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- Face-to-Face Assessment
- Care Coordination Organizations
- Responsibility for Development of Person-Centered Service Plan
- Care Coordination model
- Supporting the Participant in Development of Person-Centered Service Plan
  - Crisis plan
  - Crisis response

### Informed Choice of Providers
### Approval of the Medicaid Agency
### Maintenance of Person-Centered Service Plan Forms

### Services
- Intensive In-Home Services
  - Categorically needy
  - Medically needy
  - Provider Qualifications
- Verification of Provider Qualifications
- Service Delivery Method.
- Community-Based Respite Care
  - Categorically needy
  - Medically needy
  - Provider Qualifications
- Out-of-Home Respite
  - Categorically needy
  - Medically needy
  - Provider Qualifications
- Family Peer Support
  - Categorically needy
  - Medically needy
  - Provider Qualifications
- Expressive and Experiential Behavioral Services
  - Categorically needy
  - Medically needy

### Participant-Direction of Services
- Election of Participant-Direction
- Limited Implementation of Participant-Direction
- Financial Management
- Participant–Directed Person-Centered Service Plan
- Opportunities for Participant-Direction
- Participant–Employer Authority
- Participant–Budget Authority

### Quality Improvement Strategy

### Attachment 3.1 K
- Community First Choice State Plan Option
  - i. Eligibility
  - ii. Service Delivery Models
  - iii. Service Package
  - iv. Use of Direct Cash Payments
The following ambulatory services are provided.

As indicated on pages 2 through 8 of this Attachment, Maryland covers the services which are checked "Provided" to all medically needy groups defined in Attachment 2.2-A, pages 17, 18 and 19.

All of the limitations that apply to the categorically needy, as listed in Attachment 3.1-A, pages 10 through the end of the attachment, apply also to all medically needy groups. Therefore, we have not listed the limitations separately in this attachment.

*Description provided on attachment.

TN No. 27-0  
Supersedes  
TN No. 85-5  
Approval Date: MAR 20 1987  
Effective Date:  

HCFA ID: 0140P/0102A
1. Inpatient hospital services other than those provided in an institution for mental diseases.
   - Provided: ☑ No limitations ☑ With limitations*

2.a. Outpatient hospital services.
   - Provided: ☑ No limitations ☑ With limitations*

2.b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the plan)
   - Provided: ☑ No limitations ☑ With limitations*

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
   - Provided: ☑ No limitations ☑ With limitations*

3. Other laboratory and X-ray services.
   - Provided: ☑ No limitations ☑ With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
   - Provided: ☑ No limitations ☑ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.
   - Provided: ☑ No limitations ☑ With limitations*

4.c. Family planning services and supplies for individuals of childbearing age.
   - Provided: ☑ No limitations ☑ With limitations*

*Description provided on attachment.
3. Physicians' services, whether furnished in the office, the
    patient's home, a hospital, a nursing facility, or
    elsewhere.

   Provided: [ ] No limitations [X] With limitations*

b. Medical and surgical services furnished by a dentist (in
   accordance with section 1905(a)(5)(B) of the Act).

   Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.
AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

6. Medical care and any other type of remedial care recognized under State law, furnished
by licensed practitioners within the scope of their practice as defined by State law.
   a. Podiatrists' Services
      _x_ Provided: ___ No limitations _x_ With limitations*
   b. Optometrists' Services
      _x_ Provided: ___ No limitations _x_ With limitations*
   c. Chiropractors' Services
      ___ Provided: ___ No limitations ___ With limitations*
   d. Other Practitioner's Services
      _x_ Provided: ___ No limitations _x_ With limitations*

7. Home Health Services
   a. Intermittent or part-time nursing service provided by a home health agency or by a
      registered nurse when no home health agency exists in the area.
         _x_ Provided: ___ No limitations _x_ With limitations*
   b. Home health aide services provided by a home health agency.
      _x_ Provided: ___ No limitations _x_ With limitations*
   c. Medical supplies, equipment, and appliances suitable for use in the home.
      _x_ Provided: ___ No limitations _x_ With limitations*
   d. Physical therapy, occupation therapy, or speech pathology and audiology services
      provided by a home health agency or medical rehabilitation facility.
      _x_ Provided: ___ No limitations _x_ With limitations*
   e. Newborn early discharge assessment visit
      _x_ Provided: ___ No limitations _x_ With limitations*

*Description provided on attachment.
State/Territory: Maryland

8. Private duty nursing services.
   [X] Provided: [ ] No limitations [X] With limitations*

9. Clinic services.
   [X] Provided: [ ] No limitations [X] With limitations*

10. Dental services.
    [X] Provided: [ ] No limitations [X] With limitations*

11. Physical therapy and related services.
    a. Physical therapy.
       [X] Provided: [ ] No limitations [X] With limitations*
    b. Occupational therapy.
       [ ] Provided: [ ] No limitations [ ] With limitations*
    c. Services for individuals with speech, hearing, and language disorders
       provided by or under supervision of a speech pathologist or audiologist.
       [X] Provided: [ ] No limitations [X] With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed
    by a physician skilled in diseases of the eye or by an optometrist.
    a. Prescribed drugs.
       [X] Provided: [ ] No limitations [X] With limitations*

       Participating manufacturers' new drugs are covered (except
       excluded/restricted drugs specified in section 1927(d)(1)-(2) of the Social
       Security Act) for 6 months after FDA approval and upon notification by the
       manufacturer of a new drug.
    b. Dentures.
       [X] Provided: [ ] No limitations [X] With limitations*

   Description provided on attachment.

