call centers and mobile crisis units	IMD users	IMD users indicating use of crisis call centers and mobile crisis units	IMD users	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Process Measures • Fee schedule created of Medicaid reimbursement rates • No. of IMDs billing Medicaid under the demonstration o By region o By ASAM level o Compared with before demonstration implementation • No. of IMDs having participated in a Medicaid onboarding training (*e.g.*, how to bill): o 3.3 - 3.7D o 3.1 o 4.0 o Duals expansion • No. of grievances, appeals and critical incidents related to SUD treatment services o 3.1 o 4.0 o Duals expansion • No. of grievances, appeals and critical incidents related to SUD treatment services						
Does the ACIS pilot improve the living situations and reduce potentially unnecessary health care utilization for persons at risk of institutionalization or homelessness?	Achieved stable housing	Newly enrolled ACIS participants in each year	Number of ACIS participants newly enrolled in the year who achieved stable housing	Number of newly enrolled ACIS participants in the year	N/A	ACIS data collected by LEs; Specifically, living situation at enrollment and at ACIS service delivery	Descriptive analysis of percentage, reported annually

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	ED visits (incl. potentially-avoidable utilization)	ACIS participants pre/post participation	Number of ED visits	All ACIS participants	N/A	MMIS	Event count models with interrupted time series
	Inpatient admissions	ACIS participants pre/post participation	Number of inpatient admissions	All ACIS participants	N/A	MMIS	Event count model with interrupted time series. If outcome frequency is insufficient, then descriptive analysis.
	Inpatient admissions with substance abuse or mental health primary diagnosis	ACIS participants pre/post participation	Inpatient admissions with substance abuse or mental health primary diagnosis	All ACIS participants	N/A	MMIS	Descriptive analysis of event counts
	Nursing facility admissions	ACIS participants pre/post participation	Number of nursing facility admissions	All ACIS participants	N/A	MMIS	Event count model with interrupted time series
	Ambulatory care services	ACIS participants pre/post participation	Number of ambulatory care services	All ACIS participants	N/A	MMIS	Event count model with interrupted time series

	Process Measures
	• No. of Lead Entities participating
	  ○ Signed IA/DUA
	  ○ Successful completion of inter-governmental transfer (IGT) of funds for local match
	  ○ Completion rate of monthly implementation report						

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	• No. of Learning Collaboratives held and Lead Entity participation rate in each • No. of Lead Entities and Participating Entities with signed DUAs/contracts • No. of Lead Entities trained, licensed, and using Homeless Management Information System						
If dental benefits are extended young adults aged out of foster care would these benefits also result in reduced incidence and costs of conditions related to dental disease?	Frequency of ED visits with dental diagnoses	Former foster care children	N/A	N/A	N/A	MMIS	Compare ED use for dental services over the demonstration period
	Frequency of dental services, including preventive/diagnostic and restorative visits	Former foster care children	N/A	N/A	N/A	MMIS	Compare to similar age groups (REM and pregnant women) over the demonstration period
Does the Increased Community Services program increase transitions to the community?	Transitions of long stay nursing facility residents to community settings who are eligible to apply to the ICS program	ICS participants	ICS participants with transition from nursing facility to community	Individuals who meet the technical eligibility to apply for the ICS program	N/A	MMIS	Descriptive analysis
Does implementation of the National Diabetes Prevention Program (National DPP), proven to be sufficiently-effective to become a covered service under	All-cause hospital admissions	Compare DPP participants to cohort of prediabetic participants not enrolled in DPP	All-cause hospital admissions for DPP participants vs. prediabetic participants not in DPP	All prediabetic individuals	N/A	MMIS	Event count models

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Medicare, work equally well with preventing diabetes diagnoses for a Medicaid population?	Total cost of care	Compare DPP participants to cohort of prediabetic participants not enrolled in DPP	Total cost of care for DPP participants vs. eligible enrollees vs. prediabetic participants not in DPP	All prediabetic individuals	N/A	MMIS	Pooled cross- section time series analysis of costs
	Diabetes incidence	Compare DPP participants to cohort of prediabetic participants not enrolled in DPP	Diabetes incidence for DPP participants vs. prediabetic individuals not in DPP	All prediabetic individuals	N/A	MMIS	Binary outcome regression
	ED visit rate	Compare DPP participants to cohort of prediabetic participants not enrolled in DPP	ED visits for DPP participants vs. prediabetic patients not in DPP	All prediabetic individuals	N/A	MMIS	Event count models
	Process Measures • New provider type established in Maryland Medicaid's provider enrollment system: DPP provider • No. of DPP providers enrolled in Maryland Medicaid, by delivery mode (in-person or virtual) • No. of MCOs with at least one DPP provider contracted in their network • No. of DPPs contracted with each MCO, disaggregated by in-person and virtual, and in each: o No. of individuals enrolled o No. of individuals retained at six months o No. of individuals with at least one follow-up visit o No. of individuals with 5 or more visits o No. of individuals with 10 or more visits						

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
Does a service model that integrates primary and behavioral health care and provides evidence- based therapeutic intervention and case management services for individuals with behavioral health conditions through the Collaborative Care Model result in improved outcomes for the target population?	Monthly contact: Counts of contacts each month and proportion of participants receiving active treatment in CoCM each quarter	CoCM Pilot Program participants	No. of participants with at least one clinical contact per month[6]	Total no. of CoCM Pilot Program-enrolled participants in that quarter	N/A	CoCM provider	Event counts
	Depression screening rate: Proportion of participants receiving a depression screening per quarter	CoCM Pilot Program participants	No. of participants who received a PHQ-2 or PHQ-9 screening per quarter	No. of participants enrolled in CoCM Pilot Program who had a clinical contact during the quarter	N/A	CoCM provider	Event count models
	Depression diagnosis: Proportion of participants demonstrating clinically- significant improvement	CoCM Pilot Program participants	No. of participants enrolled in CoCM Pilot Program for 70 days or greater with either: 1) a 50% reduction from first recorded to last recorded PHQ-9; or 2) a drop from first recorded to last recorded	No. of participants enrolled in CoCM Pilot Program for 70 days or more	N/A	CoCM provider	Descriptive analyses

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

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
			PHQ-9 to less than 10				

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

Does a service model that provides a set of enhanced case management services, standardized social determinants of health screenings and care coordination through the MOM Model result in improved outcomes for the target population?	Postpartum Care: The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.	MOM program participants	No. of participants with a delivery with a postpartum visit on or between 7 and 84 days after delivery	No. of participants with a delivery	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Rate of Cesarean Sections: The percentage of deliveries that were cesarean section	MOM program participants	No. of participants with a delivery by cesarean section	No. of participants with a delivery	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	Severe maternal morbidity (SMM): Percentage of pregnancies associated with Severe Morbidity CDC-defined codes	MOM program participants	No. of participants with SMM	No. of participants	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Rate of birth complications: Percentage of deliveries that had birth complications	MOM program participants	No. of participants with birth complications	No. of participants with a delivery	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Birth weight: Percentage of children born normal, low and very low birth weight	MOM program participants	No. of children born to participants by birth weight	No. of children born to participants	N/A	MMIS, 1184 newborn processing data	Descriptive quantitative analysis of trends over time during the demonstration
	Timeliness of Prenatal Care: The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Medicaid.	MOM program participants	No. of participants with a delivery with timely prenatal care	No. of participants with a delivery	N/A	MMIS	Descriptive quantitative analysis of trends over time during the demonstration
	Caregiver risk assessment: Participants who had at least one caregiver-focused	MOM program participants	No. of participants with a caregiver-focused risk	No. of participants with a delivery	N/A	MMIS, 1184 newborn processing data	Descriptive quantitative analysis of trends over time during the demonstration

Research Question	Outcomes used to address the research question	Sample or subgroups to be compared	Numerator	Denominator	Measure Steward	Data sources	Analytic methods
	risk assessment completed during a follow-up visit after the child's birth.		assessment after birth				
	Neonatal intensive care unit (NICU) average length of stay	MOM program participants	No. of days in NICU for children born to participants with a NICU admission	No. of children born to participants with a NICU admission	N/A	MMIS, 1184 newborn processing data	Descriptive quantitative analysis of trends over time during the demonstration

Attachments

Independent Evaluator and Evaluation Budget

Selection of the Independent Evaluator

The Hilltop Institute is an independent non-partisan health research organization dedicated to advancing the health and wellbeing of people and communities. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, innovative and objective research analysis. Hilltop follows the professional, ethical, and conflict of interest expectations and responsibilities outlined in the Code of Ethics of the University of Maryland, Baltimore County. The Code of Ethics complies with the Maryland Public Ethics Law, the Maryland Whistleblower Law, and policies of the Board of Regents of the University System of Maryland (USM).

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

While MDH and Hilltop work closely together, MDH makes all of the policy choices regarding the HealthChoice program.

Evaluation Budget

The list of assigned personnel and their respective contributions and work effort is contained in Appendix A. The cost for the evaluation, inclusive of salary, fringe benefits and university overhead totals approximately $683,205.

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

Timeline and Major Milestones

As described in the Data Sources section above, Medicaid claims and encounters for health care services are not immediately available for analysis. FFS providers are allowed 12 months to submit claims for payment, and MCOs are permitted six months to submit encounters. MMIS2 data are not considered completed until 12 months have passed for submission of FFS claims. Hilltop receives MMIS2 data on a

monthly basis. For example, a claim or encounter paid on May 15, 2022 would be included in the data submission to Hilltop in early June 2022.

The evaluation period for participants will extend thru December 31, 2026. To accommodate the FFS claims run-out period, Hilltop will delay its analysis until 12 months have passed from the culmination of the demonstration period, until after January 1, 2028. With the summative evaluation due to CMS in June 2028, this will allow approximately six months for data processing and analysis for those measures that rely on claims and encounters. Maryland receives data from Local Health Departments—for the Community Health Pilots and HSI—on an ongoing, quarterly basis.

The interim evaluation report will be completed by July 2026. The report will cover the research questions and hypotheses above for an evaluation period covering CYs 2022-2024. Table 3 provides a summary of the schedule of state deliverables for the demonstration period.

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

Milestone	Date
Draft evaluation design submitted	June 30, 2022
Last day for MCO providers to submit encounters for inclusion in interim analysis	June 30, 2025
Last day for fee-for-service providers to submit claims for inclusion in interim analysis	December 31, 2025
Last day for Vital Statistics Administration data run-out for interim analysis	December 31, 2025
Last day for Maryland Department of the Environmental data run-out for interim analysis	December 31, 2025
Due date for interim evaluation report	June 30, 2026
Last day of the HealthChoice demonstration Period	December 31, 2026
Last day for MCO providers to submit encounters for inclusion in analysis	June 30, 2027
Last day for fee-for-service providers to submit claims for inclusion in analysis	December 31, 2027
Last day for Vital Statistics Administration data run-out	December 31, 2027
Last day for Maryland Department of the Environmental data run-out	December 31, 2027
Due data for draft of summative evaluation report	June 30, 2028
Due date for final summative evaluation report	*(Within 30 days of receipt of CMS comments)*
Final approved summative evaluation posted to the MDH's website	*(Within 30 days of CMS approval)*

Appendix A. Budget Justification for The Hilltop Institute

Estimated Personnel Effort and Other Costs for Summative HealthChoice Evaluation
Period of Performance: 7/1/27 – 6/30/28
Budget Justification

This is the estimated budget for the final HealthChoice Summative evaluation due June 30, 2028. During years 1-4 of the waiver, data collection and analysis will be ongoing and will culminate in interim annual reports.

Personnel and Other Costs:

Executive Direction, .21 FTE ($52,455): The executive direction team will be responsible for overall supervision of the project and will provide assistance with project management and coordination with MDH. The team will provide management oversight of the evaluation team and final review and approval of the evaluation analysis.

Project Supervision and Direction, .32 FTE ($55,280): This team will be responsible for overall supervision of the project and will provide assistance with project management and expertise on the analysis of Medicaid utilization data and risk adjustment.

Methodology and Methods Team, .29 FTE ($35,043): The methodology and methods team will develop methodologies needed for the evaluation, and will work with the Maryland Department of Health to coordinate new data collection outside of encounter reporting. The team will advise on the application of appropriate statistical methods to the analysis of the evaluation data.

Programming Team, .7 FTE ($75,101): The programming team will have primary responsibility for SAS programming to calculate HealthChoice outcome measures, including HEDIS and other quality measures.

Policy Analysts, 1.42 FTE ($169,024): The policy analyst team will collaborate with MDH on stakeholder communication, analyze Medicaid utilization data, participate in the development of information needed for the evaluation, and will work with MDH to coordinate new data collection outside of encounter reporting. The team will provide technical support to SAS programmers on data analysis and risk adjustment and will contribute to data analysis, regression analysis, and interrupted time series analyses.

Editor, .03 FTE ($2,849): The editor will provide editorial services and graphics support for the evaluation report.

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

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

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

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

Annual Estimated Budget in FY 2028: $683,205

ATTACHMENT D

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

REM Program Benefits

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

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

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

ICS Program Benefits

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

ATTACHMENT E
Evidence-Based Home Visiting Services Pilot Protocol

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

As described in STC 29, the pilot program provides evidence-based home visiting services by licensed practitioners or certified home visitors to promote health outcomes, whole person care, and community-integration for high-risk pregnant women and children up to three (3) years old. The services are described in Table One: Description of Services below which are based on evidence-based program requirements. The provider qualifications are described in Table Two: Provider Requirements below which include provider titles, licensure certification, education, training, and experience requirements. The HVS pilot program is aligned with two evidence-based models focused on the health of pregnant women.

a. Nurse Family Partnership (NFP): The NFP is designed to reinforce maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The HealthChoice section 1115 demonstration NFP pilot program will adhere to the NFP national program standards and service will be suspended once the child reaches three (3) years old.

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

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

Table One: Description of Services

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

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

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

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

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

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

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

Table Two: Provider Qualifications

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

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

	related/advanced practitioner designations e.g. nurse practitioner, nurse midwife.	HealthCare provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	services provided. Nurse supervisors may conduct home visits as required to support nurses and/or beneficiaries level of care needs. For example, if a child or caregiver is ill for a month, a Nurse Home Visitor Supervisor may visit the home to re-assess the caregiver and child and offer an appropriate level of care.	

Description of Payment Methodologies

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

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

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

Frequency of home visiting may vary from family to family, but must remain within the scope of the

evidence-based programs. Below are the home visiting frequency and intensity protocols for HFA and NFP.

Healthy Families America: HFA sites offer at least one home visit per week for the first six (6) months after the child's birth. After the first six (6) months, visits might be less frequent. Visit frequency is based on families' needs and progress over time. Typically, home visits last one hour. HFA sites begin to provide services prenatally or at birth and continue for this Pilot demonstration up to age two (2).

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

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

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

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

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

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

Per STC #28, the following protocol outlines the services and payment methodologies for the Assistance in Community Integration Services (ACIS) Pilot Program. Under this pilot program, the state will provide a set of Home and Community Based Services (HCBS) to a population that meets the needs-based criteria specified below, capped at 900 individuals annually. These services include HCBS that could be provided to the individual under a 1915(i) state plan amendment (SPA). The protocol outlines the content that would otherwise be documented in a 1915(i) SPA, and includes service definitions and payment methodologies.

Eligibility Criteria

The state's needs based criteria are specified below:

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

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

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

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

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

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

These services may include:

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

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

Housing Case Management Services – may include:

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

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

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

Improvement Strategy (42 CFR 441.745(b).

