



February 7, 2022

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

Dear Mr. Schuh:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the “Maryland HealthChoice” demonstration (Project No: 11-W-00099/3) that was approved on December 10, 2021. The technical corrections will ensure the special terms and conditions (STCs) reflect how the state will operate the Maryland HealthChoice section 1115 demonstration. A copy of the updated STCs, waivers, and expenditure authorities are enclosed.

At the state’s request, STC 17(c), STC 19(e), STC 24, Attachment F, and STC 70 (Table 2) have been revised to correct typographical errors as follows:

- STC 17(c)(i) & (ii):
 - Copayments of \$3.00 per prescription and refill for non-preferred drugs;
 - Copayments of \$1.00 per prescription and refill for preferred brand name and generic drugs, and HIV/AIDS drugs.

- STC 19(e)(i) & (ii):
 - Copayments of \$3.00 per prescription and refill for non-preferred drugs;
 - Copayments of \$1.00 per prescription and refill for preferred brand name and generic drugs, and HIV/AIDS drugs.

- STC 24 and Attachment F
STC 24
 - Under this pilot program, the state will provide a set of Home and Community Based Services (HCBS) to a population that meets that eligibility criteria in Attachment F, capped at 900 individuals annually.Attachment F

- 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.
- STC 70 (Table 2: MEG Detail for Expenditures and Member Month Reporting)
 - MOM Model “Implementation Date” and “End Date”
 - Implementation Date: 07/01/2022
 - End Date: 12/31/2026

Your project officer, Mr. Felix Milburn is available to address any questions you have related to this correspondence. Mr. Milburn can be reached at (410) 786-1315 or Felix.Milburn@cms.hhs.gov.

We look forward to continuing to work with you and your staff on the Maryland HealthChoice section 1115 demonstration.

Sincerely,

Angela D.
Garner -S



Digitally signed by Angela
D. Garner -S
Date: 2022.02.07
17:03:32 -05'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Talbatha Myatt, State Monitoring Lead, 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.

Amount, Duration, and Scope **Section 1902(a)(10)(B)**
To enable the state to provide benefits specified in the STCs to demonstration participants in the Rare and Expensive Case Management program which are not available to other individuals under the Medicaid State plan.

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

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

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

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

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

**CENTERS FOR MEDICARE & MEDICAID SERVICES
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 19, 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 24.
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 27, 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 28, 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 29, 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 32.
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 30.
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 31.

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.

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

NUMBER: 11-W-00099/3

TITLE: HealthChoice Medicaid Section 1115 Demonstration

AWARDEE: Maryland Department of Health (MDH)

I. PREFACE

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

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

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility and Enrollment, Benefits, and Programs
- V. General Reporting Requirements
- VI. General Financial Requirements Under Title XIX
- VII. General Financial Requirements Under Title XXI
- VIII. Monitoring Budget Neutrality
- IX. Evaluation of the Demonstration
- X. Schedule of State Deliverables for the Demonstration Period

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

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Interim and Summative Evaluation Reports
Attachment C: Evaluation Design [Reserved]

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 [Reserved]
Attachment H: SMI Implementation Plan [Reserved]
Attachment I: SMI Monitoring Protocol [Reserved]
Attachment J: Maternal Opioid Misuse Model Pilot Program Protocol

II. 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:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered;
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a primary care provider (PCP); and,
- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care.

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

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

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

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

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

The 2017 extension made the following changes to the demonstration:

- Created a Residential Treatment for Individuals with Substance Use Disorder (SUD) Program as part of a comprehensive SUD strategy;
- Created two Community Health Pilot programs:
 - Evidence-based Home Visiting Services (HVS) Pilot for high-risk pregnant women and children up to two (2) years of age; and
 - Assistance in Community Integration Services (ACIS) Pilot;

- Raised the enrollment cap for the Increased Community Services Program from 30 to 100; and,
- Expanded dental benefits for former foster youth.