No. 91-19
Supersedes
TN No. 90-5 Approval Date Effective Date JAN 01 1991
c. Prosthetic devices.
   /X/ Provided: // No limitations /X/ With limitations*
   // Not provided.

   d. Eyeglasses.
   /X/ Provided: // No limitations /X/ With limitations*
   // Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.
   a. Diagnostic services-
      /X/ Provided: // No limitations /X/ With limitations*
      // Not provided.

   b. Screening services.
      // Provided: // No limitations // With limitations*
      // Not provided.

   c. Preventive services.
      // Provided: // No limitations // With limitations*
      // Not provided.

   d. Rehabilitative services.
      /X/ Provided: // No limitations /X/ With limitations*
      // Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.
   a. Inpatient hospital services.
      /X/ Provided: // No limitations /X/ With limitations*
      // Not provided.

   b. Skilled nursing facility services.
      // Provided: // No limitations // With limitations*
      // Not provided.

*Description provided on attachment.
State/Territory: Maryland

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDED GROUP(S): All

c. Intermediate care facility services.
   [x] Provided: [ ] No limitations [x] With limitations*  

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.
   [x] Provided: [ ] No limitations [x] With limitations*  

   b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.
   [x] Provided: [x] No limitations [ ] With limitations*  

16. Inpatient psychiatric facility services for individuals under 21 years of age.
   [x] Provided: [ ] No limitations [x] With limitations*  

17. Nurse-midwife services.
   [x] Provided: [ ] No limitations [x] With limitations*  

18. Hospice care (in accordance with section 1905(o) of the Act).
   [x] Provided: [ ] No limitations [x] With limitations*  

*Description provided on attachment.
19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Provided: With limitations Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

Provided: Additional coverage

b. Services for any other medical conditions that may complicate pregnancy.

Provided: Additional coverage Not provided.


Provided: No limitations With limitations

Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

TN No. 92-11 Approval Date JUN 05 1992
Supersedes Effective Date NOV 01 1991
TN No. 88-6
HCFA ID: 7986E
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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).</td>
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<td>/</td>
<td>Provided: /</td>
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<td>/</td>
<td>Not provided.</td>
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<tr>
<td>23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.</td>
<td></td>
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<tr>
<td>a. Transportation.</td>
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<td>/</td>
<td>Provided: /</td>
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<tr>
<td>b. Services of Christian Science nurses.</td>
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<td>/</td>
<td>Provided: /</td>
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<tr>
<td>c. Care and services provided in Christian Science sanitoria.</td>
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<td>Provided: /</td>
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<tr>
<td>d. Skilled nursing facility services provided for patients under 21 years of age.</td>
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<td>Provided: /</td>
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<td>e. Emergency hospital services.</td>
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<td>Provided: /</td>
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<tr>
<td>f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.</td>
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<td>/</td>
<td>Provided: /</td>
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</tbody>
</table>

**Approval Date:** MAR 14 2000  
**Effective Date:** JUL 01 1999
24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

  g. Nurse Anesthetist services.
     - ☒ Provided: ☐ No limitations ☒ With limitations
     - ☐ Not provided

  h. Nurse Practitioner Services
     - ☒ Provided: ☐ No limitations ☒ With limitations
     - ☐ Not Provided
State of Maryland
PACE State Plan Amendment

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

24. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.
State/Territory: Maryland

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: ___X___

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X_ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_X_ A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X_ A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN#: 22-0007  Approval Date: 04/15/2022  Effective Date: January 1, 2022
Supersedes TN#: NEW
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Non-Emergency Medical Transportation

A. The Transportation Grants program is funded as an administrative expense under an approved cost allocation plan (CAP). This program awards grants to local jurisdiction agencies, acting as agents of the State, to administer non-emergency transportation services to recipients. Funding awarded to the local agencies is monitored quarterly using a line-item expenditure reporting format. Additionally, local agencies are required to submit invoices to the Department for a review of reasonable, allowable costs. The standards for the award and administration of these grants are set forth in State regulations.

Transportation services are provided to assure access to and from providers as required in CFR §431.53 and are available to all eligible and qualified Medicaid recipients. The Department attests that all the minimum requirements outlined in 1902(a)(87) of the Social Security Act are met. An eligible recipient may access providers via wheelchair vans, taxis, ambulances, air medical transportation, bus passes and tickets, and other forms of transportation methods approved by the Department. Recipients may access services by contacting their local jurisdiction agency for screening to determine service eligibility.