The state's needs based criteria are specified below:

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

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

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

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

Description of Payment Methodologies

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

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

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

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

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

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

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

Attachment G: SUD Monitoring Protocol

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

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

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic[a]	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc.)[b,c]	State plans to phase in reporting (Y/N)	SUD monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 1 ***(Do not delete or edit this row)***	*EXAMPLE: Assessed for SUD Treatment Needs Using a Standardized Screening Tool*	*EXAMPLE: Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period*	*EXAMPLE: Assessment of need and qualification for SUD treatment services*	*EXAMPLE: CMS-constructed*	*EXAMPLE: Other monthly and quarterly metrics*	*EXAMPLE: Medical record review or claims*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 07/01/2018-06/30/2019*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY2Q1*	*EXAMPLE: This measure requires an update to the Adult Needs and Strengths Assessment tool that reflects an ASAM level of treatment. The work is in the testing phase with anticipated go live in mid to late 2021.*
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Medical record review or claims	Month	Quarterly	Recommended	N								
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Recommended	N								
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Consistent	Consistent	Y		N		
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Consistent	Consistent	Y		N		
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period.	Milestone 2	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	N	Any instance of procedure code 'W7310', 'W7330', 'W7350', 'W7370', or 'W7375'; or, revenue code '0124' and '0169' with an SUD primary diagnosis and an MHD diagnosis in a subsequent diagnosis field.	N		
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	N	-Rather than the HCPCS and CPT codes listed in CMS specifications, Maryland uses the following codes for SBIRT services: procedure codes (99408, 99409, W7000, W7010, W7020, W7021, and W7022). The CMS-provided codes cannot be used to identify SBIRT services in the state.	N		
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
12	Medication-Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y		N		
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y	All Medicaid enrolled OTPs (PT 32), ADAA Certified Addiction Outpatient Programs (PT 50), Data 2000 Waived Practitioners (PT 20-Physician, PT 23- Nurse Practitioners, and PT 80- Physician Assistants), Adult Residential SUD Programs (PT 54), and ICF-A Programs (PT 55) with active	N		
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims; SAMHSA datasets	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase	Y	All Medicaid enrolled OTPs (PT 32), ADAA Certified Addiction Outpatient Programs (PT 50), Data 2000 Waived Practitioners (PT 20-Physician, PT 23- Nurse Practitioners, and PT 80- Physician Assistants), and ICF-A Programs (PT 55) with active enrollment during the reporting period. Data Source: Adhoc report from MMIS of SUD Medicaid providers with active enrollment during the reporting period.	N		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: · Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis · Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	N								
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission]	SUB-3: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Medical record review or claims	Year	Annually	Recommended	N								
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure][d]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: · Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). · Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	N								
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #3489; Medicaid Adult Core Set; Adjusted HEDIS measure][e]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: · Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) · Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	N								
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	Y		N		
19	Use of Opioids from Multiple Providers in Persons without Cancer (OMP) [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) [PQA, NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA, NQF #3389; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	Y		N		
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 1	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2016 - 12/31/2017	Increase	Increase	Y		N		
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Milestone 5	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	Y		N		
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	N	The metric will be generated using HEDIS proprietary software according to the current HEDIS specifications.	N		
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	Milestone 6	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	N	The metric will be generated using HEDIS proprietary software according to the current HEDIS specifications.	N		
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	N	Public release of overdose deaths within the Medicaid Program is currently restricted. Maryland is working with its partners in Vital Statistics to resolve this issue. Release of this information will be contingent on approval. Overdose deaths will not be categorized based on diagnosis. The cause of death provided from the Department of Vital Statistics is not coded as an ICD 10 diagnosis. The cause of death generally provides the substance used in the overdose, but the intent (e.g. unintentional, intentional, homicide) is not included. In addition, a majority of overdose deaths include multiple agents (i.e. synthetic and natural opioids).	N		
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Milestone 5	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	Decrease	N	Public release of overdose deaths within the Medicaid Program is currently restricted. Maryland is working with its partners in Vital Statistics to resolve this issue. Release of this information will be contingent on approval. Overdose deaths will not be categorized based on diagnosis. The cause of death provided from the Department of Vital Statistics is not coded as an ICD 10 diagnosis. The cause of death generally provides the substance used in the overdose, but the intent (e.g. unintentional, intentional, homicide) is not included. In addition, a majority of overdose deaths include multiple agents (i.e. synthetic and natural opioids).	N		
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
29	SUD Spending Within IMDs	Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	N								
33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[f]	Administrative records	Quarter	Quarterly	Recommended	N								
34	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[f]	Administrative records	Quarter	Quarterly	Recommended	N								
35	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals[f]	Administrative records	Quarter	Quarterly	Recommended	N								
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	Milestone 2	CMS-constructed	Other annual metrics	Claims; State-specific IMD database	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Decrease	No more than 30 days	N	Any instance of procedure code 'W7310', 'W7330', 'W7350', 'W7370', or 'W7375'; or, revenue code '0124' and '0169' with an SUD primary diagnosis and an MHD diagnosis in a subsequent diagnosis field.	N		
Q1	*PMDP users*	Number of PDMP checks	Health IT	State-specific	Health IT	Stata data from BHA	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
Q2	*SUD data sharing consent management*	Number of individuals for whom consent to disclose or access their SUD treatment information is	Health IT	State-specific	Health IT	ASO data from BHA	Month	Quarterly	Required	Y	01/01/2017 - 12/31/2017	Consistent	Consistent			N		
Q3	*SUD authorization*	Number of SUD authorizations per month, in support of reducing duplication and ensuring medic	Health IT	State-specific	Health IT	ASO data from BHA	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			Y		The Department is currently working with it's behavioral health administration and its behavioral health administrative services organization to generate this data. It will be included in future reports when available.
State-specific metrics																		
S1	Number of HealthChoice participants enrolled in corrective managed care program	Number of HealthChoice-enrolled participants in the Corrective managed care program each month	Health IT	State-specific	Health IT	State data from IRD	Month	Quarterly	Recommended	Y	01/01/2017 - 12/31/2017	Consistent	Consistent			N		
S2	Adjusted Initiation of AOD Treatment - Alcohol abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 or older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the initiation of AOD treatment with 14 days of the diagnosis One rate is reported: Percentage of beneficiaries with an alcohol abuse or dependence diagnosis who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. This metric differs from rate one of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S3	Adjusted Initiation of AOD Treatment - Opioid abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 or older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the initiation of AOD treatment with 14 days of the diagnosis One rate is reported: Percentage of beneficiaries with an opioid abuse or dependence diagnosis who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. This metric differs from rate two of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S4	Adjusted Initiation of AOD Treatment - Other drug abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 or older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the initiation of AOD treatment with 14 days of the diagnosis One rate is reported: Percentage of beneficiaries with another drug abuse or dependence diagnosis who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. This metric differs from rate three of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S5	Adjusted Initiation of AOD Treatment - Total AOD abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 or older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the initiation of AOD treatment with 14 days of the diagnosis One rate is reported: Total beneficiaries with an alcohol or other drug abuse or dependence diagnosis who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. This metric differs from rate four of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S6	Adjusted Engagement of AOD Treatment - Alcohol abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. One rate is reported: Percentage of beneficiaries with an alcohol abuse or dependence diagnosis who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. This metric differs from rate five of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S7	Adjusted Engagement of AOD Treatment - Opioid abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. One rate is reported: Percentage of beneficiaries with an opioid abuse or dependence diagnosis who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. This metric differs from rate six of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S8	Adjusted Engagement of AOD Treatment -Other drug abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. One rate is reported: Percentage of beneficiaries with an other drug abuse or dependence diagnosis who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. This metric differs from rate seven of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S9	Adjusted Engagement of AOD Treatment - Total AOD abuse or dependence [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. One rate is reported: Total number of beneficiaries with an alcohol or other drug abuse or dependence diagnosis who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. This metric differs from rate eight of Metric #15 in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S10	Adjusted 31-Day Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits to beneficiaries age 18 and older with a principle diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. One rate is reported: - Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 days total) This metric differs from rate one of Metric #17(1) in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S11	Adjusted 8-Day Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits to beneficiaries age 18 and older with a principle diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. One rate is reported: - Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 days total) This metric differs from rate two of Metric #17(1) in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		
S12	Adjusted 31-Day Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #0576; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 an older with a principle diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. One rate is reported: Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 days total) This metric differs from rate one of Metric #17(2) in that the state uses HEDIS software to calculate the metric, which may have differences relative to the CMS-provided technical specifications. In each monitoring report in which this metric appears, the state will describe specific differences relative to the CMS-provided technical specifications.	Milestone 6	State-specific	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2017 - 12/31/2017	Increase	Increase			N		

Table: Substance Use Disorder Demonstration Planned Metrics

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

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

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

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

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

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

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

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

State: Maryland

Demonstration Name: Maryland HealthChoice

Table: Substance Use Disorder Demonstration Planned Subpopulations

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[a,b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: *Age group* ***(Do not delete or edit this row)***	*EXAMPLE:* *Children <18, adults 18–64, and older adults 65+*	*EXAMPLE:* *Required*	*EXAMPLE:* *Metrics #1-3, 6-12, 23, 24, 26, 27*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *N*	*EXAMPLE:* *Children/Young adults 12-21, Adults 21-65*	*EXAMPLE:* *N*	*EXAMPLE:* *1, 2, 3*
Age group	Children <18, adults 18–64, and older adults 65+	Required	Metrics #1-3, 6-12, 23, 24, 26, 27	CMS-provided	Y	Y		Y	
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	Metrics #1-3, 6-12	CMS-provided	Y	Y	Maryland started covering IMD services for duals on 1/1/20 (ASAM 3.1 through 3.7WM) and will begin to include data on this subpopulation starting with the CY 2020 performance period.	Y	
Pregnancy status	Pregnant, Not pregnant	Required	Metrics #1-3, 6-12	CMS-provided	Y	Y	Maryland will calculate the pregnant subpopulations using the "MACBIS Pregnancy Code List.xls" file provided by CMS.	Y	
Criminal justice status	Criminally involved, Not criminally involved	Required	Metrics #1-3, 6-12	CMS-provided	N		Data use agreements with correctional facilities and jails specifically prohibit use of the information received for any reason other than freezing Medicaid enrollment during periods of incarceration.		
OUD population	Opioid diagnosis	Recommended	Metrics #2-12, 23, 24, 26, 27, 36	CMS-provided	Y	Y	The OUD subpopulation is identified using the HEDIS 2020 Opioid Abuse and Dependence value set. It includes the following ICD-10 diagnosis codes: F1110, F11120, F11121, F11122, F11129, F1114, F11150, F11151, F11159, F11181, F11182, F11188, F1119, F1120, F11220, F11221, F11222, F11229, F1123, F1124, F11250, F11251, F11259, F11281, F11282, F11288, F1129	Y	
[Insert row(s) for any state-specific subpopulation(s)]									

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

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

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

Medicaid Section 1115 SUD Demonstrations Monitoring Protocol (Part A) - Reporting Schedule (Version 6.0)

State: Maryland

Demonstration Name: Maryland HealthChoice

Instructions:

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

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

Table 1. Substance Use Disorder Demonstration Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SUD demonstration year (SUD DY1)	
Start date	01/01/2022
End date	12/31/2022
Dates of first quarter of the baseline reporting period for CMS-constructed metrics	
Reporting period (SUD DY and Q)	DY6Q1
Start date	01/01/2022
End date	03/31/2022
Broader section 1115 demonstration reporting period corresponding with the first SUD reporting quarter, if applicable. If there is no broader demonstration, fill in the first SUD reporting period. (Format DY#Q#; e.g., DY3Q1)	DY25Q3
First SUD monitoring report due date (per STCs) (MM/DD/YYYY)	05/30/2022
First SUD monitoring report in which the state plans to report annual metrics that are established quality measures (EQMs)	
Baseline period for EQMs	CY2021
SUD DY and Q associated with monitoring report	DY6Q3
SUD DY and Q start date (MM/DD/YYYY)	07/01/2022
SUD DY and Q end date (MM/DD/YYYY)	09/30/2022
Dates of last SUD reporting quarter:	
Start date	10/01/2026
End date	12/31/2026

Table 2. Substance Use Disorder Demonstration Reporting Schedule

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
01/01/2022	03/31/2022	05/30/2022	DY25Q3	DY6Q1	Narrative information	DY6Q1	N		
					Grievances and appeals	DY6Q1	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics		Y	State and CMS agreed to 2 quarter claims lag. Reporting to continue per previous demonstration reporting schedule.	DY5Q3
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
04/01/2022	06/30/2022	09/28/2022	DY25Q4	DY6Q2	Narrative information	DY6Q2	N		
					Grievances and appeals	DY6Q2	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY6Q1	Y	State and CMS agreed to 2 quarter claims lag. Reporting to continue per previous demonstration reporting schedule.	DY5Q4
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State and CMS agreed to 2 quarter claims lag. Reporting to continue per previous demonstration reporting schedule.	DY5
07/01/2022	09/30/2022	11/29/2022	DY26Q1	DY6Q3	Narrative information	DY6Q3	N		
					Grievances and appeals	DY6Q3	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY6Q2	Y	State and CMS agreed to 2 quarter claims lag.	DY6Q1
					Annual metrics that are established quality measures	CY2021	N	Reporting to continue per previous demonstration reporting schedule.	
					Other annual metrics		N		
10/01/2022	12/31/2022	03/01/2023	DY26Q2	DY6Q4	Narrative information	DY6Q4	N		
					Grievances and appeals	DY6Q4	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY6Q3	Y	State and CMS agreed to 2 quarter claims lag.	DY6Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
01/01/2023	03/31/2023	05/30/2023	DY26Q3	DY7Q1	Narrative information	DY7Q1	N		
					Grievances and appeals	DY7Q1	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY6Q4	Y	State and CMS agreed to 2 quarter claims lag.	DY6Q3
					Annual metrics that are established quality measures		N		

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
					Other annual metrics	DY6	Y	State and CMS agreed to 2 quarter claims lag.	n.a - will not be reported in this monitoring report.
04/01/2023	06/30/2023	09/28/2023	DY26Q4	DY7Q2	Narrative information	DY7Q2	N		
					Grievances and appeals	DY7Q2	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY7Q1	Y	State and CMS agreed to 2 quarter claims lag.	DY6Q4
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State and CMS agreed to 2 quarter claims lag.	DY6
07/01/2023	09/30/2023	11/29/2023	DY27Q1	DY7Q3	Narrative information	DY7Q3	N		
					Grievances and appeals	DY7Q3	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY7Q2	Y	State and CMS agreed to 2 quarter claims lag.	DY7Q1
					Annual metrics that are established quality measures	CY2022	N		
					Other annual metrics		N		
10/01/2023	12/31/2023	02/29/2024	DY27Q2	DY7Q4	Narrative information	DY7Q4	N		
					Grievances and appeals	DY7Q4	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY7Q3	Y	State and CMS agreed to 2 quarter claims lag.	DY7Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
01/01/2024	03/31/2024	05/30/2024	DY27Q3	DY8Q1	Narrative information	DY8Q1	N		
					Grievances and appeals	DY8Q1	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY7Q4	Y	State and CMS agreed to 2 quarter claims lag.	DY7Q3
					Annual metrics that are established quality measures		N		
					Other annual metrics	DY7	Y	State and CMS agreed to 2 quarter claims lag.	n.a - will not be reported in this monitoring report.
04/01/2024	06/30/2024	09/28/2024	DY27Q4	DY8Q2	Narrative information	DY8Q2	N		
					Grievances and appeals	DY8Q2	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY8Q1	Y	State and CMS agreed to 2 quarter claims lag.	DY7Q4
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State and CMS agreed to 2 quarter claims lag.	DY7
07/01/2024	09/30/2024	11/29/2024	DY28Q1	DY8Q3	Narrative information	DY8Q3	N		
					Grievances and appeals	DY8Q3	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY8Q2	Y	State and CMS agreed to 2 quarter claims lag.	DY8Q1
					Annual metrics that are established quality measures	CY2023	N		
					Other annual metrics		N		
10/01/2024	12/31/2024	03/01/2025	DY28Q2	DY8Q4	Narrative information	DY8Q4	N		
					Grievances and appeals	DY8Q4	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY8Q3	Y	State and CMS agreed to 2 quarter claims lag.	DY8Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
01/01/2025	03/31/2025	05/30/2025	DY28Q3	DY9Q1	Narrative information	DY9Q1	N		
					Grievances and appeals	DY9Q1	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY8Q4	Y	State and CMS agreed to 2 quarter claims lag.	DY8Q3
					Annual metrics that are established quality measures		N		
					Other annual metrics	DY8	Y	State and CMS agreed to 2 quarter claims lag.	n.a - will not be reported in this monitoring report.
04/01/2025	06/30/2025	09/28/2025	DY28Q4	DY9Q2	Narrative information	DY9Q2	N		
					Grievances and appeals	DY9Q2	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY9Q1	Y	State and CMS agreed to 2 quarter claims lag.	DY8Q4
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State and CMS agreed to 2 quarter claims lag.	DY8
07/01/2025	09/30/2025	11/29/2025	DY29Q1	DY9Q3	Narrative information	DY9Q3	N		
					Grievances and appeals	DY9Q3	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY9Q2	Y	State and CMS agreed to 2 quarter claims lag.	DY9Q1
					Annual metrics that are established quality measures	CY2024	N		
					Other annual metrics		N		
10/01/2025	12/31/2025	03/01/2026	DY29Q2	DY9Q4	Narrative information	DY9Q4	N		
					Grievances and appeals	DY9Q4	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY9Q3	Y	State and CMS agreed to 2 quarter claims lag.	DY9Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
01/01/2026	03/31/2026	05/30/2026	DY29Q3	DY10Q1	Narrative information	DY10Q1	N		
					Grievances and appeals	DY10Q1	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY9Q4	Y	State and CMS agreed to 2 quarter claims	DY9Q3
					Annual metrics that are established quality measures		N		
					Other annual metrics	DY9	Y	State and CMS agreed to 2 quarter claims lag.	n.a - will not be reported in this monitoring report.
04/01/2026	06/30/2026	09/28/2026	DY29Q4	DY10Q2	Narrative information	DY10Q2	N		
					Grievances and appeals	DY10Q2	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY10Q1	Y	State and CMS agreed to 2 quarter claims lag.	DY9Q4