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

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

The state will test whether the HealthChoice section 1115 demonstration 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 modifies three demonstration programs and adds three new demonstration programs.

Program/Services Modifications:

1. Assistance in Community Integration Services Pilot Program: The state will add 300 participants spaces for the ACIS pilot program to a total of 900 individuals annually.
2. Home Visiting Services Pilot Program: The state will increase 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 has removed any 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.

III. GENERAL PROGRAM REQUIREMENTS

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).
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. **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 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.
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 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.
- 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.
- 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 7 below, except as provided in STC 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 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.
- 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 9.
- 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 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.

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.

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.

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 7 or extension, are proposed by the state.

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.

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.

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).

IV. ELIGIBILITY AND ENROLLMENT

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.

16. 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.

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

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

Medicaid State Plan Mandatory Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Expenditure and CMS-64 Eligibility Group Reporting
New Adult Group	Childless adults and non-custodial parents ages 19-64 with income up to 133 percent of the FPL as defined in section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, pursuant to the approved state plan.	New Adult Group

TANF adults, pregnant women, parents, and caretaker adults	Families with dependent children and foster children with incomes less than 123 percent of the FPL, including individuals with incomes below the pre-July 1, 2008, TANF income thresholds.	TANF Adults 0-123
Medicaid Child	Children up to 21 years of age.	Medicaid Child
SOBRA Adults	Pregnant women with incomes above the pre-July 1, 2008, standard up to and including 250 percent of the FPL who are not enrolled in the TANF group.	SOBRA Adults
Non-Dual Blind and Disabled	Individuals whose Medicaid eligibility derives from their status as blind or disabled and who are not entitled to Medicare.	SSI/BD Adults or SSI/BD Children
Medicaid State Plan Optional Group	FPL and/or Other Qualifying Criteria	Expenditure and CMS-64 Eligibility Group Reporting
Medically Needy Adults and Children	Families with dependent children, or foster children, whose gross income and resources exceed 116 percent of the FPL but who incur medical expenses such that their income is equal to or less than 116 percent FPL.	MN Adults or MN Children
Optional targeted low-income children through age 18.	Up to first birthday: Between 185 and 200 percent of the FPL; On first birthday through age 5: between 133 and 200 percent of the FPL; and Upon sixth birthday through age 18: between 100 and 200 percent of the FPL.	MCHP (Only during periods when title XXI funding is exhausted)
Optional targeted low-income children through age 18	Between 200 percent of the FPL and 300 percent of the FPL who pay a premium.	MCHP Premium (Only during periods when title XXI funding is exhausted)
Demonstration Eligible Groups	FPL and/or Other Qualifying Criteria	Expenditures and CMS-64 Eligibility Group Reporting.
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	WBCCHP

	31, 2013.	
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 24.	ACIS
Evidence-Based Home Visiting Services (HVS) Pilot *Effective July 1, 2017	Effective July 1, 2017, expenditures for evidence-based home visiting services to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children.	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 27.	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 28.	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 29.	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	AD Transport Pilot

	jurisdictions.	
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 32.	SMI IMD

- b. HealthChoice Benefits. The HealthChoice program provides comprehensive Medicaid state plan benefits to demonstration participants. The new adult group receives benefits provided through the state’s approved alternative benefit plan (ABP) state plan.
- c. 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.
- d. Redetermination and Disenrollment. Redeterminations and disenrollment are made in accordance with the Medicaid state plan.
- e. Delivery System. Physical health and vision benefits are rendered through one of nine Medicaid MCOs; rehabilitation services (occupational therapy, physical therapy, and speech) are rendered on a fee for service basis for children (20 years old and under); dental services are rendered through a dental Administrative Services Organization (ASO); and specialty behavioral health benefits (mental health and substance use disorder benefits) are rendered through an ASO, other than those provided through the CoCM pilot. The managed care authority applies to all populations.

18. 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.