Grantees enter into contractual agreements to provide medically necessary non-emergency transportation to covered services for recipients residing in the county. Rates are negotiated with local transportation providers via the county’s individual procurement process, ensuring that transportation includes transportation for full benefit dual eligible recipients, community-based recipients and residents of long term facilities. Services are provided to both full fee-for-service recipients and managed care recipients. Through a combination of on-site visits, meetings, and documentation, each jurisdiction engages their contracted providers in a vendor oversight program that includes ensuring the contractors and employees are not excluded from receiving federal and State funds, and are maintaining the minimum requirements for vehicles, drivers, licensing, traffic violations, state drug laws, does not appear on the list of excluded parties of the Inspector General of the Department of Health and Human Services, and maintains our standards of customer service.

Maryland does not provide Transportation Services using Transportation Network Companies such as Lyft or Uber. Grantees are responsible for screening requests for transportation by recipients, arranging transportation, expanding existing and developing new transportation resources, and purchasing or providing transportation services where necessary. Subsequent to determining service eligibility, Grantees will use screening information and physician documentation to assess the mode of transport and communicate the least costly mode to its vendor. Screening services and transportation services must be performed by separate entities. When transportation is provided through the local jurisdiction, Grantees may perform both functions.
Ambulance providers are required to be licensed by the State Office of Commercial Ambulance Licensing and Regulation. These agencies provide regulatory oversight for the drivers and set vehicle safety standards. A family member may not be a provider as he/she is considered as a primary resource for transportation.

*Services for medical necessary ambulance transportation and for Individuals with disabilities Education Act (IDEA) are found in Attachment 3.1A pg 30-30A and Attachment 4.19B.*
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Non-Emergency Medical Transportation

B. Monies from a grant provided under these regulations may not be used to pay for the following:

1. Emergency transportation services;
2. Medicare ambulance services;
3. Transportation to and from non-Medicaid Veterans Administration services;
4. Transportation between a nursing facility and a hospital for routine diagnostic tests, nursing services, or physical therapy which can be performed at the nursing facility;
5. Transportation services from a facility for treatment which the treatment is provided by the facility in which the recipient is located;
6. Transportation to receive nonmedical services;
7. Gratuities of any kind;
8. Transportation between a medical day care facility and the recipient’s home;
9. Transportation to or from a State facility while the patient is a resident of that facility;
10. Transportation of non-Medical assistance recipients;
11. Trips for purposes related to education, recreational activities, or employment;
12. Transportation of anyone other than the recipient, except for an attendant accompanying a minor or when an attendant is medically necessary;
13. Wheelchair van service for ambulatory recipients;
14. Ambulance service for a recipient who does not need to be transported on a stretcher;
15. Transportation between a Community Rehabilitation Program (CRP) and the recipient’s home;
16. Transportation between a Day Rehabilitation Program and the recipient’s home;
17. Transportation to or from services that are not medically necessary; and
18. Transportation to a more distant provider primarily for the convenience of the participant or provider.
State/Territory: Maryland

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

See Attachment 3.1A
Pages: 12C, 12C-1, 12D, 12E
provider is in part dependent upon the ability to report detailed performance metrics, measure improvement in care coordination, and gauge clinical outcomes on a provider level. Providers who do not currently use a robust EHR or clinical management system may determine that such a tool is necessary to meet the reporting and care coordination requirements of the Health Home program, as well as to improve their overall care capabilities.

**Quality Measurement**

- The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.

- The State provides assurance that it will identify measurable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Hospital admissions- asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
<td>Hospital admissions with asthma complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>Claims/Encounters</td>
</tr>
<tr>
<td>Frequency of Data Collection:</td>
<td>Monthly, Quarterly, Annually, Continuously, Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Hospital admissions- diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
<td>Hospital admissions with diabetes-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>Claims/Encounters</td>
</tr>
<tr>
<td>Frequency of Data Collection:</td>
<td>Monthly, Quarterly, Annually, Continuously, Other</td>
</tr>
</tbody>
</table>

Evaluations

- The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

**Hospital Admissions**

- **Measure:** Hospital admissions- asthma
  - Measure Specification, including a description of the numerator and denominator.
  - Hospital admissions with asthma complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.
  - Data Sources: Claims/Encounters
  - Frequency of Data Collection: Monthly, Quarterly, Annually, Continuously, Other