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State and CMS agreed to 2 quarter claims lag.	DY9
07/01/2026	09/30/2026	11/29/2026	DY30Q1	DY10Q3	Narrative information	DY10Q3	N		
					Grievances and appeals	DY10Q3	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY10Q2	Y	State and CMS agreed to 2 quarter claims lag.	DY10Q1
					Annual metrics that are established quality measures	CY2025	N		
					Other annual metrics		N		
10/01/2026	12/31/2026	03/01/2027	DY30Q2	DY10Q4	Narrative information	DY10Q4	N		
					Grievances and appeals	DY10Q4	Y	n.a - state not reporting	n.a - state not reporting
					Other monthly and quarterly metrics	DY10Q3	Y	State and CMS agreed to 2 quarter claims lag.	DY10Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
[Add rows for all additional demonstration reporting quarters]									

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

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

Medicaid Section 1115 Substance Use Disorder Demonstrations
Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

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

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

State	Maryland
Demonstration name	Maryland HealthChoice
Approval period for section 1115 demonstration	*Enter the current approval period for the section 1115 demonstration as listed in the current special terms and conditions (STC), including the start date and end date (MM/DD/YYYY – MM/DD/YYYY).* *Start Date:* 01/01/2022 *End Date:* 12/31/2026
SUD demonstration start date[a]	*Enter the start date for the section 1115 SUD demonstration or SUD component if part of a broader demonstration (MM/DD/YYYY).* 01/01/2022
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*Enter SUD demonstration implementation date (MM/DD/YYYY).* 07/01/2017
SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives	*Enter summary of the SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives.* The coverage of residential treatment and withdrawal management services expands Maryland's current SUD benefit package to cover the full continuum for care for SUD treatment as described in the national treatment guidelines published by the American Society of Addiction Medicine (ASAM Criteria). SUD services approved through the state plan as well as residential treatment and withdrawal management services approved through this demonstration will be available to all Maryland Medicaid participants aged 21-64 with the exception of dual eligibles. ASAM levels 3.3-3.7WM will be covered beginning July 1, 2017. ASAM level 3.1 will be covered beginning January 1, 2019. Dual eligibles will be covered for SUD residential treatment services for ASAM levels 3.1-3.7WM beginning January 1, 2020. ASAM level 4.0 coverage for all Maryland Medicaid participants aged 21-64 with a primary diagnosis of SUD and a secondary mental health condition will begin July 1, 2019. An independent evaluation will assess whether the SUD program reforms and services delivered through this demonstration are effective in improving health outcomes and decreasing healthcare costs and utilization. The evaluation is designed to demonstrate achievement Maryland's goals, objectives, and metrics for the demonstration. Thus, the specific aims of the evaluation, which align with the demonstration's goals and objectives, are to capture the impact of the demonstration on increased access to clinically appropriate care; reduced substance use related deaths; and reduced emergency department visits. In addition, researchers will assess the impact of providing the full continuum of SUD services, especially residential treatment, on emergency department utilization, inpatient hospital utilization, and readmission rates to the same level of care or higher

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

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

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

2. Acknowledgement of narrative reporting requirements

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

3. Acknowledgement of budget neutrality reporting requirements

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

4. Retrospective reporting

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

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

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

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

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

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

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

Not applicable; monitoring protocol applies to a demonstration extension period

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
Maryland HealthChoice Demonstration
Last submission: July 13, 2022

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	*Maryland*
Demonstration name	*HealthChoice*
Approval date	*December 14, 2021*
Approval period	*January 1, 2022 through December 31, 2026*
Implementation date	*Proposed: January 1, 2022*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question. This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Maryland has completed this action. Psychiatric hospitals: The MDH Office of Health Care Quality (OHCQ) regulates psychiatric hospitals, providing state licensure, and on behalf of CMS, it provides certification and recertification. OHCQ also conducts various types of hospital surveys under federal or state authority to determine compliance with federal and state regulations.

participating in Medicaid	*Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.* N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Maryland has completed this action. The MDH Office of Health Care Quality (OHCQ) regulates psychiatric hospitals, providing state licensure, and on behalf of CMS, it provides certification and recertification. OHCQ also conducts various types of hospital surveys under federal or state authority to determine compliance with federal and state regulations.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Maryland has completed this action. Maryland uses an Administrative Service Organization (ASO) for ensuring beneficiaries access to the appropriate level of care based on their presenting diagnoses and medical necessity criteria (MNC) review. The ASO monitors lengths of stay. based on periodic MNC reviews that are based on Department established authorization periods.

	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Maryland has completed this action. The State confirms that it complies with federal program integrity requirements. All enrolled programs have an initial Medicaid site survey by the Behavioral Health Administration (BHA). Medicaid re-evaluates every enrolled program after five years. BHA license renewal occurs every three years. Every three years, psychiatric hospitals are subject to the requirements of Joint Commission accreditation. Services at these levels of care require authorization and periodic re-authorization for MNC criteria performed by the ASO. Medicaid and BHA in partnership with OIG have established program integrity protocols, including monitoring of licensure, data mining, and other oversight to safeguard against fraud, waste, and abuse.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.* Maryland has completed this action.

physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	Psychiatric hospitals are required to perform a medical evaluation upon admission that includes a physical exam, screening for co-occurring SUD, screening for suicidal ideation, and a medical review of systems. Prior to admission medical clearance of someone under consideration for psychiatric admission occurs, as per COMAR definition, when the individual has been evaluated by a physician, a physician's assistant, or a nurse practitioner, and the evaluator has confirmed with the receiving inpatient facility that the receiving facility has the capacity to provide the necessary and appropriate medical management of the individual. The psychiatric hospitals participating in the waiver program are already providing SUD-level of care under the prior waiver. A psychiatric hospital that is not able to appropriately manage a patient's medical needs would transfer the patient to a facility able to manage those needs.
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status: Provide information on current state policies and requirements for ensuring quality of care in psychiatric hospitals and residential settings.*
	Future Status: Describe planned activities to address milestone not already met and any other plans for enhanced quality assurance policies for inpatient and residential treatment settings.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.

SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* Maryland has these actions in place. Discharge planning is required in state regulations and overseen as a part of the accreditation process for all hospitals in Maryland. Accreditation is overseen by the Maryland Office of Health Care Quality (OHCQ). To facilitate discharge or transfer, the hospital shall: (1) Assess the patient's needs beginning at an early stage of the patient's hospitalization and as the patient's needs change throughout the hospitalization; (2) Develop plans for the patient's discharge or transfer with input, if appropriate, from the patient, the family, or other interested party; (3) Identify appropriately qualified staff, such as registered nurses or licensed social workers, who have the knowledge and experience necessary to determine what services or type of providers can best meet the patient's discharge needs; (4) Arrange or help to arrange for services needed to meet the patient's needs after discharge; and (5) Provide the patient, or the provider who is responsible for providing continuing care to the patient, with written discharge instructions and other necessary medical information in a form the patient or provider can understand. For additional information, please see Maryland's regulations. Additionally, all hospitals in Maryland are accredited by the Joint Commission, which has its own standards around hospital discharges.

	In the Child, Adolescent, and Young Adult Services (CAYAS) space, general care coordination is part of the expected role of the Targeted Case Management (TCM) providers. TCM care coordination Child and Adolescent services are provided to assist participants in gaining access to needed medical, mental health, social, educational and other services. This service, established through a 1915(b) waiver, exists with three levels of intensity (Level I-General; Level II-moderate; Level III-Intensive). These programs are intended to provide "wrap around services" to high needs youth to prevent need for higher levels of care. Each level provides increased quantities of care coordination encounters. All inpatient or partial hospitalization (PHP) discharges would qualify for TCM Level II unless the individual has specific risk factors which might increase qualifications up to TCM Level III. Medical necessity for the higher level (under the level II and III) categories can occur after inpatient and RTC admissions. The highest level of care (level III) requires more than one admission within the prior 12 months, except for youth under the age of 6 These programs are intended to provide "wrap around services" to high needs youth to prevent need for higher levels of care. While the referral to TCM levels of care can be made from an inpatient setting, currently the engagement does not happen until after discharge. Expansion of this process to make it more robust in utilization and implementation design is priority for CAYAS division. Examples of wraparound services available through C&A TCM, or Care Coordination, include: service coordination (case management), linkage to needed community based services to incl somatic services, behavioral health services, self-help or support groups; assistance w/applying for & maintaining entitlements; assistance addressing housing needs; assistance with assessing & improving ADLs; advocacy & assistance obtaining education/special education services (ex. IEP); crisis care and outreach as needed; family support; transportation assistance (access to local mass transit/ MA-based transport), linkage to legal assistance, etc. Additional information on TCM criteria can be found here, see p. 35: https://maryland.optum.com/content/dam/ops-maryland/documents/provider/Maryland_State%20Supp%20Clin%20Crit_12.31_Final%20(4).pdf Psychiatric hospitals are expected to initiate discharge planning at the beginning of service delivery, including early and ongoing communication with an individual's community provider. If an individual is without a community provider a quick referral occurs. A discharge plan is included with the hospital authorization request to the ASO. Community providers can provide information on baseline levels of functioning and medication history, assist with any needs in the area of housing and benefits, and meet with individuals at the hospital. Individuals admitted to state psychiatric hospitals engage in discharge efforts upon admission. This begins with a multi-disciplinary team assessment including psychiatry, nursing, social work, and rehabilitation staff.

	These assessments are used to help determine treatment goals. In addition, treatment teams must address court requirements for those who are court-ordered to state hospitals for evaluation and treatment. As the individual continues to improve, the treatment team then makes recommendations regarding what level of care the individual will need next. Prior to discharge, a discharge meeting is scheduled and the community-based provider meets with the individual and the treatment team to go over the course of hospitalization and recommendations. Copies of aftercare referrals and discharge summaries are given to community-based providers. The treatment team at the psychiatric hospital and community providers continue to collaborate post-discharge, as needed. Additionally, to further support discharges from psychiatric hospitals, the Assertive Community Treatment (ACT) fidelity scale contains the following anchor on which all ACT teams are rated "INVOLVEMENT IN PSYCHIATRIC HOSPITALIZATION DECISIONS: The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the client (e.g., activating a crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary and involuntary admissions), contact with the client during their hospital stay, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge medications and community disposition (e.g., housing, service planning)." In order to achieve a full rating, the ACT team must be involved in 90% or more of psychiatric hospital admissions and discharges. The following LBHA requirements are in the Administrative Conditions of Award with the LBHAs and also support discharge planning: • Develop local strategies and implement specific actions to reduce Emergency Department and inpatient hospitalization. The Vendor (LBHA) shall meet with local hospital to establish an enhanced level of communication and coordination between hospital personnel, and Crisis System providers to enhance the use of community-based alternatives to inpatient admission. • Meet annually with local hospitals and Emergency Rooms to provide education and training on access to and services within the PBHS. • Assist with Emergency Department (ED) diversion for child, adolescent, adult, and older adult consumers as funds permit, with clinical staff available for consultation with an ED, day treatment and inpatient staff.

	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers. The State of Maryland has been undergoing a transformation in its healthcare system to achieve better health for Marylanders, including higher quality of healthcare, better integration between systems of care, and decreased costs. The new Total Cost of Care (TCOC) model with CMS builds on the prior All-Payer model that realigned hospital-based care and reimbursement structures to a global budgeting approach. As the system evolves, MDH recognizes that there are challenges to identify appropriate community placements for individuals who have more complex medical and behavioral health conditions, creating significant issues for timely patient discharges from both hospitals' emergency departments and inpatient acute care. The challenges center on individual health conditions, and relate to the availability and coordination of resources and services across multiple sectors necessary to support these individuals. The Department has been developing approaches to address post-acute discharge challenges for patients in acute care settings, including identifying barriers for billing for co-occurring disorders, increasing utilization for Screening, Brief Intervention, and Referral to Treatment (SBIRT) among hospitals and primary care providers, and enhancing resources to identify community-based behavioral health providers. At the same time, strategies for prevention and diversion from acute care settings for complex and high utilizer patients was equally critical to prevent log jams from occurring across the continuum of care especially if the community-based infrastructure was weak. In many instances, strengthening the community-based capacity serves not only to prevent acute inpatient hospitalization, but also to enhance the ability of acute care settings to place individuals in the least restrictive environments. Expansion of this process to make it more robust in utilization and implementation design is a priority for CAYAS division.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* Maryland has completed these actions. While coordinating with housing is not required as a part of the accreditation process, Maryland regulations do require aftercare services, which can include referrals to housing supports when necessary for the patient (Md. HEALTH-GENERAL Code Ann.10-709; Code of Maryland Regulations 10.21.05). Psychiatric hospitals complete a psychosocial assessment at admissions that includes an assessment of housing needs. Hospitals make referrals to appropriate community providers and resources, which include additional case management services that support referrals to housing assistance and services. Additionally, there is an anchor of the ACT fidelity scale that measures: "INVOLVEMENT IN PSYCHIATRIC HOSPITALIZATION DECISIONS: The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the client (e.g., activating a crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary and involuntary admissions), contact with the client during their hospital stay, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge medications and community disposition (e.g., housing, service planning)."

	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers. N/A
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* Maryland has completed this action. The ASO contract requires follow up after hospitalization to occur within 72 hours of release for all beneficiaries. The Department measures the ASO on follow up appointments kept after psychiatric hospitalizations within 7 and 30 days as part of the protocol.
	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* Maryland has these strategies in place. The Local Behavioral Health Authority (LBHAs) work in partnership with the hospitals to ensure patients have access to community-based services. This includes education of hospital employees to ensure they have a comprehensive understanding of the community-based resources available to patients within the hospital's jurisdiction. LBHA's also develop hospital diversion programs that target vulnerable individuals, particularly those engaged with high intensity level of services. When these individuals present at the ED, the Assertive Community Treatment Team (ACT) team is contacted by the hospital. The ACT team assesses whether the person can be safely treated in the community, and where this is possible, the person is diverted from the hospital. There are currently 25 ACT teams. There are providers in the following counties: Anne Arundel, Baltimore City/County, Carroll, Cecil, Charles, Dorchester, Frederick, Harford, Howard, Midshore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties), Montgomery, Prince Georges, Washington and Wicomico. However, there is a need for ACT services in both Southern and Western Maryland. Communities are expected to develop sufficient ACT team capacity to serve approximately .06% of their adult population. BHA has identified two areas of the state where there is not sufficient Mobile Treatment and ACT Team capacity, southern and western Maryland. The Fidelity Team at BHA, Clinical Services Division, submitted a proposal and was awarded funding through Block Grants for Community Mental Health Services/ American Rescue Plan Act ("ARPA Supplemental - MH") to expand ACT in Southern and Western Maryland. The ASO contract requires the ASO to use data exchanges to coordinate care with the MCOs, LBHAs, and hospitals for high utilizers; and to monitor high-risk or at-risk participants and refer them to additional care coordination services.

Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.

The funding awarded through SAMHSA Mental Health Block Grant from the American Rescue Plan Act of 2021, will support two ACT teams, one in southern and one in Western Maryland. Implementation of the team in southern Maryland will begin this fiscal year and continue into next, with the second team in Western Maryland with implementation beginning towards the end of next fiscal year. Both will be fully implemented, and able to be sustained by fee for service system by August of 2025.