19. Increased Community Services (ICS) Program

- a. Participation. Expenditures for home and community-based and state plan services provided to individuals over the age of 18 who were determined Medicaid eligible while residing in a nursing facility based on an income eligibility level of 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR) after consideration of incurred medical expenses, meet the state plan resource limits, and are transitioning imminently, or have transitioned, to a non-institutional community placement, subject to the following conditions:
 - i. Individuals must meet one of the following criteria:
 - a. Is residing (and has resided for at least ninety (90) consecutive days) in a nursing facility and is receiving Medicaid benefits for nursing home services furnished by such nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for

purposes of determining the ninety (90) day nursing home stay requirement;
or

- b. Is currently receiving services through the Home and Community-Based Options waiver, and whose income exceeds the income eligibility threshold by no more than 5 percent. These individuals would be permitted to transition directly into the ICS program as long as they continued to meet the nursing facility level-of-care standard. The ninety (90) day nursing home stay requirement does not apply to these individuals.
 - ii. Individuals are not otherwise eligible for a waiver program operated under the authority of section 1915(c) of the Act; and,
 - iii. The cost to Medicaid for the individual in the community must be less than the cost to Medicaid if the individual were to remain in the institution based on individual cost neutrality.
- b. Benefits. This program provides Medicaid state plan benefits and home and community-based services identical to those provided under the Community Options 1915(c) waiver. These services enable the participant to live at home with appropriate supports rather than in a nursing facility.
 - c. Enrollment Cap. The number of participants that may be enrolled in the ICS program at any one time is limited to 100. The state will create a registry that identifies all individuals eligible for the program who have indicated interest in receiving home and community-based services. The registry will be sorted based on date and time of interest. As slots become available, the state shall will notify individuals on the registry in numerical order of the opportunity to participate in the ICS program. Interested individuals will have fifteen (15) days to indicate whether or not they are still interested in participating. If after fifteen (15) days an individual fails to respond, a second letter will be mailed to the individual. If state receives no response in seven (7) days after the second letter is mailed, the state will remove the individual's name from the registry, and offer that slot to the next person on the registry.
 - d. Assurances. For the ICS population the state will comply with the HCBS assurances contained in 42 C.F.R. 441.302.
 - e. Cost Sharing. All cost-sharing must be in compliance with Medicaid requirements for state plan populations that are set forth in statute, regulation and policies and all demonstration enrollees must be limited to a five percent aggregate cost sharing limit per family. Cost sharing must be equal to or less than:
 - i. 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.
- f. Delivery System. The state will operate the ICS program in a manner consistent with its approved Community Options 1915(c) waiver program and must meet all quality, administrative, operational, and reporting requirements contained therein.
- g. Redetermination and Disenrollment. Redetermination and disenrollment decisions will be made in accordance with the Medicaid State plan.

20. 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.

21. 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 18.
- 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 20.
- g. Employed Individuals with Disabilities (EID) participants as of October 1, 2008.

h. Certain foster care groups:

- i. A child receiving an adoption subsidy who is covered under the parent’s private insurance;
- ii. A child under State supervision receiving an adoption subsidy who lives outside the state; and
- iii. A child under State supervision who is in an out-of-state placement.

22. 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 23, 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	State plan

		individualized treatment 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 Managed Population-Specific High Intensity Residential Services	Clinically managed therapeutic rehabilitative facility for adults with cognitive impairment including developmental delay that provides rehabilitation services to recipients with 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.	Section 1115 demonstration (Covered for recipients aged 21 to 64)
3.5	Clinically Managed High Intensity Residential Services	Clinically managed therapeutic community or residential treatment facility providing high intensity services for adults or medium intensity services for adolescents when determined to be medically necessary and in accordance with an individualized treatment plan. Staffed by licensed/credentialed clinical staff, including addiction counselors, licensed clinical social workers, licensed professional counselors, physicians/physician extenders, and credentialed mental health professionals.	Section 1115 demonstration (Covered for recipients aged 21 to 64)
3.7	Medically Monitored Intensive Inpatient Services	Medically monitored inpatient services in a freestanding residential facility or inpatient unit of an acute care hospital or psychiatric unit when determined to be medically necessary and in accordance with an individualized treatment plan. Includes 24-hour clinical supervision including physicians, nurses, addiction counselors and behavioral health specialists.	Section 1115 demonstration (Covered for recipients aged 21 to 64)
4.0	Medically Managed Intensive Inpatient Hospital Services	Acute care general or psychiatric hospital with 24/7 medical management and nursing supervision and counseling services (16 hours per day). Managed by addiction specialist physician with interdisciplinary team of credentialed clinical	State plan