- **Measure:** Hospital admissions- diabetes
  - Measure Specification, including a description of the numerator and denominator.
  - Hospital admissions with diabetes-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.
  - Data Sources: Claims/Encounters
  - Frequency of Data Collection: Monthly, Quarterly, Annually, Continuously, Other
<table>
<thead>
<tr>
<th>Measure: Hospital admissions- heart disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
</tr>
<tr>
<td>Hospital admissions with congestive heart failure and/or heart disease as a primary or secondary diagnosis, per 1000 Health Home participants per month.</td>
</tr>
<tr>
<td>Data Sources: Claims/Encounters</td>
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<tr>
<td>Frequency of Data Collection:</td>
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<td>Monthly</td>
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<tr>
<td>Quarterly</td>
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<td>Continuously</td>
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<td>Other</td>
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<tr>
<th>Measure: Hospital admissions- hepatitis C</th>
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<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
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<tr>
<td>Hospital admissions with hepatitis C-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.</td>
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<tr>
<td>Data Sources: Claims/Encounters</td>
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<tr>
<td>Frequency of Data Collection:</td>
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<td>Other</td>
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<table>
<thead>
<tr>
<th>Measure: Hospital admissions- HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
</tr>
<tr>
<td>Hospital admissions with HIV/AIDS-related complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.</td>
</tr>
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<td>Other</td>
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<table>
<thead>
<tr>
<th>Measure:</th>
<th>Hospital admissions- hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
<td></td>
</tr>
<tr>
<td>Hospital admissions with hypertension related complications as a secondary diagnosis, per 1000 Health Home participants per month.</td>
<td></td>
</tr>
</tbody>
</table>

**Data Sources:**
Claims/Encounters

**Frequency of Data Collection:**
- Monthly
- Quarterly
- Annually
- Continuously
- Other

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Hospital admissions- kidney disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
<td></td>
</tr>
<tr>
<td>Hospital admissions with chronic kidney disease complications as a primary or secondary diagnosis, per 1000 Health Home participants per month.</td>
<td></td>
</tr>
</tbody>
</table>

**Data Sources:**
Claims/Encounters

**Frequency of Data Collection:**
- Monthly
- Quarterly
- Annually
- Continuously
- Other

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Hospital admissions- mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
<td></td>
</tr>
<tr>
<td>Hospital admissions with mental health conditions as a primary or secondary diagnosis, per 1000 Health Home participants per month.</td>
<td></td>
</tr>
</tbody>
</table>

**Data Sources:**
Claims/Encounters

**Frequency of Data Collection:**
- Monthly
- Quarterly
- Annually
- Continuously
- Other

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Hospital admissions- obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
<td></td>
</tr>
<tr>
<td>Hospital admissions with obesity related complications as a secondary diagnosis, per 1000 Health Home participants per month.</td>
<td></td>
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</tbody>
</table>

**Data Sources:**
Claims/Encounters

**Frequency of Data Collection:**
- Monthly
- Quarterly
<table>
<thead>
<tr>
<th>Measure:</th>
<th>Hospital admissions - substance use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
<td>Hospital admissions with substance use disorder as a primary or secondary diagnosis, per 1000 Health Home participants per month.</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>Claims/Encounters</td>
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<tr>
<td>Frequency of Data Collection:</td>
<td>Monthly</td>
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<tr>
<td>Data Sources:</td>
<td>Claims/Encounters</td>
</tr>
<tr>
<td>Measure:</td>
<td>Hospital costs</td>
</tr>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
<td>Hospitalization costs per member per month, aggregated and by Health Home provider.</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>Claims/Encounters</td>
</tr>
<tr>
<td>Frequency of Data Collection:</td>
<td>Monthly</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>Claims/Encounters</td>
</tr>
<tr>
<td>Measure:</td>
<td>Inpatient admissions</td>
</tr>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
<td>Inpatient admissions per 1000 Health Home participants per month, stratified by mental health diagnoses and all other diagnoses.</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>Claims/Encounters</td>
</tr>
<tr>
<td>Frequency of Data Collection:</td>
<td>Monthly</td>
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<tr>
<td>Data Sources:</td>
<td>Claims/Encounters</td>
</tr>
<tr>
<td>Measure:</td>
<td>Mental health readmissions</td>
</tr>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
<td>Mental health readmissions within 30 days.</td>
</tr>
<tr>
<td>Data Sources:</td>
<td>Claims/Encounters</td>
</tr>
<tr>
<td>Claims/Encounters</td>
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<td>Frequency of Data Collection:</td>
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**Measure:**

<table>
<thead>
<tr>
<th>Potentially preventable readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
</tr>
<tr>
<td>Potentially preventable readmissions within 30 days as a percentage of potentially preventable hospital admissions, stratified by mental health diagnoses and all other diagnoses.</td>
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</tbody>
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**Data Sources:**

- Claims/Encounters

**Frequency of Data Collection:**

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<td>Other</td>
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<table>
<thead>
<tr>
<th>Emergency Room Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure:</td>
</tr>
<tr>
<td>Emergency department costs</td>
</tr>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
</tr>
<tr>
<td>Emergency Department costs per member per month, aggregated and by HH provider.</td>
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</table>

**Data Sources:**

- Claims/Encounters

**Frequency of Data Collection:**

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<td>Other</td>
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<table>
<thead>
<tr>
<th>Emergency department visits- asthma</th>
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</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
</tr>
<tr>
<td>Asthma ED visit rate per 1000 Health Home participants per month.</td>
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</tbody>
</table>

**Data Sources:**

- Claims/Encounters

**Frequency of Data Collection:**

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<tr>
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<tr>
<td>Other</td>
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</tbody>
</table>
### Measure: Emergency department visits - diabetes

**Measure Specification**, including a description of the numerator and denominator.
Diabetes-related ED visit rate per 1000 Health Home participants per month.