In order to be eligible to deliver ACT services, the program must first be accredited by an MDH-approved accreditation organization and licensed by BHA under COMAR 10.63 as a Mobile Treatment Services (MTS) provider. Once in possession of an active, valid BHA-issued accreditation-based license, the program submits a comprehensive training plan for review to the Local Behavioral Health Authority of the jurisdiction in which EBP services are to be provided. Upon LBHA review and comment, the LBHA forwards the proposed training plan to BHA for approval. Individualized training, technical assistance is provided to the program in accordance with the approved training plan by the University of Maryland School of Medicine, Department of Psychiatry, Behavioral Health System Improvement Collaborative, Evidence-Based Practice Center or other BHA-approved entity. Upon completion of the requisite training and with the advice and recommendation of the EBP consultant and trainer, the MTS program submits a request to BHA for an ACT fidelity assessment and evaluation to be conducted of the MTS program to determine the program's adherence to Evidence-Based Practice (EBP) fidelity standards and ACT model practices. Only those licensed MTS programs that have been designated by BHA as an EBP program, at the team level, and which team has been determined by BHA to have met the established ACT EBP fidelity and practice standards are eligible to receive reimbursement for ACT services through the Public Behavioral Health System (PBHS). As a mechanism to prevent model drift and ensure continued, each team submits to an annual or biennial fidelity assessment and evaluation and must continue to meet established EBP ACT

	fidelity and practice standards in order to maintain the EBP ACT designation and to receive PBHS reimbursement for ACT services. As the programs are ramping up to full capacity and receiving targeted training and technical assistance, BHA and the associated LBHAs will continually monitor the program's capacity and capability to meet program standards. Based on this review and analysis, BHA will refine its projections as to when these programs will meet requirements to bill the Fee-for-Service PBHS for ACT services rendered and will ensure that BHA budget projections submitted to DBM reflect these analyses. Services will be available earlier, but will be funded with FBG funds.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. FY 2022 - RFP completed and implemented by Anne Arundel Local Authority for interested ACT providers. Provider has been selected and Project Lead located at local authority to be hired in FY 2022. FY 2023 - Implement a Team in Southern Maryland. FY 2024 - Implement a Team in Western Maryland. By August of 2025, both ACT teams implemented and sustained by the fee for service PBHS.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status: Provide information on the state's current care coordination benefits/requirements including actions to connect beneficiaries with community-based care including pre-discharge planning, post discharge follow-up, and information-sharing among providers.* The ASO is currently responsible for coordination of Release of Information (ROI) forms. Completed forms allow the ASO to release authorization and claims data to the enrollee's MCO—along with additional providers specified by the patient—and thereby coordinate care across the continuum of care. Behavioral health services are carved out of the MCO package, these forms are used to ensure coordination between somatic and mental health providers.

	Future Status: Describe planned improvements to care coordination benefits/requirements and connections to community-based care, including pre-discharge planning, post discharge follow-up, and information-sharing among providers.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action.

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* Maryland has a strategy in place. The initial assessment has been completed. The Department's behavioral health ASO is required in its contract to support network adequacy and addressing gaps in services or geographic locations; this includes an annual strategic plan to increase provider enrollment within the PBHS, geo-mapping activities by jurisdiction and provider type to note service availability and gaps in services and ongoing reporting and collaboration with BHA to improve the provider network. Based on the SAMHSA/Crisis Now Model, BHA is continuing to prioritize the development and increase the availability of crisis stabilization services across the state. BHA supports and monitors numerous behavioral health services throughout the state. Behavioral health, including mental health, are assessed annually primarily driven by the Crisis Response Grant program outlined in HB 1092 (2018) which seeks proposals to establish or expand crisis response programs.

stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	*Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools.* Maryland will update the assessment annually. HB 108, Behavioral Health Crisis Response Services Modifications (Ch 75 of the Acts of 2021), cross-filed as SB 286, Behavioral Health Crisis Response Services Modifications (Ch 756 of the Acts of 2021) was introduced in the 2021 Maryland General Assembly and was enacted under Article II, Section 17(c) of the Maryland Constitution - Chapters 755 and 756), with an effective date of October 1, 2021. HB 108 adds $5.0 million of annual funding for State Fiscal Years (FY) 2023, 2024, and 2025. Part of the funding for FY23 shall be awarded for competitive grants for Mobile Crisis Teams. The bill also stipulates annual data collection on the number of behavioral health calls received by police, attempted and completed suicides, unnecessary hospitalizations, hospital diversions, arrests and detentions of individuals with behavioral health diagnoses, and diversion of arrests and detentions of individuals with behavioral health diagnoses. The Department was also awarded a planning grant through the CMS State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.html.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. Medicaid will continue to work with BHA on strategies to assess the behavioral health network adequacy.

Prompts	Summary
3.b Financing plan	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* Maryland is in compliance; Maryland funds a wide variety of behavioral health services through its 1115 waiver, which spans the continuum of care as outlined in Tables 3 and 5 of Maryland's renewal application. See the discussion regarding crisis services above and discussion regarding bed registry work below. The 1115 demonstration has a budget neutrality requirement for certain services, including the services provided to beneficiaries in an IMD. The Department submits regular quarterly budget neutrality reports to CMS. The State's budget funds other behavioral health services through other authorities, such as the State Plan.
	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. See Section 5.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* The bed registry is in place and has been operational since February 2022. The Department is in the process of updating its bed registry; please see the Future Status section.

	Future Status: In 2021, by the introduction of new requirements under state law, enacted under Ch. 29 (2021 Laws of Maryland), all prior Maryland Bed Availability Registry (MD-BAR) work was halted as a new expansive design approach was explored for implementation across the state. Current functional requirements, as outlined in House Bill 1121, are more extensive in scope, utility, capacity, and implementation. The Maryland Mental Health and Substance Use Disorder Registry and Referral System will establish a regularly updated searchable inventory or "bed registry" of treatment options of varying intensity and duration that are used to stabilize the behavioral health related emergency. The system will have the capability to allow a provider of mental health and substance use disorder services to update registry information including real-time availability of services. The services inventory will include not only all crisis, residential, and acute care general hospital inpatient beds, but also the addition of outpatient behavioral health providers and available appointments. Crisis counselors, hospital emergency room staff, in addition to any healthcare provider across the state, will use the system. It is the intent of the system for all end users to have access to the system in order to identify and access available inpatient, outpatient mental health and substance use services. Expanded functionality over prior system configurations gives providers the ability to make referrals to care on behalf of their patient. The future system enables the quick search for available settings, identifying the most appropriate and proximate settings and ease the transition and admission to a facility for care. It will not only improve timely access to available beds; but also expand the range of treatment options to include the less restrictive and lower cost options to inpatient care like community crisis respite, stabilization units and outpatient services. Currently, MDH contracted with a vendor to conduct a feasibility study for any future system. The Department sanctioned a feasibility study designed to give a brief overview of high-level requirements, potential partner vendors, and assistance available from the state-designated health information exchange, CRISP, recommendations for vendor selection and policy/programmatic implications of the behavioral health bed registry and referral system. Information was gathered from a review of research, discussions with other states' experiences with bed registries, and review of three potential vendors. The recently received feasibility study will guide the state steering committee through any design, vendor selection implementation decisions, and funding considerations. The legislatively mandated steering committee meets quarterly and includes representatives from various behavioral health

	stakeholders at the state and local level. The advisory committee is led under the direction of the Deputy Secretary of Behavioral Health. The committee was formed and began meeting in October 2021 and continues to meet quarterly. A Behavioral Health Provider Directory/Resource Directory is being developed in coordination with Maryland's 211 Press 1 Hotline. The online resource directory is scheduled to launch 3/1/22. The resource directory will provide users an opportunity to search for a specific behavioral health need in a specific geographic area (by zip code). The search generates providers of those services in that geographic area. The study is complete and the advisory council meetings are ongoing. As part of any future bed registry and behavioral health crisis system it is the task of BHA to develop a standardized data collection, reporting and performance measurement system to capture, summarize and highlight pertinent, client-level and actionable crisis services information including service utilization, effectiveness, performance and outcome measures. Providers and local behavioral health authorities will receive this information to improve quality of care. The Maryland Department of Health Office of Enterprise Technology will lead any efforts to secure state funding of the major IT project. It is anticipated that funding will begin in state fiscal year 2023 (July 1, 2022-June 30, 2023). Through the first half of 2022, provider engagement activities will begin, including hosting Advisory Committee meetings, listening sessions, and targeted outreach to hospitals and community providers. This process will allow the Department to orient all of the various stakeholders to the goals of the system and what they should expect to be delivered initially and in the future. Additionally, the Department is developing a provider directory and planning a pilot project to study referral challenges and opportunities for reducing hospital stay time for individuals needing community based behavioral health services.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. Provider engagement activities, including hosting Advisory Committee meetings, listening sessions, and targeted outreach to hospitals and community providers – Targeted to be completed in 2022
3.d State requirement that	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.*

providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	There is no current requirement that providers use a patient assessment tool to determine appropriate level of care for adults. CAYAS is rolling out early components of comprehensive crisis stabilization model that will be utilizing CAT as initial data collection screening tool (along with others of provider/county selection). The Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment will be used as a more robust longer term tool and incorporates existing TCM III / 1915i waiver opportunity for Evidence Based Practices (EBP) intensive in home stabilization services for highest needs youth. The Daily Living Activities- 20 (DLA-20) is required for Psychiatric Rehabilitation Programs for Adults (PRP-A), Residential Rehabilitation Programs (RRP), Mobile Treatment Services (MTS) programs, and Assertive Community Treatment (ACT) programs. This is used as part of the overall medical necessity determination to ensure that individuals are properly placed in the appropriate program, and to judge the necessity for ongoing stay. Accreditation standards encourage the use of standardized instruments for evaluation. Similar to the use of the DLA-20 in these above levels of care, for other levels, the Adult Needs and Strengths Assessment (ANSA) will be incorporated into the overall medical necessity determinations for proper program placement, and judging the necessity for ongoing stays.
	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. CAYAS is rolling out early components of comprehensive crisis stabilization model that will be utilizing CAT as initial data collection screening tool (along with others of provider/county selection). The Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment will be used as a more robust longer term tool and incorporates existing TCM III / 1915i State Plan Amendment (SPA) opportunity for Evidence Based Practices (EBP) intensive in home stabilization services for highest needs youth.

	The Daily Living Activities- 20 (DLA-20) is required for Psychiatric Rehabilitation Programs for Adults (PRP-A), Residential Rehabilitation Programs (RRP), Mobile Treatment Services (MTS) programs, and Assertive Community Treatment (ACT) programs. This is used as part of the overall medical necessity determination to ensure that individuals are properly placed in the appropriate program, and to judge the necessity for ongoing stay. Accreditation standards encourage the use of standardized instruments for evaluation. Similar to the use of the DLA-20 in these above levels of care, for other levels, the Adult Needs and Strengths Assessment (ANSA) will be incorporated into the overall medical necessity determinations for proper program placement, and judging the necessity for ongoing stays.
	Summary of Actions Needed: Specify list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. The milestone will be completed by the end of Calendar Year 2022.

Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status: Provide information on the status of the state's assessment of mental health provider availability and an overview of the current continuum of care, including crisis stabilization, the state's ability of the state to track availability of beds, and the use of patient assessment tools.* Currently BHA has funded several projects that have supported crisis stabilization centers within the state. Current stabilization centers are not operated under any formalized policy. The Department, which is establishing national best practices, monitors current stabilization centers based on the conditions of awards to ensure quality services are provided.
	Future Status: Describe plans to expand community-based services, including references to the financing plan as appropriate, and the state's plans to improve annual assessments of the availability of mental health providers and the state's ability to track availability of beds, and plans to encourage widespread use of patient assessment tools. In February 2021, The Behavioral Health Administration launched the Maryland Crisis System Workgroup (MCSW). This workgroup is composed of over 95 diverse stakeholders from around Maryland including representatives from state government, local government, providers, advocates, and people with lived experience. The workgroup has conducted an environmental scan of what services are being funded in the crisis space. Through this work, BHA is working to standardize best practices and policy, funding sustainability and data evaluation, and developing child/adolescent/young adult crisis services. Through this workgroup BHA will formalize the Maryland hybrid crisis system that will address the continuum of crisis care. MCSW has proposed the development of a comprehensive, public/private, integrated behavioral health crisis care system. Specifically, Maryland residents will have 24/7 behavioral health (mental health and addiction) access to hotline, crisis walk-in/urgent care, community response (mobile crisis) teams and stabilization services that provide care in the most effective, least restrictive, person and family focused. Meetings are held every other month. The meeting schedule for 2022 is: 2/15/22; 4/19/22; 6/21/22; 8/16/22; 10/18/22; 12/20/22.

	The Department is working to develop Regional Crisis Centers across Maryland as identified in the 2021 Facilities Master Plan. This is being developed in partnership with Western (Garrett, Allegany, Washington) and Southern Maryland (St. Mary's, Charles, Calvert) Counties to develop urgent care centers which will serve as regional comprehensive crisis center hubs. Ideally a regional comprehensive crisis center will include a 24/7 urgent care walk-in center, 23 hour stabilization beds, have the capacity to accept emergency petitions, initiate pharmacologic medications, withdrawal management capabilities for all substances along with initiation of medications for treatment of opioid use disorder, integrate peers and have the capacity for warm handoff to short term stabilization services or traditional community outpatient resources when necessary. Additionally, the Department was also awarded a planning grant through the CMS State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying- community-based-mobile-crisis-intervention-services/index.html. The planning grant provides funding to develop, prepare for, and implement qualifying community-based mobile crisis intervention services under the Medicaid program. The grant will help Maryland integrate community-based mobile crisis intervention services into the Medicaid programs which is a critical component of establishing a sustainable and public health-focused crisis system. The intended start date for these services in Medicaid is July 1, 2023. The Department is working with the Crisis Services Subcommittee of the Commission to Study Mental Behavioral Health in Maryland. This subcommittee is devoted to enhancing crisis services throughout the State. The Opioid Operational Command Center (OOCC) awarded a grant to the Department to increase the availability of comprehensive crisis stabilization services for mental health (MH) by leveraging the outpatient mental health center (OMHC) provider network. The Department formed a stakeholder workgroup to inform the process and collaborated with Hilltop to produce data analysis and an environmental scan. The Maryland Health Services Cost Review Commission (HSCRC) has also awarded three Regional Partnership Catalyst Grants totaling approximately 79 million dollars for the expansion of behavioral health (BH) crisis services rooted in the Crisis Now model over a period of five years.

	The Greater Baltimore Region Integrated Crisis System (GBRICS) received nearly 45 million dollars to implement a care-traffic control system, increase same day access to services, and expand mobile crisis teams in Baltimore City and Baltimore, Carroll, and Howard counties. Totally Linking Care in Prince George's County and Southern Maryland received over 22 million dollars to implement care traffic control, crisis bed expansion, mobile crisis team expansion, and crisis receiving and stabilization services. Tri-County Behavioral Health Engagement (TRIBE) received over 11 million dollars to build a hub-and-spoke like model for crisis stabilization in Somerset, Wicomico, and Worcester counties. The Department has engaged all of the HSCRC awardees in order to align efforts to enhance the crisis response system. See additional discussion on bed registry and related activities above.

	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. The workgroup needs to establish the best practices, sustainability, and data collection requirements. The key milestone will be the ability to find funding that is not tied to grant awards, potentially through Medicaid and other commercial payors. The Department will engage in the planning process described in its grant awarded by CMS. Proposed revisions to the State Plan Amendment are anticipated to be completed 12/31/22.

SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	*Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.* Maryland has adopted these strategies. To increase engagement in transitional support services and allow for care coordination, TCM III enrollment is permitted prior to age 18 and eligible youth can continue to receive 1915i waiver services until age 21. A memorandum of agreement (MOA) is currently under draft with Maryland State Department of Education (MSDE), Division of Rehabilitation Services (DORS), and Department of Disability (DOD) to align efforts in vocational/rehabilitative space. These include: ● Maryland Early Intervention Program (MEIP) and Healthy Transitions (HT) programs designed to identify and engage SMI youth and young adults (YA) and their families. ● Building collaborative relationships with MSDE through Center for School Based Mental Health to promote EBP screening and evaluation tools across all BH issues, as well as parent engagement tools / strategies (adding to efforts currently funded under SOR grant and AWARE grant). Maryland BHA has been a pioneer in implementation of high fidelity individualized placement and support (IPS) model of supported employment services, disseminating these in its Transitional Age Youth (TAY) Maryland Model programs for both youth and young adults with or at are at risk for an SMI or SED and adults with an SMI. Employment is a powerful incentive for youth and young adults and is often a mechanism to facilitate engagement and retention in treatment services, particularly when the symptoms or functional limitations related to mental illness interferes with the individual's ability to acquire or retain competitive employment. The TAY Maryland Model is specifically developed for working with youth and young adults with emotional/behavioral difficulties and serious mental health conditions (SMHC) to provide youth led family supported age appropriate services. Core services, provided to all youth include intensive case management to include

	individualized multi-systems service coordination (to assist the youth in the process of learning to understand and lead their own interdisciplinary team); guidance in the development of an individualized person centered care plan and skills development in goal setting progress measurement, and maintenance; community based services and relevant skills development delivered in environments of the youth's choosing and comfort level; assistance and guidance in understanding their mental health needs and taking charge/responsibility for treatment choices; providing access to appropriate mental health treatment and services; and guidance in the process of community resource mapping and recognition/understanding of available natural supports. It is a training that is provided to all TAY Providers with annual or two year training/refresher. At this time BHA is working on an assessment to test the model and this is still ongoing. In order to coordinate and to integrate supported employment efforts with mental health treatment, Maryland has adopted an EBP approach to require that the that the employment specialist regularly collaborates with members of a multidisciplinary treatment team, as applicable. The treatment team is broadly defined, and includes the case manager, the psychiatric rehabilitation counselor, the residential or housing specialist, the therapist, the psychiatrist, family member, peer advocate, and any other individuals who may be involved in the treatment and rehabilitation of the individual. The following goals have been identified for the Clinical Coordination service: ● in pursuit of the consumer's goals for competitive employment, to establish a working alliance with the clinician and to enlist his or her support for the consumer's interests and desires; ● to enhance the program's ability to engage and to retain consumers in supported employment through assertive engagement and follow-up; ● to facilitate effective, efficient communication between the consumer and clinical, rehabilitation, and treatment providers as a means to coordinate care; ● when desired by the consumer, to encourage timely, fully integrated interventions which collectively support the individual in identifying and selecting employment options, resolving employment-related crises, and in preserving employment placements; and ● to incorporate employment-related issues in treatment and rehabilitation plans and to ensure congruence of rehabilitation and treatment goals, interventions, activities, and plans.