		staff knowledgeable of biopsychosocial dimensions of addictions.	
Opioid Treatment Services	Opioid Maintenance Therapy	Physician-supervised daily or several times weekly opioid agonist medication and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder in Maryland Department of Health (MDH) licensed methadone clinics in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of Maryland requirements.	State plan
Opioid Treatment Services	Office Based Opioid Treatment	Physician-supervised medication and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder by primary care providers and other physician offices in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of Maryland requirements.	State plan
1 WM	Ambulatory Withdrawal Management Without Extended On-Site Monitoring	Ambulatory withdrawal management without extended on-site monitoring with specialized psychological and psychiatric consultation and supervision.	State plan
2 WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring	Ambulatory withdrawal management with extended on-site monitoring with clinical (medical) consultation and supervision.	State plan
3.7 WM	Medically Monitored Inpatient Withdrawal 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.

23. 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.

24. 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 900 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 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 (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.

- 25. 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.
- 26. 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.
- 27. 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 $\geq 25 \text{ kg/m}^2$; $\geq 23 \text{ kg/m}^2$, 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.

- 28. 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

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.

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
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 D0274.
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

Code	Description
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).

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

CoCM Pilot Program Eligibility Requirement:

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

CoCM Pilot Program Services:

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

- 1) Evidence Based Therapeutic Intervention Services:

- i. **Behavioral activation:** A therapeutic intervention that is often used to treat depression, which includes scheduled activities to change the environment of the beneficiary and improve the mood of the beneficiary.
 - ii. **Motivational interviewing and problem-solving therapy:** A therapeutic intervention that helps beneficiaries establish and embrace behavioral changes that support better health outcomes.
- 2) Targeted Case Management Services:
- i. Care coordination;
 - ii. Monitoring and treatment services using a validated clinical rating scale;
 - iii. Caseload review and consultation for patients who do not show clinical improvement; and
 - iv. Referrals
 - a) In the case that a beneficiary requires additional psychiatric services outside the collaborative care intervention, the behavioral health care manager, under the direction of the psychiatric consultant, will schedule psychiatric or crisis services.

30. 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 outreach² 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

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.

calls and one letter in the mail).

31. 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.

32. 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:

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 34 below.

33. 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 33(e). 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 39.
- 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.**
 1. 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;

2. 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;
3. 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;
4. 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;
5. 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);

6. 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.**
1. 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);
 2. 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;
 3. 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;
 4. 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);
 5. 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.**

1. 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;
2. Commitment to implementation of the SMI/SED financing plan described in STC 33(e);
3. 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;
4. 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**

1. 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;
2. 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;
3. 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 33), 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 42).

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.
 1. 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.

2. 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 33, 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.

34. 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 41 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 33 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 33(d);
- 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.

35. 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.

36. 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 37.

37. 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) Q RTPs are not subject to the 30-day average length of stay requirement as described in STC 32 or the 60-day length of stay requirement as described in STC 36 for the first 2 years of the demonstration period.

V. GENERAL REPORTING REQUIREMENTS

- 38. 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.

- 39. 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.
- 40. Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.
- 41. 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.
- 42. Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate 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 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 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 challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. Performance Metrics. Per applicable CMS guidance and technical assistance, the performance metrics will provide data to support tracking the state's progress with the demonstration policies and initiatives towards their corresponding milestones and/or goals, and must cover all key policies under this demonstration. 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 beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals.