**Data Sources:**
- Claims/Encounters

**Frequency of Data Collection:**
- Monthly
- Quarterly
- Annually
- Continuously
- Other

### Measure: Emergency department visits - heart disease

**Measure Specification**, including a description of the numerator and denominator.
Congestive heart failure and/or heart disease ED visit rate per 1000 Health Home participants per month.

**Data Sources:**
- Claims/Encounters

**Frequency of Data Collection:**
- Monthly
- Quarterly
- Annually
- Continuously
- Other

### Measure: Emergency department visits - hepatitis C

**Measure Specification**, including a description of the numerator and denominator.
Hepatitis C-related ED visit rate per 1000 Health Home participants per month.

**Data Sources:**
- Claims/Encounters

**Frequency of Data Collection:**
- Monthly
- Quarterly
- Annually
- Continuously
- Other

### Measure: Emergency department visits - HIV/AIDS

**Measure Specification**, including a description of the numerator and denominator.
HIV/AIDS-related ED visit rate per 1000 Health Home participants per month.

**Data Sources:**
- Claims/Encounters

**Frequency of Data Collection:**
- Monthly
- Quarterly
- Annually
<table>
<thead>
<tr>
<th>Measure:</th>
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<tr>
<td>Emergency department visits- hypertension</td>
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<td>Measure Specification, including a description of the numerator and denominator.</td>
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<tr>
<td>Hypertension related ED visit rate per 1000 Health Home participants per month.</td>
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<td>Data Sources: Claims/Encounters</td>
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<td>Frequency of Data Collection:</td>
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<tr>
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<tr>
<td>Emergency department visits- kidney disease</td>
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<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
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<tr>
<td>Chronic kidney disease ED visit rate per 1000 Health Home participants per month.</td>
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<td>Data Sources: Claims/Encounters</td>
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<td>Frequency of Data Collection:</td>
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<tbody>
<tr>
<td>Emergency department visits- obesity</td>
</tr>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
</tr>
<tr>
<td>Obesity-related complications ED visit rate per 1000 Health Home participants per month.</td>
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<tr>
<td>Data Sources: Claims/Encounters</td>
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<tr>
<th>Measure:</th>
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<tr>
<td>Emergency department visits- substance use</td>
</tr>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
</tr>
<tr>
<td>Substance use disorder ED visit rate per 1000 Health Home participants per month.</td>
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<tr>
<td>Data Sources: Claims/Encounters</td>
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<tr>
<td>Frequency of Data Collection:</td>
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<tr>
<td>Measure: Emergency department visits</td>
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<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
</tr>
<tr>
<td>Emergency Department (ED) visit rate per 1000 Health Home participants per month, stratified by mental health diagnoses and all other diagnoses.</td>
</tr>
<tr>
<td>Data Sources: Claims/Encounters</td>
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</table>

<table>
<thead>
<tr>
<th>Measure: Skilled Nursing Facility Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
</tr>
<tr>
<td>Skilled Nursing Facility admission rate per 1000 Health Home participants per month, all facility admissions.</td>
</tr>
<tr>
<td>Data Sources: Claims/Encounters</td>
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<table>
<thead>
<tr>
<th>Measure: Skilled Nursing Facility costs</th>
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<tr>
<td>Measure Specification, including a description of the numerator and denominator.</td>
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<tr>
<td>Skilled nursing facility costs per member per month, aggregated and by HH provider.</td>
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Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
The State plans to capture hospital admission rates and readmission rates per 1000 Health Home participants per month.

With the aid of state and academic partners, the State will use ED classifications developed by researchers at the New York University Center for Health and Public Service Research to classify the appropriateness of ED care for Health Home participants and compare usage with groups of OMT, MT and PRP participants receiving care non-Health Home PRP, MT and OMT providers. This methodology categorizes emergency visits as follows:

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

The State also may use hospital readmissions data for Health Home participants to determine if care managers are establishing prompt contact with patients and their physicians to coordinate care after hospitalization discharge.

Chronic Disease Management
The State may modify standardized assessment tools using claims data, encounter data, pharmacy data, and qualitative interviews with Health Home administrative staff and providers, to determine implementation of the following components:

1. inclusion of preventive and health promotion services;
2. coordination of care between primary care, specialty providers and community supports;
3. emphasis on collaborative patient decision making and teaching of disease self-management;
4. structuring of care to ensure ongoing monitoring and follow-up care;
5. facilitation of evidence-based practice; and
6. use of clinical information systems to facilitate tracking of care as well as integration between providers.

In addition, the State may conduct comparative evaluations that focus on groups at-risk to incur high costs to determine the success and cost-effectiveness of the Health Homes.

Coordination of Care for Individuals with Chronic Conditions
Using the Chronic Health Homes tool on eMedicaid, the State will monitor Health Home providers to ensure they are coordinating care effectively for participants. The State may assess provision of care coordination services by measuring:

1. the level of contacts made by care managers during and after hospitalization;
2. the frequency of telephonic and/or face-to-face contact with participants after hospitalization discharge;
3. the level of active care management for high-risk participants; and
4. behavioral activity and engagement of high-risk participants in response to care management interventions.