	Future Status: The COVID-19 MH Federal Block Grants (FBG) and American Rescue Plan Act (ARPA) MH FBG funding expansions have both provided significant allocations towards early interventions for youth with first (early) episodes of psychosis. The aforementioned programs, including treatment, integrated rehabilitation and vocational training will be expanding to several additional locations as a result of these awards. These new locations will increase both the geographic coverage and capacity of these valuable evidence-based programs. The COVID 19 Mental Health FBG Supplemental Grant has a Project Period & Budget Period of 03/15/2021 - 03/14/2023. Funding will expand several current programs including: 1. Behavioral Health Assisted Living Programs- There is a Pilot project currently in Eastern Shore- will fund behavioral health assisted living programs in up to four regions. 2. Mental Health Family Peer Support Expansion-project would expand existing Family Peer Support and Navigation (intervention and mental health wellness and recovery support) services to families (expand the age range and jurisdictional reach of services). 3. Expansion of Child Crisis Services - Central and Western Region- to build upon the very limited crisis services available in Washington County and potentially incorporating additional providers, Affiliated Sante (Carroll Co) and Frederick Co Health Department, to provide child focused crisis and stabilization services to the county and/or region. 4. 211 Press 1 Statewide Crisis Hotline- funding in order to optimize the current 211 Press 1 statewide crisis hotline system. The State of Maryland is coordinating with SAMHSA and Vibrant Emotional Health to integrate 988 with the currently operational Maryland 211 press 1 hotline. The national 988 call center is scheduled to go-live July 16,2022. The 211 press 1/988 call centers will coordinate with other crisis system components such as the Maryland bed registry, mobile crisis teams and walk-in/urgent care centers. The ARPA Mental Health FBG Supplemental Grant has a Project Period & Budget Period of: 09/01/2021 - 09/30/2025. Funding will expand several current programs including: 1. Operation Rollcall Expansion- purpose of this project is to expand the current capacity of MCV's Operation Roll Call program. Operation Roll Call provides SMVF with a weekly or bi-weekly call providing support and connection to those that are socially isolated and/or suffering from SMI or SED in silence. 2. Maryland Assertive Community Treatment Team Expansion ("ACT Team Expansion")- development of two Assertive Community Treatment (ACT)teams in two underserved areas of Maryland 3. Crisis Walk-in/BH Urgent Care Peer Expansion Project- This proposal looks to expand positions for peer recovery

	specialists specifically within funded Crisis Walk-In Centers and Behavioral Health Urgent Care Centers. 4. Training Crisis Peer Expansion Project-This proposal supports the Crisis Walk-in and BH Urgent Care Peer Expansion proposal and will fund the required training the peer workforce needs in order to obtain the credential in Maryland and provide effective services to individuals in crisis. 5. Mental Health Family Peer Support- will allow for the continuation of the provision of Family Peer Support and Navigation (intervention and recovery support) services. Additional interagency collaboration between MSDE and MDH/BHA continues to be defined, both through the Center for School Based Mental Health and the establishment of regional school based consultation teams and shared partnership to support the efforts of Project Bounce Back and the expansion of adolescent and transitional aged youth centered resources through the efforts of the Boys and Girls Clubs, LinkedIn Learning, Microsoft, KPMG, Discourse Analytics and eCare Vault. In regards to the MOA, there will be continued conversation with DORS and BHA to work to operationalize the agreement. These efforts are still ongoing All contracts have been executed for COVID-19 and ARPA to its respective vendor to fund expansion and enhancement of services through 3/14/2023 (COVID-19) and 9/30/25 (ARPA). COVID-19 funding went to our Maryland Early Intervention Program (EIP) to focus on three things: staffing- hotline, peer specialists, and supported employment specialist; create a manual with evidence-based approaches to crisis reduction and management among those with emerging psychosis symptoms; and further embed a culturally responsive and equitable perspective into Maryland EIP pre-service training resources. ARPA funding went to two of our First Episode Psychosis (FEP) programs: Johns Hopkins Bayview and Family Services Montgomery County to provide Crisis Support services to individuals with first episode psychosis (FEP) who are not able to receive adequate care due to lack of resources available to meet the needs of their acuity, lack of step-down care from inpatient units, wait lists into FEP outpatient programs, insurance barriers, location barriers and lack of crisis services for immediate assistance.
	Summary of Actions Needed: As this has evolved, funding will be awarded to Garrett County for the development of a new Mobile Crisis team (all ages) to serve Garrett and Allegany Counties. Start-up funding for Southern Maryland (St Mary's, Calvert and Charles) will also be awarded to develop mobile crisis/mobile response stabilization services. Finally, additional funding is being awarded to expand child services in Washington, Frederick, greater Eastern Shore region, and potentially other counties served by Affiliated Sante (Carroll, Baltimore Counties). The Department expects statewide services to begin on July 1,

	2023. All funding should be released prior to that date. Crisis Walk-in/Urgent Care Center funding is being awarded to Calvert County. This is new funding which will allow the jurisdiction to expand their currently operating walk-in/urgent care center. Four counties were selected to develop Peers in Walk-in/Urgent Care centers. The counties include: Frederick, Harford, Howard and St. Mary's. Contracts/scopes of work are currently being developed.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status: Provide information on current strategies to increase earlier identification/engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.* The Maryland Early Intervention Program (MEIP) is a specialized program for young people with SMI of early psychosis and currently providing additional staffing support to their MEIP hotline, supported employment and education specialists, and peer support specialists; exploring and developing evidence-based approaches to crisis reduction and management among those with emerging psychosis symptoms; and improving outreach and education (O&E) working with one of our Historically Black Colleges and Universities (HBCUs) as the pandemic has highlighted and exacerbated pre-existing disparities and equity gaps in mental health care outcomes, particularly those among marginalized racial groups, indicating the need for both intensified and novel outreach and education efforts to address these needs. It is the idea that all of these areas will assist with earlier identification/engagement in treatment. Also, BHA has increased our capacity to serve 25 more individuals who are experiencing their first episode of psychosis by implementing a new program in Prince George's County. BHA is currently able to serve 245 individuals throughout our six providers who provide treatment to this population. The Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) and related tele-psychiatry efforts again offer consultation regarding diagnosis and treatment to pediatric and other PCPs to improve identification and early intervention of SMI. Specifically BHIPP provides real time consultation resources for child/adolescent and early developmental concerns. These resources are available via telephonic or telehealth, as well as expanding co-location of social workers or physician assistants trainees into pediatric practices in our underserved communities. PCPs and other healthcare providers also received a suicide prevention kit. It contains information on suicide prevention trainings, screening and assessment tools, decision tree, safety planning, and referrals to specialty care. The Collaborative Care Model (CoCM) pilot program will also be leveraged to increase integration of behavioral health services in non-specialty care settings, along with continued promotion of SBIRT. The CoCM pilot program began

	providing services in July 2020 in three pilot sites across Maryland. CoCM is a patient-centered, evidence-based approach for integrating physical and behavioral health services in primary care settings that includes: (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement. A collaborative care team is responsible for delivery and management of patient-centered care. Proponents of the model suggest that merging behavioral health with primary care normalizes and de-stigmatizes treatment for behavioral health disorders for the patient. This in turn encourages patients to seek access to the evidence-based behavioral health services available in their regular primary care clinics resulting in improved patient outcomes. Patients are screened through a standardized questionnaire, such as the PHQ-9 for depression or the GAD-7 for anxiety. The CoCM incorporates a team of three providers: (1) a primary care provider (PCP), (2) a behavioral health (BH) care manager, and (3) a psychiatric consultant. In Maryland's Medicaid program, a physician, nurse practitioner, nurse midwife, or physician assistant may serve as a PCP. The BH care manager possesses formal education or specialized training in behavioral health. The role is typically filled by a nurse, clinical social worker, or psychologist who is trained to provide coordination and intervention who works under the oversight and direction of the PCP. Together, the BH care manager and the PCP form the primary care team. The psychiatric consultant is typically either a licensed psychiatrist or psychiatric nurse practitioner. For purposes of the CoCM Pilot Program, an addiction medicine specialist or any other behavioral health medicine specialist as allowed under federal regulations governing the model may also serve as a consultant. The CoCM is still ongoing; MDH will conduct a full evaluation after the end of the pilot in June 2023.
	Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI. For FY23 under MEIP BHA plans to put out a survey to collect information on providers serving transitional aged youth with psychosis so that the Hotline can refer across the state and to identify providers interested in receiving

	education and training resources related to this target population and provide it to them. The benefits to implementing this project could include: increasing access to services among this vulnerable population, especially in rural regions, improving the quality of care for these individuals by providing informational resources and consultation to the service providers, and promoting the expansion of first episode psychosis programs across the state. CAYAS is expanding collaboration with MSDE to support screening and early intervention tools across many diagnostic categories. BHA has, in collaboration with University of Maryland, Baltimore (UMB) Center for School Based Mental Health, repeatedly provided MSDE with an extensive list of recommendations, resources and training opportunities across a wide array of MH and SUD screening and early intervention topics. These also include recommendations regarding how to implement a regional approach to providing consultative services to the schools and how to begin to integrate these proposed services into the developing BH crisis and stabilization system. Finally, the Behavioral Health System of Care Integration and Optimization Workgroup formed in 2019, paused during CY 2020 due to COVID-19, and reconvened in fall 2021, aims to better serve Medicaid participants by developing a System of Care that addresses the needs to individuals by aligning the roles of Medicaid, the Behavioral Health Administration (BHA), the nine MCOs, the administrative services organization (ASO) that administers behavioral health benefits in Medicaid, and local systems management. The key themes for potential initiatives under discussion by the workgroup are: • Value-based payment, measure-based care, quality measurement, and provider management; • Case management, care coordination, and clearly defining roles within the system; • Integration of care; and • Data sharing The workgroup is considering and vetting a variety of programs and projects with the potential to forward progress on the themes outlined above. Expansion of CoCM is one proposal under consideration. Other initiatives under discussion include but are not limited to establishing standards for behavioral health provider networks and quality; development of a formal structure for addressing high utilizers of services; identification of barriers to billing for co-occurring disorders; review of supports needed by MCOs to further increase uptake of SBIRT by providers; and enhancements to

	CRISP to improve data sharing, Discussion by the workgroup regarding selection of an initiative to move forward are ongoing.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. BHA CAYAS and Maryland's partners at UMB Systems Evaluation Center (SEC) met with MABHA on 3/16/22 to share this initiative and gather information from each LBHA/CSA Representative. MDH will have ongoing meetings with the partner at UMB SEC as MDH starts working with the LBHA/CSA to send an email out to their BH Providers to participate in the survey. The timeline: get surveys out by May 2022, review surveys June/July 2022, compile responses Aug/Sept 2022 and resend surveys out Oct/Nov 2022 in case MDH missed any BH Providers. Based on responses BHA will be able to update our Provider Directory housed at our Hotline, provide trainings/consultations to BH Providers who request training/consultation, and the goal to help BH Providers increase their referrals. MDH will conduct an evaluation in 2023 of its CoCM Pilot Program after the pilot ends on June 30, 2023. MDH will submit the finished evaluation report to the Maryland legislature on or before November 1, 2023. MDH will continue to work with the pilot sites and the evaluator to collect pilot data and will implement findings from the pilot programs.

Prompts	Summary
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.* Expanding crisis stabilization services for youth is one of the primary goals and objectives of CAYAS, an ongoing $7M multi-grant funded effort to expand upon existing crisis resources and lay out a framework for a statewide-specialized child/adolescent crisis and stabilization system. As noted above, TCM III/ 1915i bundle provides a platform for highest intensity youth to access longer term, EBP based in-home stabilization services. The Maryland Early Intervention Program (MEIP) supports individuals, families, and professionals who may encounter early psychosis. MEIP increases earlier identification through: Outreach and Education Services- to behavioral health providers, schools, and primary care settings: Clinical Services- for 12-30 year olds who present with clinical high risk symptoms that may be predictive of future psychosis, who have early signs of psychosis or are in the initial stages of psychoses; Consultation Services- servicing providers regarding identification and treatment for individuals who may be experiencing symptoms that may be predictive of future psychosis; and Training and Implementation Support Services- support established Early Intervention Teams (EIT) throughout the state and provide trainings, resources, coordination of service delivery. MEIP also provides a 24/7 hotline to all MD residents and providers for assessments, consultation, training requests, and referrals. This initiative also provides training of early identification of psychosis assessments/screenings to students in the UMB Social Work program. The Healthy Transitions (HT) program is also designed to identify youth with or in prodromal stages of SMI, in addition to SED. HT also provides outreach and education, clinical services, and consultation to those within the program and to those not in the program seeking information and resources. Both MEIP and HT provided extensive EBP programming including family engagement support to help maintain these adolescents and young adults with SMI in treatment. Additional information and plan framework are available if more details are required.
	Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI. The state will continue to work on CAYAS.

	During FY22 and FY23 the CAYAS unit will explore the creation of a fidelity assessment to assess the current providers who serve those experiencing their first episode of psychosis to ensure a few things: the model being used to serve this population is effective, to assess the screenings/assessments being used, assess the EBPs being used, assess outreach and education, and assess the effectiveness of ongoing trainings.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. The state will continue to implement CAYAS. The IA with UMB Evidence Based Practice (EBP) Center was executed in December 2021, BHA had a first meeting 3/31/22 to discuss timeline: year 1 (June 2022) with the UMB EBP Center BHA will work on the draft fidelity assessment created back in 2016 to understand if its components are still relevant while comparing it to other FEP fidelity scales ex.: PA and MA's FEP assessment and year 2 (July 2022-June 2023) after finalizing the assessment, a pilot fidelity assessment will be conducted by BHA to all FEP providers in the state, and BHA will review the information with UMB EBP Center to determine the effectiveness of the assessment. If acceptable, the assessment will be used to assess all FEP providers in the future.
4.d Other state strategies to increase earlier identification/engagement,	*Current Status: Provide information on current strategies to increase earlier identification/ engagement in treatment, integration of behavioral care in non-specialty settings, and specialized programs for young people with SED/SMI.* N/A

integration, and specialized programs for young people	*Future Status: Describe planned strategies to increase early identification/ engagement in treatment, integration of behavioral health care in non-specialty settings, and availability of specialized programs for young people with SED/SMI.* The COVID 19 Mental Health FBG Supplemental Grant has a Project Period & Budget Period of 03/15/2021 - 03/14/2023. Funding will expand several current programs including: 1. Behavioral Health Assisted Living Programs- There is a Pilot project currently in Eastern Shore- will fund behavioral health assisted living programs in up to four regions. 2. Mental Health Family Peer Support Expansion-project would expand existing Family Peer Support and Navigation (intervention and mental health wellness and recovery support) services to families (expand the age range and jurisdictional reach of services). 3. Expansion of Child Crisis Services - Central and Western Region- to build upon the very limited crisis services available in Washington County and potentially incorporating additional providers, Affiliated Sante (Carroll Co) and Frederick Co Health Department, to provide child focused crisis and stabilization services to the county and/or region. 4. 211 Press 1 Statewide Crisis Hotline- funding in order to optimize the current 211 Press 1 statewide crisis hotline system. The State of Maryland is coordinating with SAMHSA and Vibrant Emotional Health to integrate 988 with the currently operational Maryland 211 press 1 hotline. The national 988 call center is scheduled to go-live July 16,2022. The 211 press 1/988 call centers will coordinate with other crisis system components such as the Maryland bed registry, mobile crisis teams and walk-in/urgent care centers. The ARPA Mental Health FBG Supplemental Grant has a Project Period & Budget Period of: 09/01/2021 - 09/30/2025. Funding will expand several current programs including: 6. Operation Rollcall Expansion- purpose of this project is to expand the current capacity of MCV's Operation Roll Call program. Operation Roll Call provides SMVF with a weekly or bi-weekly call providing support and connection to those that are socially isolated and/or suffering from SMI or SED in silence. 7. Maryland Assertive Community Treatment Team Expansion ("ACT Team Expansion")- development of two Assertive Community Treatment (ACT)teams in two underserved areas of Maryland 8. Crisis Walk-in/BH Urgent Care Peer Expansion Project- This proposal looks to expand positions for peer recovery specialists specifically within funded Crisis Walk-In Centers and Behavioral Health Urgent Care Centers. 9. Training Crisis Peer Expansion Project-This proposal supports the Crisis Walk-in and BH Urgent Care Peer Expansion proposal and will fund the required training the peer workforce needs in order to obtain the credential in