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. Administrative costs for this demonstration should be reported separately on the CMS-64.

- 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 33(d).

- 43. 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.
- 44. 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 10. CMS will withdraw an authority, as described in STC 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.
- 45. 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 38.
- 46. 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.
47. **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.

VI. EVALUATION OF THE DEMONSTRATION

48. **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 38.
49. **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.
50. **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 54 and 55.

- 51. 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.
- 52. 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, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF). CMS underscores the importance of the state undertaking a well-designed beneficiary survey to assess, for instance, beneficiary understanding of the various demonstration policy components, including the waiver of retroactive eligibility, beneficiary experiences with access to and quality of care, as well as changes in incidence of beneficiary medical debt.

- 53. 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.
- 54. 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.

55. 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.

- a) 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.
- b) 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.

56. 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 10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

57. **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.
58. **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.
59. **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.

VII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

60. **Allowable Expenditures.** 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
61. **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.

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.

- 62. 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.
- 63. 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:
- 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.

64. 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.

65. 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.

66. 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 38.

67. 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.

68. 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.

69. 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 1: 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.
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 1: 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.
Assistance in Community Integration Services (ACIS) Pilot Program	Main			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	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.

Table 1: Master MEG Chart

Program (BCCTP)					
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.
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).

70. 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 2: 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 individuals with incomes below the pre-July 1, 2008, TANF income thresholds.	Exclude expenditures for services and populations listed in STC 17(e)	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/1997	12/31/2026
Medicaid Children	Children up to 21 years of age.	Exclude expenditures for services and populations listed in STC 17(e)	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 17(e)	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 17(e)	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	Exclude expenditures for services and populations	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/1997	12/31/2026

Table 2: MEG Detail for Expenditure and Member Month Reporting

	who are not enrolled in the TANF group.	listed in STC 17(e)						
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 17(e)	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 17(e)	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 FPL as defined in section 1902(a)(10)(A)(i)(V III) of the Act and 42 CFR 435.119, pursuant to the approved state plan.	Exclude expenditures for services and populations listed in STC 17(e)	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	Y	07/01/1997	12/31/2026
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	7/1/2017	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	1/1/17	12/31/26
Residential Treatment for Individuals	Expenditures for SMI treatment in IMDs	None	Follow standard CMS-64.9 category	Date of service	MAP	Y	1/1/22	12/31/26

Table 2: MEG Detail for Expenditure and Member Month Reporting

with Serious Mental Illness			of service definitions ; Line 2A – Mental Health Facility Services - Reg. Payments for IMD					
Assistance in Community Integration Services (ACIS) Pilot Program	Expenditures for the ACIS Pilot as described in STC 28.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	N	7/1/17	12/31/26
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	N	7/1/17	12/31/26
HealthChoice Diabetes Prevention Program (DPP) Pilot Program	Expenditures for a National Diabetes Prevention Program for individuals 18-64 who have prediabetes or are at high risk of developing type 2 diabetes as described in STC 31.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	N	7/1/19	12/31/26
Adult Dental Program	Expenditures for a limited dental benefit for full dually eligible adults (21-64) as described in STC 33.	None	Line 8 – Dental Services OR Line 18A – Medicaid - MCO	Date of service	MAP	N	4/1/19	12/31/26
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	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	N	07/01/2017	12/31/26

Table 2: MEG Detail for Expenditure and Member Month Reporting

	income level at or below 300 percent of the Social Security Income Federal Benefit Rate (SSI FBR).							
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	N	1/1/14	12/31/26
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	N	07/01/2017	12/31/26
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 34.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	N	7/1/20	12/31/26
Maternal Opioid Misuse (MOM) Model pilot program	Expenditures to establish a MOM care coordination model.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	N	7/1/22	12/31/26
Medicaid Alternative Destination Transport Pilot Program	Expenditures for SMI treatment in IMDs.	None	Follow standard CMS-64.9 category of service definitions	Date of service	MAP	N	1/1/22	12/31/26

Table 2: MEG Detail for Expenditure and Member Month Reporting

ADM								
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71. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 3: 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

72. **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

73. **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.