Oversight activities may include, but not be limited to: medical chart and care management record review, site audits, team composition analysis, and review of types and number of contacts.

Assessment of Program Implementation
The State will have the capacity to assess and monitor ongoing performance of the Health Homes program with the aid of claims and encounter data, pharmacy data, the eMedicaid case management tracking tool, and regularly
scheduled educational activities and meetings. Through a combination of evaluation data, information from training sessions, feedback from the regional meetings, and information gathered from practice representatives and participants, the State and Health Home providers may identify ineffective practices and implementation challenges and develop potential solutions. The State may assess if Health Homes have developed and implemented a tool to track and monitor recipient encounters with providers and inpatient facilities. The State may also perform evaluations of patient volume levels, the percentage of participants who opt out of Health Home services, achievement of participation goals set by each Health Home provider, and retention rates.

Processes and Lessons Learned
The State may provide training and education opportunities for health home providers, such as webinars, regional meetings, and/or training sessions to foster shared learning, information sharing, and problem solving. These forums may permit discussion of successful and unsuccessful implementation strategies, along with frequent communication, feedback, learning activities, and technical assistance. The State also may monitor Health Home processes by assessing evaluation data, conducting medical chart and care management record reviews, site audits, team composition analysis, and review of types and number of contacts between Health Home case managers and participants.

Assessment of Quality Improvements and Clinical Outcomes
The State requires each Health Home to use eMedicaid to input information related to participants' services and overall health. In addition to assisting the Health Home with coordination of care and case management, the tool tracks data linked to chronic conditions, such as Body Mass Index (BMI), blood pressure, and others. Data collected may inform the individual's plan of care, proper follow-up protocols upon the recipient's hospitalization discharge, health promotion services, and management of chronic conditions.

The State's current HEDIS™ measures for Medicaid-eligible adults that correspond with measures recommended by CMS for Health Home efforts are Ambulatory Care - Sensitive Condition Admission, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, and Controlling High Blood Pressure. The State may opt to evaluate additional HEDIS™ measures for adults that link to overall health promotion, such as Adult BMI Assessment, Medical Assistance with Smoking and Tobacco Use Cessation, Comprehensive Diabetes Care: Hemoglobin A1c Testing and LDL-C Screening, Annual Monitoring for Patients on Persistent Medications, Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening in Women Ages 21-24, Postpartum Care Rate, Controlling High Blood Pressure, and the CAHPS survey to evaluate experience of care. These measures may be obtained using claims data, encounter data, medical chart reviews, survey responses, and pharmacy data. The State also may incorporate Medicare data to evaluate the Health Home's impact on the dual eligible population.

The endpoint evaluation may also identify and assess the number and types of outcomes indicative of poorly managed care of chronic conditions at the patient level. Examples include multiple ED visits, hospital re-admissions, and preventable disease-specific complications.

Estimates of Cost Savings
☑ The State will use the same method as that described in the Monitoring section.

If no, describe how cost-savings will be estimated.

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
General Eligibility Requirements

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

- The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

- An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

- An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

- Yes  
- No
Medicaid Eligibility

Indicate the other electronic means below:

<table>
<thead>
<tr>
<th>Name of Method</th>
<th>Description</th>
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<tbody>
<tr>
<td>Service Access and Information Link</td>
<td>SAIL is a web-based screening and application tool that will allow Maryland applicants to complete the following: Am I Eligible? - A series of questions to help you decide for which social services benefits you and members of your family may want to apply. Start an application: Apply on-line any time of day or night for the following programs: Food Supplement Program, Temporary Cash Assistance, Temporary Disability Assistance Program, Medical Assistance (Aged, Blind, Disabled only), Medical Assistance Long Term Care, Maryland Energy Assistance Program, Electric Universal Service Program, Child Care Subsidy Program.</td>
</tr>
</tbody>
</table>

The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☒ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

☐ Once every 12 months

☐ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

☐ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

☒ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☐ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.
Medicaid Eligibility

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
APPLICATION FOR HOSPITAL PRESUMPTIVE (TEMPORARY) ELIGIBILITY FOR MEDICAL ASSISTANCE

PART I – INFORMATION FOR DETERMINATION (ITEMS LABELED WITH '* 'ARE REQUIRED)

- First Name: *Middle Name: *Last Name: Suffix:
- Family Size: *Household Gross Monthly Income: *Maryland Resident? □ Yes □ No
- Date of Birth: □ U.S. Citizen, U.S. National or Qualified Non-Citizen? □ Yes □ No
- *Sex: □ Male □ Female

If readily available, also tell us the following:

- Are you pregnant? □ Yes □ No
- Social Security Number: _______ - ____ - _______

Other insurance coverage?

□ Yes □ No
*In Foster Care at age 18? □ Yes □ No
*Already have Medicaid? □ Yes □ No
Already have Medicare?