	Maryland and provide effective services to individuals in crisis. 10. Mental Health Family Peer Support- will allow for the continuation of the provision of Family Peer Support and Navigation (intervention and recovery support) services.
	Summary of Actions Needed: Specify a list of actions needed to be completed to meet milestone criteria. Include persons or entities responsible and timeframe for completion of each action. N/A

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of nonhospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status* Currently BHA has funded several projects that have supported crisis stabilization centers within the state. Current crisis services are monitored by the state based on the conditions of awards to ensure quality services are provided. BHA established and publicized a 3-digit crisis call-center number to access acute and non-acute services and resources. The crisis call centers link to those and other services to address the needs of the caller wherever mobile crisis exist.
	Future Status BHA in collaboration with the Opioid Operational Command Center (OOCC), Medicaid and other external stakeholders have formulated the Maryland Crisis System Workgroup. The workgroup has conducted an environmental scan of what services are being funded in the crisis space. Through this work, BHA is working to standardize best practices and

	policy, funding sustainability and data evaluation. Through this workgroup BHA will formalize the Maryland hybrid crisis system that will address the continuum of crisis care, including the integration of 988 crisis calls into the existing crisis call system. In February, 2021, The Behavioral Health Administration launched the Maryland Crisis System Workgroup (MCSW). This workgroup is composed of over 95 diverse stakeholders from around Maryland including representatives from state government, local government, providers, advocates, and people with lived experience. A statewide Behavioral Health Crisis System vision was identified: A comprehensive, public/private, integrated behavioral health crisis care system will be developed. Specifically, Maryland residents will have 24/7 behavioral health (mental health and addiction) access to hotline, crisis walk-in/urgent care, community response (mobile crisis) teams and stabilization services that provide care in the most effective, least restrictive, person and family focused. Meetings are held every other month. The meeting schedule for 2022 is: 2/15/22; 4/19/22; 6/21/22; 8/16/22; 10/18/22; 12/20/22. The Department is working to develop Regional Crisis Centers across Maryland as identified in the 2021 Facilities Master Plan. This is being developed in partnership with Western (Garrett, Allegany, Washington) and Southern Maryland (St. Mary's, Charles, Calvert) Counties to develop urgent care centers which will serve as regional comprehensive crisis center hubs. Ideally a regional comprehensive crisis center will include a 24/7 urgent care walk in center, 23 hour stabilization beds, have the capacity to accept emergency petitions, initiate pharmacologic medications, withdrawal management capabilities for all substances along with initiation of medications for treatment of opioid use disorder, integrate peers and have the capacity for warm handoff to short term stabilization services or traditional community outpatient resources when necessary. There are currently 9 walk-in/urgent care centers in Maryland. There are 2 currently being developed. They are scheduled to open: Eastern Shore -Summer, 2022 (June), and Southern Maryland - Fall, 2022 (September-November). A Request for Expression of Interest (REOI) is scheduled for release in April, 2022 targeting the Western Maryland Region. The REOI is seeking proposals to develop/expand crisis services in the region. The Southern Maryland urgent care is currently being developed. It is scheduled to open late 2022 (September-November). Additionally, the Department was also awarded a planning grant through the CMS State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-

	community-based-mobile-crisis-intervention-services/index.html. The planning grant provides funding to develop, prepare for, and implement qualifying community-based mobile crisis intervention services under the Medicaid program. The grant will help Maryland integrate community-based mobile crisis intervention services into the Medicaid programs which is a critical component of establishing a sustainable and public health-focused crisis system. The intended start date for these services in Medicaid is July 1, 2023. The Department will engage in the planning process described in its grant awarded by CMS. Based on SAMHSA Best Practices, BHA has developed the Maryland Crisis System Model and the 4 components which will be minimum for each location (ie regional hubs as per Facilities Master Plan.) These components are a Call Center (integrate to statewide,) Mobile Response Teams (often called mobile crisis teams), Urgent Care (walk-in centers), and Short-term Stabilization Services. There are additional requirements of the "urgent/walk in centers." BHA intends for those to be regionally operationalized, and for the mobile response teams to be more local in scope. BHA is defining and describing consistent expectations (staffing and service provision) for all of these components statewide, as well as consistent evaluation, assessment and data collection elements. This work is very much in progress, and expected to be completed late spring. The expansion of these services into all regions is dependent, but expected to be statewide by FY 2023. Full array may take a few more years. Currently underway, the Maryland Medicaid Administration and BHA are working closely (meeting bi-weekly) to develop the funding structure for mobile crisis teams and walk-in/urgent care/stabilization center. The structure includes developing the definitions of the services, defining the provider type/services, qualifications of the provider, eligibility, and reimbursement rate. Proposed revisions to the State Plan Amendment are anticipated to be completed 12/31/22. See Milestone 3.e. for additional information on investments is the crisis continuum of care.

	Summary of Actions Needed The workgroup needs to establish the best practices, sustainability, and data collection. The key milestone will be the ability to find funding that is not tied to grant awards, potentially through Medicaid and other commercial payors. Maryland Crisis System and the 4 components will be statewide by July 1, 2023; however it may take longer. BHA already has a number of these services funded under a wide variety of sources. The purpose of the grant is to help the state utilize Medicaid funding mechanisms. BHAS has a contracted agency who is assisting in this by the end of grant (expected 8/30/2022).
F.b Increase availability of ongoing community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current Status* A statewide assessment was completed to ascertain locations of current ACT teams and current Mobile Treatment Services providers to establish where services were most needed. This was done by population count based on the 2019 census data and then converted into a formula for adults over 18, needing ACT services, in each jurisdiction in Maryland. These jurisdictions were then shown using geo mapping software to display highlighted areas needing services.
	Future Status: In response to SAMHSA Mental Health Block Grant funding from the American Rescue Plan Act of 2021, a plan for the expansion of ACT in Maryland was submitted and approved. The Assertive Community Treatment Expansion program will be implemented through LBHAs and Core Service Agencies (CSAs). CSA will be selected using a statewide assessment to ascertain locations of current ACT teams and current Mobile Treatment Services providers. This also established where significant gaps in the service continuum and lack of ACT services exist, thus providing comprehensive community mental health services and a strong continuum of care for persons with serious mental illness. The funding awarded will support two teams, one in southern and one in Western Maryland. Implementation of the team in southern Maryland will begin this fiscal year and continue into next, with the second team in Western Maryland with implementation beginning towards the end of next fiscal year. Both will be fully implemented, able to be

	sustained by fee for service system by August of 2025. BHA will partner with the local behavioral health authorities to implement the Assertive Community Treatment Expansion program. Discussions with the identified local behavioral health authority for year 1, began in the Fall of 2021. The Conditions of Award /Statement of Work for State Fiscal Year 22 has been developed and signed by both BHA and the local health authority. The local authority will begin the work of hiring a Project Director and begin the Request for Proposal (RFP) for interested providers in southern Maryland in January 2022. The BHA, evidence-based Practice Manager, the Project Director at the local authority and the provider selected will collaborate and begin the process of hiring and training required staffing with the goal of being able to offer these services in Southern Maryland prior to the end of the state fiscal year (June 30, 2022) and continuing into State fiscal year 2023. The implementation process will be followed in State fiscal year 2024, to implement a team in Western Maryland.

	Summary of Actions Needed: FY 2023 - Implement a Team in Southern Maryland. FY 2024 - Implement a Team in Western Maryland. By August of 2025 - Both teams implemented and sustained by the fee for service PBHS.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education. Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	Over the last seven years, Maryland has placed considerable emphasis on advancing HIT and engaging stakeholders in planning and implementation activities. The State has a long tradition of hospital-to-hospital and hospital-to government collaboration on projects, including the award-winning Maryland Patient Safety Center. The Department is working in partnership with the State HIE, CRISP, to enable both the ASO and MCOs to receive alerts for the patient panels, which include emergency department visits and inpatient admissions. The state's HIE has a mature data network and data integration capabilities to inform care and service providers on patient's medical history, care plans, and risk assessments. Maryland Medicaid (Medicaid) providers can leverage CRISP's technical capabilities through routed data, portal, and integrated data reports. CRISP's network provides MDH and providers access to both data and tools; thereby improving an individual's health, quality of care, and Maryland's population health. The primary care coordination technology used by CRISP is Encounter Notification Service (ENS) which enables healthcare providers to receive real-time alerts when that provider's active patient has an encounter with one of the organizations sharing encounter information to CRISP (such as hospitals, skilled nursing facilities, and ambulatory providers). ENS allows for improved care coordination between settings. Care coordinators and nurses can choose to call the hospital to relay important patient information or can call the patient to schedule a post-discharge encounter to reduce the risk of a readmission. CRISP also displays the organizations that are part of a patient's care team, thereby enabling proactive coordination and reducing duplication of services.

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smdl80ll.pdf

Prompts	Summary
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	*Enter text here* Maryland has a Medicaid Health IT Plan. Maryland does not have a standalone Behavioral Health IT Plan.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	The Department intends to assess the applicability of standards referenced in the ISA and 45 CFR 170 Subpart B and will include them, as appropriate in Maryland's Medicaid Managed Care contracts. MDH's Medicaid Enterprise Systems Modular Transformation Program (MMT) has submitted Advanced Planning Documents to CMS for funding in support of Enterprise Integration Solutions, Electronic Documents Management Systems, and the CMS Interoperability Rule. These efforts are part of MMT's overall process to move up the MITA maturity scale. The Department made significant investments to enhance privacy and security capabilities and maturity, including but not limited to, recruiting subject matter experts to build out a security team to conduct routine monitoring as well as system and infrastructure assessments. This team will also be instrumental in developing the overall enterprise security model for continued protection of Maryland's Medicaid data. Much of the state's health IT infrastructure is reused across these purposes. For example, CRISP receives Medicaid claims and encounter data to share them with providers at the point of care. The same database and application programming interfaces (APIs) are being reused to supply data to third party applications on behalf of patients as required by the CMS Interoperability Rule. By consolidating these services, investments to align with industry standards and security protocols are more impactful.

[2] Available at https://www.healthit.gov/isa/.

Prompts	Summary
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and referrals from physician/mental health provider to physician/mental health provider	*Current State: # and/or % of Behavioral Health Providers who have adopted "Certified" EHRs (CEHRT-Certified EHR Technologies) and utilize it for e-referrals and or closed loop referrals.* *1) # and/or % of Behavioral Health Providers who utilize "Direct" secure messaging for e-referrals and or closed loop referrals* *2) # and/or % of Primary Care Providers who have adopted "Certified" EHRs (CEHRT-Certified EHR Technologies) that are utilizing it for e-referrals and or closed loop referrals with mental health providers* *3) # or % of Primary Care Providers who utilize "Direct" secure messaging for e-referrals and or closed loop referrals with Mental Health Providers* Maryland is developing specific critical supportive infrastructure. CRISP does have an MPI-based matching process, which allows the patient data from different sources to link together such that when a user makes a data request; clinical content from across the state is presented in a single view for a particular patient, within CRISP itself or within an EHR through standard APIs. The Social Determinants of Health (SDOH) eReferral Tool is available through the CRISP web-based portal designed

[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.

[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/nowrong-door/index.html.

	to allow providers and select members of their staff to refer patients to various health programs, such as diabetes prevention programs, and Community Based Organizations (CBO), and mental health providers across the region. The eReferral Tool allows somatic providers to send referrals directly to participating providers, along with important notes and medical results for the patient. Receiving providers respond within the tool and provide updates on patient status, which are shared with the referring provider and the patient's care team. Specific counts of primary care providers utilizing e-referrals and or closed loop referrals with mental health providers is indeterminate at this time.
	Future State: Describe thefuture state ofthe health ITfunctionalities outlined below: Maryland plans to expand the use of the eReferral Tool to new providers in the coming years. In addition, some providers already use external systems to generate e-referrals. CRISP plans to support a vendor-agnostic approach that enables display of external referrals in CRISP to provide providers with a more holistic view of patient care across organizations.
	Summary ofActions Needed: Specify a list ofaction items, milestones and responsible individuals/departments needed to make progress in movingfrom the current tofuture state: Technical support to onboard mental health providers in particular will be included. General oversight of service operations by CRISP management personnel and technical support provided by personnel in the field and through the CRISP help desks to eReferral Tool participants will also be included. Technical support activities include ensuring participants are properly configured, utilizing the service, and providing updated panels of patients on a consistent basis to remain compliant with privacy and security protocols. General troubleshooting and resolution of participant-specific questions will also be addressed by technical support personnel.

Prompts	Summary
1.2 Closed loop referrals and ereferrals from institution/hospital/clinic to physician/mental health provider	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* The Social Determinants of Health (SDOH) eReferral Tool is available through the CRISP web-based portal designed to allow providers and select members of their staff to refer patients to various health programs, such as diabetes prevention programs, Community Based Organizations (CBO), and mental health providers across the region. Specific counts of primary care providers utilizing e-referrals and or closed loop referrals with mental health providers is indeterminate at this time.
	Future State: Describe the future state of the health IT functionalities outlined below: In its recent MITA State self-assessment, the Department identified care management as a high priority for capability improvements. Many of the targeted improvements related to care management could be further enhanced by integrating with CRISP's care coordination, point of care, and population health reporting services. The use of the SDOH eReferral Tool will expand the overall use of closed-loop referral tools by Medicaid programs.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: General oversight of service operations by CRISP management personnel and technical support provided by personnel in the field and through the CRISP help desks to eReferral Tool participants will also be included. Technical support activities include ensuring participants are properly configured, utilizing the service, and providing updated panels of patients on a consistent basis to remain compliant with privacy and security protocols. Technical support personnel also address general troubleshooting and resolution of participant-specific questions.

1.3 Closed loop referrals and ereferrals from physician/mental health provider to community based supports	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* The SDOH eReferral Tool is available through the CRISP web-based portal designed to allow providers and select members of their staff to refer patients to various health programs, such as diabetes prevention programs, and Community Based Organizations (CBO) across the region.
	Future State: Describe the future state of the health IT functionalities outlined below: The SDOH eReferral Tool could expand the overall use of closed-loop referral tools by Medicaid programs. The tool will also allow physicians/mental health providers to link patients with community-based supports. By encouraging referrals to be shared through the state-designated HIE – either directly in the CRISP tools or via integrations with existing platforms – providers will have access to a complete set of resources utilized by their patients.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: General oversight of service operations by CRISP management personnel and technical support provided by personnel in the field and through the CRISP help desks to eReferral Tool participants will also be included. Technical support activities include ensuring participants are properly configured, utilizing the service, and providing updated panels of patients on a consistent basis to remain compliant with privacy and security protocols. Technical support personnel also address general troubleshooting and resolution of participant-specific questions.

Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* CRISP's mature data network and data integration capabilities inform Medicaid care and service providers on patient's medical history, care plans, and risk assessments. Medicaid providers can leverage CRISP's technical capabilities through routed data, portal, and integrated data reports. CRISP's network provides Medicaid and providers access to data and tools improving individual's health, quality of care, and Maryland's population health. Health care providers and MCOs are sharing clinical documents with CRISP, including care plans in most cases. Although the care plans are not edited within a central source, they are available to all members of the care team and therefore influence the design and updates of local care plans. CRISP has also developed a separate module for Maryland's Maternal Opioid Misuse Model (MOM Model) called the MOM Care Coordination Module (MOM CCM) that houses a care plan and care plan update. This is shared with patient's providers who have access to CRISP. Care alerts also are sent that are MOM specific when a patient enrolls into MOM and upon discharge that other providers can see within CRISP.
	Future State: CRISP will continue to build connectivity across the state, with a particular focus on mental health providers. The consent utility within CRISP allows patients to register consents compliant with 42 CFR Part 2, allowing these sensitive documents to be shared with care teams according to patient preferences.
	Summary of Actions Needed: General oversight of service operations by CRISP management personnel and technical support provided by personnel in the field and through the CRISP help desks to eReferral Tool participants will also be included. Technical support activities include ensuring participants are properly configured, utilizing the service, and providing updated panels of patients on a consistent basis to remain compliant with privacy and security protocols. Technical support personnel also

	address general troubleshooting and resolution of participant-specific questions

Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* Primary Care Coordination technology used by CRISP is ENS which enables healthcare providers to receive real-time alerts when that provider's active patient has an encounter with one of the organizations sharing encounter information to CRISP (such as hospitals, skilled nursing facilities, and ambulatory providers). ENS allows for improved care coordination between settings. As providers receive real-time alerts, they can access clinical records within CRISP. These records often include discharge summaries and care plans. Mental health providers utilize CRISP for both real-time alerts and clinical records. Behavioral Health Care Coordination technology (DataLink): MDH/ASO are working with LBHAs linked with local detention centers. If a behavioral health client is incarcerated, a DataLink alerts LBHAs. This is an effort to ensure coordination of care between jails and providers. The current focus is on the 16 counties that have a signed Memorandum of Understanding (MOU) in place. ECG accounts have been set up for 16 county LBHAs and detention centers.
	Future State: MDH is working in partnership with the State HIE, CRISP, to enable both the ASO and MCOs to receive alerts for the patient panels, which include emergency department visits and inpatient admissions. These alerts are configurable so the ASO and MCOs can focus on specific types of encounters or patients with specific health concerns. For example, MCOs receive alerts as new patients transfer into their MCO, and the alerts include information such as high-risk patient flags. CRISP will continue to integrate with providers, parse clinical data, and present alert options for the ASO

	and MCOs. Behavioral Health Care Coordination technology (DataLink): BHA, in collaboration with ASO, will be working with the remaining 7 counties to review the process and reason for the DataLink project and to establish the necessary MOUs to begin sharing data.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: MDH will continue to collaborate with CRISP and BHA to integrate new providers, develop new alerts, and execute the DataLink project.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Maryland has not yet reached this milestone. However, the Long Terms Services and Supports Maryland (LTSS Maryland) portal is being updated to integrate existing programs and waivers. 1915(c) Community Pathways, Family Supports, and Community Supports waivers require continuation and expansion of functionality to improve oversight of the Developmental Disabilities Administration (DDA) program by providing tracking and reporting of billing, case management, and assessments. Implementation will support waiver assurances by allowing accurate tracking and reporting on service utilization, billing activities, assessments, and other case management data to ensure that the necessary services are provided appropriately within policy and regulatory guidelines The DDA State-only program supplements the 1915(c) Community Pathways, Family Supports and Community

	Supports Waivers. This project will develop a system that solely handles processing of non-Medicaid, state-only services and integration with LTSSMaryland to improve care coordination and service tracking for participants who receive services via both State-only and Medicaid reimbursable payment streams. The current system integration will assist with over medical record transitions from youth-oriented systems of care to the adult behavioral health system through electronic communications.
	Future State: Describe the future state of the health IT functionalities outlined below: Enhancements to improve reporting and workflow may be required during the further rollout of the DDA modules in FFY22.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Continue integration of DDA into LTSS Maryland
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries who are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Home and Community Based Options Waivers mentioned above utilize LTSS Maryland to enter medical information, plans of service, and facilitate detailed assessments, service authorizations, and claims submissions. Providers enter specific plans of care for youth-oriented waivers into LTSS.
	Future State: Describe the future state of the health IT functionalities outlined below: Continue to maintain and monitor current LTSS system.

	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Continue to maintain and monitor current LTSS system.

Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Home and Community Based Options Waivers mentioned above utilize LTSS to enter medical information, plans of service, and facilitate detailed assessments, service authorizations, and claims submissions. Providers enter specific plans of care for youth-oriented waivers into LTSS.
	Future State: Describe the future state of the health IT functionalities outlined below: N/A
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: N/A
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42	*Current State: Describe the current state of the health IT functionalities outlined below:* Maryland's HIE, CRISP, launched a consent tool in Spring 2021 which enables SUD providers to share data protected by 42 CFR Part 2 through the HIE. This project will improve care coordination between SUD providers and other health care providers, strengthen continuity of care for patients throughout SUD treatment levels, and ease SUD workflow burden when obtaining consent and disclosing information. SUD providers who have executed a qualified service organization agreement (QSOA) with CRISP will share SUD data with the HIE. CRISP will only share SUD information once a patient has registered consent via the CRISP tool. CRISP

CFR part 2 and state laws)	is focusing on sharing relationship information based on patient panels submitted by SUD providers. CRISP is exploring sharing additional data elements with the pilot sites. SUD data will have a notice that states SUD information cannot be re-disclosed due to Part 2 requirements. SUD providers will access the consent tool though the CRISP Unified Landing Page (ULP) or EMR single sign-on (SSO) and will have the option to register a new consent or search for an existing consent on file. There are two forms to document patient consent for Part 2 data sharing (provider or payer) and a consent history log. Patients will indicate their consent preferences and will electronically sign the consent form. Providers must attest to providing patient education and verifying patient identity before registering consent. In addition, the Department is working in partnership with the State HIE, CRISP, to enable both the ASO and MCOs to receive alerts for the patient panels, which include emergency department visits and inpatient admissions.
	Future State: Describe the future state of the health IT functionalities outlined below: Maryland is continuing development on a consent manager and data router to facilitate the exchange of substance use data across the health care system and the integration of data with rules-based exchange provided at the point of care (in-context ENS reporting).
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: CRISP will continue to develop consent manager for providers with a long-term goal of integration at the payer level.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* Providers can share screening information on patients' social determinants of health with CRISP in a number of different formats, including through inputting a structured questionnaire accessible via CRISP, sending SDOH diagnosis codes, or exporting screening questions and answers directly from EMRs. Providers are able to view the information on each patient's available SDOH information within CRISP, eliminating repetitive questions and enhancing coordination of care.

	Future State: The screening capture and display module will be enhanced to include additional types of data and data sources.
	Summary of Actions Needed: General oversight of service operations by CRISP management personnel and technical support provided by personnel in the field and through the CRISP help desks to screening participants will also be included. Technical support activities include ensuring participants are properly configured, and utilizing the service, and remain compliant with privacy and security protocols. Technical support personnel will address general troubleshooting and participant-specific questions.

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Maryland currently allows telehealth and audio-only visits for nearly behavioral health services. Services delivered via telehealth may be provided in the participant's home, a provider's office, or another secure setting. Certain services are where delivery of services via telehealth is not clinically appropriate must be offered in person. For example, OMHCs must maintain the capability to offer services on site. Rules for delivery of group services/activities by psychiatric rehabilitation programs and child and adolescent respite services have reverted back to pre-pandemic requirements and these services must be delivery in-person. In addition, use of telehealth to deliver residential treatment services is limited. At a maximum, only 50% of therapeutic services can be performed via telehealth.

	Future State: Describe the future state of the health IT functionalities outlined below: N/A
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: N/A
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* The state has developed HIT tools to identify persons at risk for hospitalization if they are infected with COVID-19. These algorithms use multiple sources of data to predict risk and are leveraged by Medicaid and MCOs to direct participant outreach.
	Future State: Describe the future state of the health IT functionalities outlined below: Future work could focus on adapting this technology or other models to identify patients that are at risk for discontinuing engagement in their treatment, and notify their care teams in order to ensure treatment continues or resumes.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Scope and plan the work, evaluate risk tool expansion, design, pilot and test, implement statewide.

[5] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

Prompts	Summary
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Much of the provider community, both somatic and mental health, connects to CRISP and share patient rosters. These connections create a robust Master Person Index, which can link records across settings. CRISP links and shares somatic episodes of care and their corresponding clinical documents. Care alerts are currently available to providers and MCOs following hospitalization or ED utilization, which can help flag events such as experience of a first episode of psychosis. CRISP's mature data network and data integration capabilities inform Medicaid care and service providers on patient's medical history, care plans, and risk assessments. Medicaid providers can leverage CRISP's technical capabilities through routed data, portal, and integrated data reports. CRISP's network provides Medicaid and providers access to data and tools improving individual's health, quality of care, and Maryland's population health. Health care providers and MCOs are sharing clinical documents with CRISP, including care plans in most cases. Care plans are not edited within a central source, but they are available to all members of the care team and therefore influence the design and updates of local care plans and coordination efforts.
	Future State: Describe the future state of the health IT functionalities outlined below: CRISP has developed a separate module for Maryland's Maternal Opioid Misuse Model (MOM Model) called the MOM Care Coordination Module (MOM CCM) that houses a care plan and care plan update. Patient providers have access to CRISP and can view the MOM CCM. Care alerts also sent that are MOM specific when a patient enrolls into MOM and upon discharge that other providers can see within CRISP. In the future, this type of model could be replicated in combination with other care coordination components and analytic tools to identify persons during their first episode of psychosis and improve the care coordination as well as the workflow.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Maryland will continue to work with the HIE to develop care alerts and leverage data available in the HIE to better

9/28/21 Submitted on 9/28/21	coordinate care for individuals with SMI. CRISP is working to establish more connectivity with mental health providers. CRISP will link patient consents and records across settings and make them available based on consent preferences.

Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* Parents and caretakers have access to their children's records; however, at this time the care team does not have the ability to link a child's electronic medical records with their respective parent/caretaker medical records.
	Future State: Describe the future state of the health IT functionalities outlined below: The future state of this health IT functionality is unknown at this time.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Specific action items are unknown at this time.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* Much of the provider community, both somatic and mental health, connects to CRISP and share patient rosters. These connections create a robust Master Person Index, which can link records across settings. CRISP links and shares somatic episodes of care and their corresponding clinical documents. *Future State:* CRISP is working to establish more connectivity with mental health providers. CRISP will link patient consents and records across settings and make them available based on consent preferences.
	Summary of Actions Needed: Specify a list of action items, milestones and responsible individuals/departments needed to make progress in moving from the current to future state: Establish connectivity with mental health providers, assure EMR update among providers

- **Section 3: Relevant documents**

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

Attachment I: SMI Monitoring Protocol

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

Substance Use Disorder (SUD)

Note: PRA Disclosure Statement to be added here

Serious Mental Illness and Serious Emotional Disturbance (SMI/SED)

Note: PRA Disclosure Statement to be added here

Table: Serious Mental Illness and Serious Emotional Disturbance Planned Metrics

#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline period (MM/DD/YYYY – MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data source, definition, codes, target population, etc.)**	State plans to phase in reporting (Y/N)	SMI/SED monitoring report in which metric will be phased-in (Format HY/QN; e.g. HY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 20 (Do not delete or edit this one)	*EXAMPLE: Beneficiaries With SMI/SED Treated in an IMD for Mental Health*	*EXAMPLE: Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year*	*EXAMPLE: Milestone 3*	*EXAMPLE: CMS-constructed*	*EXAMPLE: Other annual metrics*	*EXAMPLE: Claims*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020-12/31/2020*	*EXAMPLE: Increase*	*EXAMPLE: Consistent*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (for specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY8Q1*	*EXAMPLE: The demonstration site will be updating its EHR during the start of the demonstration. We plan to phase in reporting after the system update has been completed by mid to late 2021 (DY2).*
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings	Two rates will be reported for this measure: · SUB-2 Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay · SUB-2a Patients who received the brief intervention during the hospital stay	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Medical record review or claims	Year	Annually	Recommended									
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Decrease	Decrease	Y				
6	Medication Continuation Following Inpatient Psychiatric Discharge	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2021-12/31/2022	Increase	Increase	Y				
7	Follow-up After Hospitalization for Mental Illness Ages 6 to 17 (FUH-CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: · Percentage of discharges for which the child received follow-up within 30 days after discharge · Percentage of discharges for which the child received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
8	Follow-up After Hospitalization for Mental Illness Age 18 and Older (FUH-AD)	Percentage of discharges for beneficiaries age 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: · Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge · Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence Age 18 and Older (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: · Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit · Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
10	Follow-Up After Emergency Department Visit for Mental Illness Age 18 and Older (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: · Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit · Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended									
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended									
13	Mental Health Services Utilization - Inpatient	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	Consistent	Consistent	Y		N	DY2Q3	
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	Decrease	Decrease	Y				
15	Mental Health Services Utilization - Outpatient	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
16	Mental Health Services Utilization - ED	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	Decrease	Decrease	Y				
17	Mental Health Services Utilization - Telehealth	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
18	Mental Health Services Utilization - Any Services	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
18a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: · ALOS for all IMDs and populations · ALOS among short-term stays (less than or equal to 60 days) · ALOS among long-term stays (greater than 60 days)	Milestone 3	State Specific	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	1/1/2022-12/31/2022	Consistent	No more than 30 days	Y				
18b	Average Length of Stay in IMDs (IMDs receiving FFP only)	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: · ALOS for all IMDs and populations · ALOS among short-term stays (less than or equal to 60 days) · ALOS among long-term stays (greater than 60 days)	Milestone 3	State Specific	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	1/1/2022-12/31/2022	Consistent	No more than 30 days	Y				
20	Beneficiaries With SMI/SED Treated in an IMD For Mental Health	Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year	Milestone 3	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Consistent	Consistent					
21	Count of Beneficiaries With SMI/SED (monthly)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 11 months before the measurement period	Milestone 4	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
22	Count of Beneficiaries With SMI/SED (annually)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period	Milestone 4	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
23	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (SPC/MI-AD)	Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (> 9.0%)	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
24	Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Recommended									
25	Screening for Depression and Follow-up Plan: Ages 12 to 17 (CDF-CH)	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Electronic medical records	Year	Annually	Recommended									
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: · Percentage of children and adolescents on antipsychotics who received blood glucose testing · Percentage of children and adolescents on antipsychotics who received cholesterol testing · Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who meet the following criteria: · age 18 years and older, and · completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Increase	Increase	Y				
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Consistent	Consistent	Y				
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Consistent	Consistent	Y				
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED- Not Inpatient or Residential	Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries in the demonstration population during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Consistent	Consistent	Y				
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Consistent	Consistent	Y				
36	Grievances Related to Services for SMI/SED	Number of grievances filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	1/1/2022-12/31/2022	Decrease	Decrease	Y				
37	Appeals Related to Services for SMI/SED	Number of appeals filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	1/1/2022-12/31/2022	Decrease	Decrease	Y				
38	Critical Incidents Related to Services for SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	1/1/2022-12/31/2022	Decrease	Decrease	Y				
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Total Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Consistent	Consistent	Y				
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Per capita Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	1/1/2022-12/31/2022	Consistent	Consistent	Y				
State-specific metrics																		
(Insert row(s) for any additional state-specific metrics by right-clicking on row 50 and selecting "Insert")																		

State: Maryland
Demonstration Name: Maryland HealthChoice Program

Table: Serious Mental Illness and Serious Emotional Disturbance Definitions

Narrative description of the SMI/SED demonstration population		
EXAMPLE [a] Adults age 18 or older with serious mental illness or children under the age of 18 with a serious emotional disturbance living within the state.		
	Serious Mental Illness (SMI)	**Serious Emotional Disturbance (SED)**
Narrative description of how the state defines the population for purposes of monitoring (including age range, diagnosis groups, and associated service use requirements)	*Maryland defines the SMI population as the population that has an ICD-10-CM diagnosis from the list below during the measurement period and age 18 or older at the start of the measurement period*	*Maryland defines the SED population as the population that has an ICD-10-CM diagnosis from the list below during the measurement period and Children and Adolescents age under 18 at the start of the measurement period*
Codes used to identify population [b] *States may use ICD-10 diagnosis codes or state-specific treatment, diagnosis, or other types of codes to identify the population. When applicable, states should supplement ICD-10 codes with state-specific codes.*	*For consistency with the Maryland Behavioral Health Administration, the Maryland Medicaid program will use the diagnosis codes below for 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations:* *Adults 18 and older with one of the following diagnoses: "F200" "F201" "F202" "F203" "F205" "F2081" "F2089" "F209" "F21" "F22" "F23" "F24" "F250" "F251" "F258" "F259" "F28" "F29" "F3010" "F3011" "F3012" "F3013" "F302" "F308" "F309" "F310" "F3110" "F3111" "F3112" "F3113" "F312" "F3130" "F3131" "F3132" "F314" "F315" "F3160" "F3161" "F3162" "F3163" "F3164" "F3173" "F3174" "F3175" "F3176" "F3177" "F3178" "F3181" "F3189" "F319" "F320" "F321" "F322" "F323" "F3281" "F3289" "F329" "F330" "F331" "F332" "F333" "F338" "F339" "F349" "F600" "F601" "F602" "F603" "F604" "F605" "F606" "F607" "F6081" "F6089" "F609" "F630"*	*For consistency with the Maryland Behavioral Health Administration, the Maryland Medicaid program will use the diagnosis codes below for 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations:* *Children and Adolescents under 18 years old with one of the following diagnoses:* *"F200" "F201" "F202" "F203" "F205" "F2081" "F2089" "F209" "F21" "F22" "F23" "F250" "F251" "F258" "F259" "F28" "F29" "F3010" "F3011" "F3012" "F3013" "F302" "F308" "F309" "F310" "F3110" "F3111" "F3112" "F3113" "F312" "F3130" "F3131" "F3132" "F314" "F315" "F3160" "F3161" "F3162" "F3163" "F3164" "F3173" "F3174" "F3175" "F3176" "F3177" "F3178" "F3181" "F3189" "F319" "F320" "F321" "F322" "F323" "F3281" "F3289" "F329" "F330" "F331" "F332" "F333" "F338" "F339" "F341" "F3481" "F3489" "F349" "F39" "F4001" "F4010" "F4011" "F408" "F409" "F410" "F411" "F413" "F418" "F419" "F430" "F4310" "F4311" "F4312" "F4320" "F4321" "F4322" "F4323" "F4324" "F4325" "F4329" "F438" "F439" "F440" "F441" "F442" "F4481" "F4489" "F449" "F488" "F489" "F5000" "F5001" "F5002" "F502" "F5081" "F5082" "F5089" "F509" "F600" "F601" "F602" "F603" "F604" "F605" "F606" "F607" "F6081" "F6089" "F609" "F631" "F632" "F6381" "F6389" "F639" "F6811" "F6813" "F843" "F848" "F849" "F900" "F901" "F902" "F908" "F909" "F911" "F912" "F913" "F918" "F919"*
Procedure (e.g., CPT, HCPCS) or revenue codes used to identify/define service requirements [b] *If the state is not using procedure or revenue codes, the state should include the data source(s) (e.g., state-specific codes) used to identify/define service requirements.*	*N/A*	*N/A*

[a] The examples are based on a definition of SMI from the National Committee for Quality Assurance (NCQA). The examples provided are intended to be illustrative only. The example codes provided are not comprehensive.
[b] States may choose to include codes as separate tabs in this workbook.