74. **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

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

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 modified budget neutrality expenditure limit.

VIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 75. 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.
- 76. 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.

- 77. 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.
- 78. 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 4: 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

Table 4: Main Budget Neutrality Test										
Assistance in Community Integration Services (ACIS) Pilot Program	PC	WW Only	n/a							
Home Visiting Services Pilot Program	PC	WW Only	n/a							
HealthChoice Diabetes Prevention Program (DPP) Pilot Program	PC	WW Only	n/a							
Adult Dental Program	PC	WW Only	n/a							
Increased Community Services (ICS)	PC	WW Only	n/a							
Breast and Cervical Cancer Treatment Program (BCCTP)	PC	WW Only	n/a							
Presumptive Eligibility for Pregnant Women (PEPW)	PC	WW Only	n/a							
Collaborative Care Model (CoCM) Pilot Program	PC	WW Only	n/a							
Maternal Opioid Misuse (MOM) Model Pilot Program	PC	WW Only	n/a							
Medicaid Alternative Destination Transport Pilot Program	PC	WW Only	n/a							

*PC – Per Capita, AG - Aggregate

79. **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 .

- 80. 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.

Table 5: Hypothetical Budget Neutrality Test 1

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 Individuals w/ Serious Mental Illness	P C	Both		5.2%	\$15,370	\$16,169	\$17,010	\$17,895	\$18,825	\$19,804

- 81. 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 5: Hypothetical Budget Neutrality Test 2

MEG	PC or AG	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

- 82. Hypothetical Budget Neutrality Test 3:** 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.

Table 5: Hypothetical Budget Neutrality Test 3

MEG	PC or AG	WO W 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

- 83. Hypothetical Budget Neutrality Test 4:** 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.

Table 5: Hypothetical Budget Neutrality Test 4

MEG	PC or AG	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

84. **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.
85. **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.
86. **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 6: 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

IX. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 7: 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 33
60 calendar days after receipt of CMS comments	Revised SMI Implementation Plan (including Health IT Plan)	STC 33
150 calendar days after demonstration approval	SUD Monitoring Protocol	STC 23
60 calendar days after receipt of CMS comments	Revised SUD Monitoring Protocol	STC 23
150 calendar days after demonstration approval	SMI Monitoring Protocol	STC 34
60 calendar days after receipt of CMS comments	Revised SMI Monitoring Protocol	STC 34

Table 7: Schedule of Deliverables for the Demonstration Period		
Date	Deliverable	STC
180 calendar days after demonstration approval	Draft Evaluation Design	STC 50
60 days after receipt of CMS comments	Revised Evaluation Design	STC 51
No later than 60 calendar days after December 31, 2024	SUD and SMI Mid-Point Assessment Report	STC 43
60 days after receipt of CMS comments	Revised SUD and SMI Mid-Point Assessment Report	STC 43
June 30, 2024, or with renewal application	Draft Interim Evaluation Report	STC 54(c)
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 54(d)
Within 18 months after June 30, 2025	Draft Summative Evaluation Report	STC 55
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 55(b)
Monthly Deliverables	Monitoring Calls	STC 46
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4 th quarter.	Quarterly Monitoring Reports, including implementation updates	STC 42
	Quarterly Budget Neutrality Reports	STC 42(c)
Annual Deliverables - Due 90 calendar days after end of each 4 th quarter	Annual Monitoring Reports	STC 42