□ Yes □ No

PART II – IMPORTANT CONTACT INFORMATION

- Home Address:
- *City: *State: *Zip Code: *County:
- Mailing Address (if different):
  - City: State: Zip Code: County:
- Telephone:
  - Home Work Cell
- E-mail address:

PART III – PRESUMPTIVE DETERMINATION: Hospitals representative must make the determination based on the REQUIRED information in Part I only and give the applicant an approval or denial notice.

Eligible?

□ Yes □ No

If yes, check the eligibility group:

□ Child (Medicaid) □ Pregnant Woman □ Former Foster Youth <26
□ Child (MCHP) □ Parent/caretaker relative □ Adult

PART IV – SIGNATURES

Applicant: By signing, you are attesting that the information you provided for this form is true as far as you know and that you have received a copy of the Approval Notice that lists your Rights and Responsibilities, or a Denial Notice. We will keep your information secure and private.

Signature of Applicant (or legal guardian) ___________________________ Date ___________________________

Signature of Authorized Representative (if applicant unable to sign) ___________________________ Relationship to Applicant ___________________________ Date ___________________________

Hospital Representative: By signing, you are attesting that you have accurately recorded the information provided by the applicant or someone representing the applicant, made a determination based on that information, and provided the applicant with an Approval Notice that lists their Rights and Responsibilities or a Denial Notice.

Signature of Hospital Representative ___________________________ Date ___________________________

STATE OF MARYLAND
DHMH

To find out if you qualify for regular Medicaid or other health coverage, you must complete this application for Temporary Eligibility. While you wait to learn if you qualify for regular Medicaid or other health coverage, you can get your health services through Temporary Eligibility for Medicaid.
§1915(i) State plan HCBS

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. (Specify the state’s service title(s) for the HCBS defined under “Services” and listed in Attachment 4.19-B):

- Intensive In-Home Services
- Community-Based Respite Care
- Out-of-Home Respite Care
- Family Peer Support
- Expressive and Experiential Behavioral Services

2. Concurrent Operation with Other Programs. (Indicate whether this benefit will operate concurrently with another Medicaid authority):

Select one:

| X | Not applicable |
| O | Applicable |

Check the applicable authority or authorities:

- Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Specify:
  (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);
  (b) the geographic areas served by these plans;
  (c) the specific 1915(i) State plan HCBS furnished by these plans;
  (d) how payments are made to the health plans; and
  (e) whether the 1915(a) contract has been submitted or previously approved.

- Waiver(s) authorized under §1915(b) of the Act.
  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

  Specify the §1915(b) authorities under which this program operates (check each that applies):

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective...
3. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** (Select one):

- The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (select one):
  - The Medical Assistance Unit *(name of unit)*
  - Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)*

  *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*

- The State plan HCBS benefit is operated by *(name of agency)*

  Maryland Department of Health- Behavioral Health Administration

  This HCBS benefit is operated by the Behavioral Health Administration, a separate agency of the state that is not a division/unit of the Medicaid agency under the Maryland Department of Health organizational structure. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.
4. **Distribution of State plan HCBS Operational and Administrative Functions.**

![Check this box the state assures that]: When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

*(Check all agencies and/or entities that perform each function):*

<table>
<thead>
<tr>
<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
<th>Local Non-State Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Individual State plan HCBS enrollment</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2 Eligibility evaluation</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>3 Review of participant service plans</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>4 Prior authorization of State plan HCBS</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>5 Utilization management</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>6 Qualified provider enrollment</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>7 Execution of Medicaid provider agreement</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8 Establishment of a consistent rate methodology for each State plan HCBS</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9 Rules, policies, procedures, and information development governing the State plan HCBS benefit</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10 Quality assurance and quality improvement activities</td>
<td>☑</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

*(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):*
2. The State Medicaid Agency performs eligibility evaluation in partnership with the contracted Administrative Services Organization (ASO), the Behavioral Health Administration (BHA), and the local Core Service Agency (CSA)/Local Behavioral Health Authority.

3. The BHA, ASO, and CSA/LBHA perform reviews of participant services plans.

4. BHA ASO

5. The State Medicaid Agency is responsible for utilization management in partnership with the ASO and the BHA.

6. The State Medicaid Agency works in partnership with the ASO and the BHA to perform qualified provider enrollment.

8. The State Medicaid Agency and BHA work in partnership to establish a consistent rate methodology for each State plan HCBS.

9. Rules, policies, procedures, and information development governing the State plan HCBS benefit are developed by the State Medicaid Agency in partnership with the BHA.

10. Quality assurance and quality improvement activities are performed by the State Medicaid Agency and the BHA.
(By checking the following boxes the State assures that):

5. **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement)*:

6. **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.
1. **Projected Number of Unduplicated Individuals To Be Served Annually.**  
   *(Specify for year one. Years 2-5 optional):*  
   
<table>
<thead>
<tr>
<th>Annual Period</th>
<th>From</th>
<th>To</th>
<th>Projected Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>10/1/19</td>
<td>9/30/20</td>
<td>200</td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

---

**Financial Eligibility**

1. **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State’s Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **New 1915(i) Medicaid Eligibility Group.** In addition to providing State plan HCBS to individuals described in item 1 above, the state is also covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the federal poverty level, or who are eligible for HCBS under a waiver approved for the state under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (as described in Attachment 2.2A, pages 27 of the State Plan).