Table: Serious Mental Illness and Serious Emotional Disturbance Planned Subpopulations

						Subpopulations		Relevant metrics	
Subpopulation category	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[a,b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: *Age group* ***(Do not delete or edit this row)***	*EXAMPLE:* *Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)*	*EXAMPLE:* *Required*	*EXAMPLE:* *Metrics #11, 12, 13, 14, 15, 16, 17, 18, 21, 22*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *N*	*EXAMPLE:* *Children/Young adults (ages 12-20), Adults (ages 21-65)*	*EXAMPLE:* *N*	*EXAMPLE:* *11, 12, 13, 14*
Standardized definition of SMI[d]	Individuals who meet the standardized definition of SMI	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y			Y	
State-specific definition of SMI	Individuals who meet the state-specific definition of SMI	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	State-specific	N				
Age group	Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)	Required	Metrics #11, 12, 13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Disability	Eligible for Medicaid on the basis of disability, Not eligible for Medicaid on the basis of disability	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided					
Criminal justice status	Criminally involved, Not criminally involved	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided					
Co-occurring SUD	Individuals with co-occurring SUD	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided					
Co-occurring physical health conditions	Individuals with co-occurring physical health conditions	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided					
State-specific subpopulations									
QRTPs that are IMDs	Individuals treated within QRTPs that are IMDs	State-specific	Metrics #19a and 19b	State-specific	Y				

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Reporting schedule (Version 3.0)

State Maryland

Demonstration Name Maryland HealthChoice Program

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the SMI/SED demonstration reporting schedule in Table 2. All ce accurately auto-populated.

(2) Review the state's reporting schedule in the SMI/SED demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column F, select Y or state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting "Explanation for deviations (if column H="Y")" and use column J, “Proposed deviation in measurement period from standard reporting schedule in column G,” to indicate the (column G). All other columns are locked for editing and should not be altered by the state.

Table 1. Serious Mental Illness and Serious Emotional Disturbance Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SMI/SED demonstration year:	
Start date	01/01/2022
End date	12/31/2022
Dates of first quarter of the baseline period for CMS-constructed metrics:	
(SMI/SED DY and Q (Format DY#Q#; e.g., DY1Q1)	DY1Q1
Start date	01/01/2022
End date	03/31/2022
Broader section 1115 demonstration reporting period corresponding with the first SMI/SED reporting quarter, if applicable. If there is no broader demonstration, fill in the first SMI/SED reporting period. (Format DY#Q#; e.g., DY3Q1)	DY25Q3
First SMI/SED monitoring report due date (per STCs) (MM/DD/YYYY)	05/30/2022
First SMI/SED monitoring report in which the state plans to report annual metrics that are established quality measures (EQMs):	
EQMs (Format CY#; e.g.,	CY2022
SMI/SED DY and Q associated with monitoring report (Format DY#Q#; e.g., DY1Q1)	DY2Q3
SMI/SED DY and Q start date	07/01/2023
SMI/SED DY and Q end date	09/30/2023
Dates of last SMI/SED reporting quarter:	
Start date	10/01/2026
End date	12/31/2026

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
01/01/2022	03/31/2022	05/30/2022	DY25Q3	DY1Q1	Narrative information	DY1Q1	N		
					Grievances and appeals	DY1Q1	N		
					Other monthly and quarterly metrics				
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics				
04/01/2022	06/30/2022	09/28/2022	DY25Q4	DY1Q2	Narrative information	DY1Q2	N		
					Grievances and appeals	DY1Q2	N		
					Other monthly and quarterly metrics	DY1Q1	N		
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2022	09/30/2022	11/29/2022	DY26Q1	DY1Q3	Narrative information	DY1Q3	N		
					Grievances and appeals	DY1Q3	N		
					Other monthly and quarterly metrics	DY1Q2	N		
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics				
10/01/2022	12/31/2022	03/01/2023	DY26Q2	DY1Q4	Narrative information	DY1Q4	N		
					Grievances and appeals	DY1Q4	N		
					Other monthly and quarterly metrics	DY1Q3	N		
					Annual availability assessment	AA1	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2023	03/31/2023	05/30/2023	DY26Q3	DY2Q1	Narrative information	DY2Q1	N		
					Grievances and appeals	DY2Q1	N		
					Other monthly and quarterly metrics	DY1Q4	N		
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics	DY1	N		
04/01/2023	06/30/2023	09/28/2023	DY26Q4	DY2Q2	Narrative information	DY2Q2	N		
					Grievances and appeals	DY2Q2	N		
					Other monthly and quarterly metrics	DY2Q1	N		
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics				

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
07/01/2023	09/30/2023	11/29/2023	DY27Q1	DY2Q3	Narrative information	DY2Q3	N		
					Grievances and appeals	DY2Q3	N		
					Other monthly and quarterly metrics	DY2Q2	N		
					Annual availability assessment				
					Annual metrics that are established quality measures	CY2022	N		
					Other annual metrics				
10/01/2023	12/31/2023	02/29/2024	DY27Q2	DY2Q4	Narrative information	DY2Q4	N		
					Grievances and appeals	DY2Q4	N		
					Other monthly and quarterly metrics	DY2Q3	N		
					Annual availability assessment	AA2	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2024	03/31/2024	05/30/2024	DY27Q3	DY3Q1	Narrative information	DY3Q1	N		
					Grievances and appeals	DY3Q1	N		
					Other monthly and quarterly metrics	DY2Q4	N		
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics	DY2	N		
04/01/2024	06/30/2024	09/28/2024	DY27Q4	DY3Q2	Narrative information	DY3Q2	N		
					Grievances and appeals	DY3Q2	N		
					Other monthly and quarterly metrics	DY3Q1	N		
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics				

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
07/01/2024	09/30/2024	11/29/2024	DY28Q1	DY3Q3	Narrative information	DY3Q3	N		
					Grievances and appeals	DY3Q3	N		
					Other monthly and quarterly metrics	DY3Q2	N		
					Annual availability assessment				
					Annual metrics that are established quality measures	CY2023	N		
					Other annual metrics				
10/01/2024	12/31/2024	03/01/2025	DY28Q2	DY3Q4	Narrative information	DY3Q4	N		
					Grievances and appeals	DY3Q4	N		
					Other monthly and quarterly metrics	DY3Q3	N		
					Annual availability assessment	AA3	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2025	03/31/2025	05/30/2025	DY28Q3	DY4Q1	Narrative information	DY4Q1	N		
					Grievances and appeals	DY4Q1	N		
					Other monthly and quarterly metrics	DY3Q4	N		
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics	DY3	N		
04/01/2025	06/30/2025	09/28/2025	DY28Q4	DY4Q2	Narrative information	DY4Q2	N		
					Grievances and appeals	DY4Q2	N		
					Other monthly and quarterly metrics	DY4Q1	N		
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2025	09/30/2025	11/29/2025	DY29Q1	DY4Q3	Narrative information	DY4Q3	N		
					Grievances and appeals	DY4Q3	N		
					Other monthly and quarterly metrics	DY4Q2	N		
					Annual availability assessment				
					Annual metrics that are established quality measures	CY2024	N		
					Other annual metrics				

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
10/01/2025	12/31/2025	03/01/2026	DY29Q2	DY4Q4	Narrative information	DY4Q4	N		
					Grievances and appeals	DY4Q4	N		
					Other monthly and quarterly metrics	DY4Q3	N		
					Annual availability assessment	AA4	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
01/01/2026	03/31/2026	05/30/2026	DY29Q3	DY5Q1	Narrative information	DY5Q1	N		
					Grievances and appeals	DY5Q1	N		
					Other monthly and quarterly metrics	DY4Q4	N		
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics	DY4	N		
04/01/2026	06/30/2026	09/28/2026	DY29Q4	DY5Q2	Narrative information	DY5Q2	N		
					Grievances and appeals	DY5Q2	N		
					Other monthly and quarterly metrics	DY5Q1	N		
					Annual availability assessment				
					Annual metrics that are established quality measures				
					Other annual metrics				
07/01/2026	09/30/2026	11/29/2026	DY30Q1	DY5Q3	Narrative information	DY5Q3	N		
					Grievances and appeals	DY5Q3	N		
					Other monthly and quarterly metrics	DY5Q2	N		
					Annual availability assessment				
					Annual metrics that are established quality measures	CY2025	N		
					Other annual metrics				

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
10/01/2026	12/31/2026	03/01/2027	DY30Q2	DY5Q4	Narrative information	DY5Q4	N		
					Grievances and appeals	DY5Q4	N		
					Other monthly and quarterly metrics	DY5Q3	N		
					Annual availability assessment	AA5	N		
					Annual metrics that are established quality measures				
					Other annual metrics				
[Add rows for all additional demonstration reporting quarters]									

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

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

AA# refers to the Annual Assessment of the Availability of Mental Health Services ("Annual Availability Assessment") and the SMI/SED DY in which the Annual Availability Assessment will be submitted (for example, "AA1" refers to the Annual Availability Assessment that will be submitted with the state's annual monitoring report for SMI/SED DY1). Data in each Annual Availability Assessment should be reported as of the month and day indicated in the state's approved monitoring protocol. If the state cannot submit its Annual Availability Assessments when it submits its annual monitoring reports, it should propose and describe a reporting deviation in Columns G and H.

Attachment J: Maternal Opioid Misuse Model Protocol

Maternal Opioid Misuse (MOM) Model Protocol

The Maternal Opioid Misuse (MOM) Model Pilot Program will operate less than statewide from July 1, 2022 through December 31, 2022. The state expects for the MOM Model to operate statewide beginning January 1, 2023. The state may submit a request to modify the protocol to specify additional jurisdictions.

Time Period	Jurisdictions
July 1, 2022 through December 31, 2022	St. Mary's County
	[Placeholder for additional jurisdictions]

Attachment K:
Reentry Monitoring Protocol [Reserved]

Attachment L:
Reentry Demonstration Initiative Services

Covered Service	Definition
Case Management	Comprehensive case management will underpin the demonstration's services and facilitate participants' transition and access to post-release services and care in the community, leveraging Community Health Workers as part of the case management team to support the individual's overarching case management goals. Maryland proposes to provide reentry case management services in a manner similar to the current "Targeted Case Management" benefit offered to people with serious mental illness (SMI). Maryland intends to create a similar benefit for this proposed demonstration population, beginning with people diagnosed with substance use disorder (SUD) or SMI, with the potential of expanding to other identified populations in future years. Case management will begin 90 days prior to release and will leverage Community Health Workers as appropriate to support the individual's overarching case management goals. Case management will follow CMS guidelines laid out in the April 2023 State Medicaid Director Letter on Reentry Strategies. Specific activities will include: a) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, education, social or other services; b) Development (and periodic revision) of a specific care plan based on the information collected through the assessment; c) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed supportive and stabilizing services, including activities that help link the individual with medical, social and education providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and d) Monitoring and follow-up activities, including activities and communications that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary.
Medication Assisted Treatment (MAT) Services	MAT includes medication in combination with counseling/behavioral therapies, as appropriate and individually determined, and will be available for substance use disorders (including alcohol use disorder) as clinically appropriate in the 90-day pre-release period. MAT will include services of Certified Peer Recovery Specialists as clinically appropriate to support an individual's recovery.
30-day Supply of Prescription Medications	30-day supply of all prescription medications provided to the individual immediately upon release from a correctional facility, as clinically appropriate based on the medication and indication.

Attachment M:
Reentry Demonstration Initiative Health-Related Criteria

Qualifying Condition	Definition
Substance use disorder (SUD)	A person with a "Substance Use Disorder" (SUD) shall either: i. Meet SUD criteria, according to the criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders or the International Statistical Classification of Diseases and Related Health Problems; OR ii. Have a suspected SUD diagnosis that is being assessed through the Texas Christian University Drug Screening 5 (TCU5), the Treatment Assignment Protocol (TAP), or other state approved screening tool.
Serious mental illness (SMI)	A person with a "Serious Mental Illness" is a person who is currently receiving mental health services or medications OR meets both of the following criteria: Has one of the following diagnoses: ● F20.0 Paranoid Schizophrenia ● F20.1 Disorganized Schizophrenia ● F20.2 Catatonic Schizophrenia ● F20.3 Undifferentiated schizophrenia ● F20.5 Residual schizophrenia ● F20.81 Schizophreniform Disorder ● F20.89 Other schizophrenia ● F20.9 Schizophrenia, unspecified ● F22 Delusional Disorders ● F25.0 Schizoaffective Disorder, Bipolar Type ● F25.1 Schizoaffective Disorder, Depressive Type ● F25.8 Other Schizoaffective Disorders ● F25.9 Schizoaffective Disorder, unspecified ● F28 Other Specified Schizophrenia Spectrum and Other Psychotic Disorder ● F29 Unspecified Schizophrenia Spectrum and Other Psychotic Disorder ● F31.0 Bipolar I Disorder, Current or Most Recent Episode Hypomanic ● F31.13 Bipolar I Disorder, Current or Most Recent Episode Manic, Severe ● F31.2 Bipolar I Disorder, Current or Most Recent Episode Manic, With Psychotic Features ● F31.4 Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe ● F31.5 Bipolar I Disorder, Most Recent Episode Depressed, With Psychotic Features ● F31.63 Bipolar I Disorder, Mixed, Severe, Without Psychotic Features

	• F31.64 Bipolar I Disorder, Mixed, Severe With Psychotic Features • F31.81 Bipolar II Disorder F31.9 Bipolar I Disorder, Unspecified • F33.2 Major Depressive Disorder, Recurrent Episode, Severe • F33.3 Major Depressive Disorder, Recurrent Episode, With Psychotic Features • F60.3 Borderline Personality Disorder • Or other state-approved diagnosis from the ICD-10 CM, Chapter 5, "Mental, Behavioral Health, and Neurodevelopmental Disorders," subchapter F60-69 AND Meets the following functional limitations: Serious mental illness is characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following: • Inability to maintain independent employment, • Social behavior that results in interventions by the mental health system, • Inability, due to cognitive disorganization, to procure financial assistance to support living in the community, • Severe inability to establish or maintain a personal support system, or • Need for assistance with basic living skills.
The definitions align with ICD-10 CM, Chapter 5, "Mental, Behavioral Health, and Neurodevelopmental Disorders." The conditions listed in Chapter 5: subchapter 1, "Mental disorders due to known physiological conditions" (F01 to F09), subchapter 8, "Intellectual disabilities" (F70 to F79), and subchapter 9, "Pervasive and specific developmental disorders" (F80 to F89) are excluded.	

Attachment N:
Reentry Demonstration Initiative Implementation Plan [RESERVED]

Attachment O:
Reentry Demonstration Initiative Reinvestment Plan [RESERVED]