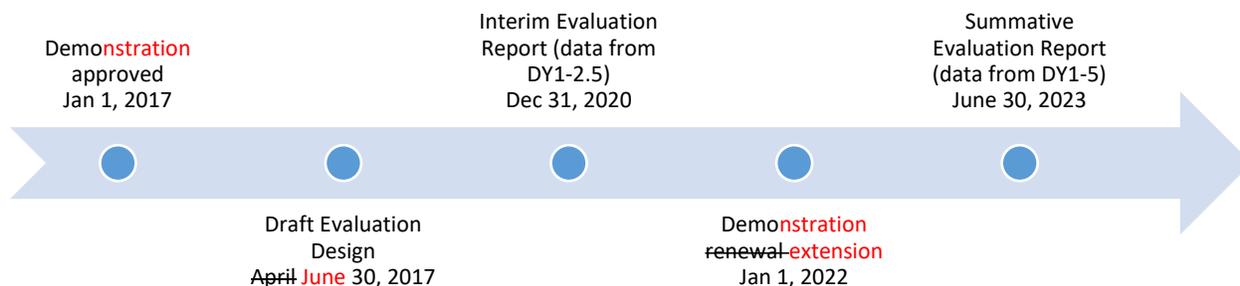
ATTACHMENT A Developing the Evaluation Design

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/hciatwoaimsdvr.rs.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.

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.

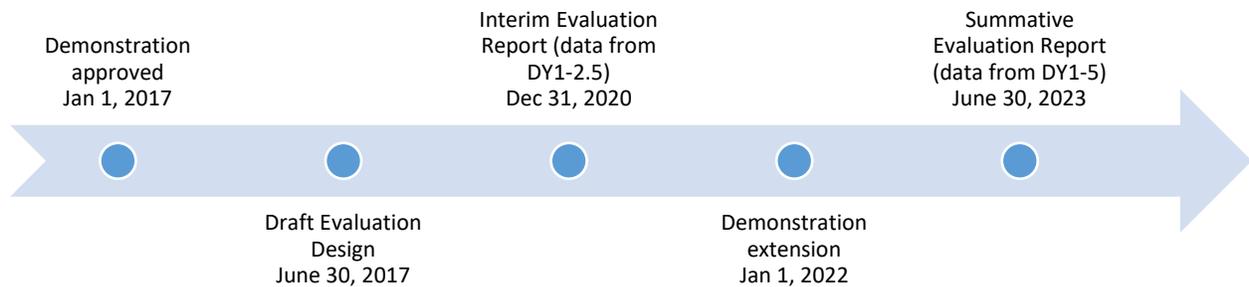
Attachment B: Preparing the Interim and Summative Evaluation Reports

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).

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.

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

ATTACHMENT C
Evaluation Design [RESERVED]

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	<p>The HVS Pilot Project will provide home visit services to expectant mothers during their pregnancy. The prenatal home visit services will provide:</p> <ul style="list-style-type: none"> • 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	<p>The HVS Pilot Project will provide home visit services to Medicaid eligible mothers during their sixty (60) day postpartum period.</p> <ul style="list-style-type: none"> • Diet and nutritional education; • Stress management; • STD prevention education;

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Evidence-Based Home Visiting Services Pilot Protocol

	<ul style="list-style-type: none"> • 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	<p>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.</p> <ul style="list-style-type: none"> • 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.

ATTACHMENT E
Evidence-Based Home Visiting Services Pilot Protocol

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

<i>Home Visitor Provider Qualifications</i>				
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.

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Evidence-Based Home Visiting Services Pilot Protocol

		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.

ATTACHMENT E
Evidence-Based Home Visiting Services Pilot Protocol

	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.	
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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

ATTACHMENT E
Evidence-Based Home Visiting Services Pilot Protocol

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

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Evidence-Based Home Visiting Services Pilot Protocol

Washington	Health Department	Accredited
Wicomico	Health Department	Accredited

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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.

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- 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

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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	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

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		experience.		in providing these services.
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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.

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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 [Reserved]

Attachment H: SMI Implementation Plan [Reserved]

Attachment I: SMI Monitoring Protocol [Reserved]

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]