3. **Medically Needy (Select one):**
   - [ ] The State does not provide State plan HCBS to the medically needy.
   - [x] The State provides State plan HCBS to the medically needy. *(Select one):*
     - [ ] The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.
     - [x] The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

---

**Evaluation/Reevaluation of Eligibility**
1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual. Independent evaluations/revaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>Directly by the Medicaid agency</td>
</tr>
<tr>
<td>●</td>
<td>By Other (<em>specify State agency or entity under contract with the State Medicaid agency</em>): The Behavioral Health Administration, in conjunction with a contracted administrative services organization, and Core Services Agencies or Local Behavioral Health Authorities, the local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level.</td>
</tr>
</tbody>
</table>

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. (*Specify qualifications*):

The independent evaluation and reevaluation will be completed by the Administrative Services Organization (ASO) on behalf of the Department. Maryland-licensed mental health professionals trained in the use of the applicable standardized tools will perform the evaluations. This may include Psychiatrists, Nurse Psychotherapists (ARNP-PMH), Psychiatric Nurse Practitioners (CRNP-PMH), Licensed Clinical Social Workers, Licensed Clinical Professional Counselors, or a Psychologist.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The Administrative Services Organization (ASO), on behalf of the Department will verify eligibility, perform the independent evaluation of needs-based criteria, and pre-authorize all of the medically appropriate mental health services. Final eligibility determination rests with the SMA and the ASO will present its eligibility determination to the Department for final approval and enrollment. A licensed mental health professional will conduct the evaluation, based upon Maryland’s definition of medically necessary treatment which requires services or benefits to be:

1. Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
2. Consistent with currently accepted standards of good medical practice;
3. The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
4. Not primarily for the convenience of the consumer, family, or provider.

The evaluator will be familiar with the medical necessity criteria and will use those criteria and the individual’s clinical history to determine eligibility. The evaluator will utilize a psychosocial assessment to generate a score on the ECSII or CASII for the youth, and will compare that to the score generated by the Core Service Agency or Local Behavioral Health Authority based on the same documentation. If necessary, the evaluator will gather additional information by telephone or other means in conjunction with the CSA/LBHA.
Specific eligibility criteria, including re-evaluation criteria, are outlined in #5 below.

Once the evaluator has determined eligibility for services, a Care Coordination Organization will work with the child and family to develop an individualized Plan of Care (POC) that is consistent with the principles of Care Coordination (i.e. strengths-based, individualized, community-based, etc.). The CCO will review the POC at least every 45 days, with a review by the ASO when there is a change to the POC that necessitates a pre-authorization.

Re-Evaluation:
The ASO will review the most recent POC along with other documentation including financial eligibility at least annually as part of the review for continued eligibility for services. The medical re-evaluation, including a CASII or ECSII, will be completed by the ASO based on:
1. An updated psychosocial assessment from a treating mental health professional supporting the need for continued HCBS benefit services;
2. A CASII or ECSII review by a licensed mental health professional at the Care Coordination Organization (with a CASII score of 3 to 6 or ECSII score of 3 to 5) as outlined in Section 1a of the response below to Question 5 “Needs-based HCBS Eligibility Criteria”;
3. A review of HCBS benefits service utilization over the past 6 months.

The ASO will make the final re-evaluation determination and inform the SMA of its decision.

4. [✓] **Reevaluation Schedule.** *(By checking this box the state assures that)*: Needs-based eligibility reevaluations are conducted at least every twelve months.

5. [✓] **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that)*: Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual’s support needs, and may include other risk factors: *(Specify the needs-based criteria)*:
A child or youth must demonstrate the following minimum requirements to be considered for or to remain in 1915(i) services:

1. **Impaired Functioning & Service Intensity:** A licensed mental health professional (including Psychiatrists, Nurse Psychotherapists (ARNP-PMH), Psychiatric Nurse Practitioners (CRNP-PMH), Licensed Clinical Social Workers, Licensed Clinical Professional Counselors, or a Psychologist.) must complete or update a comprehensive psychosocial assessment within 30 days of the submission of the application to the ASO. The psychosocial assessment must outline how, due to the behavioral health disorder(s), the child or adolescent exhibits a significant impairment in functioning, representing potential serious harm to self or others, across settings, including the home, school, and/or community. The serious harm does not necessarily have to be of an imminent nature. The psychosocial assessment must support the completion of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASSII) for youth ages 6-21.

   a. Youth must receive a score of:
      
      i. 3 (moderate service intensity targeted to multiple and/or complex areas of concern that interfere with child and family functioning), 4 (High Service Intensity) or 5 (Maximal Service Intensity) on the ECSII or
      
      ii. 3 (intensive outpatient services), 4 (intensive integrated services without 24 hour psychiatric monitoring), 5 (Non-Secure, 24-Hour, Medically Monitored Services) or 6 (Secure, 24- Hours, Medically Managed Services) on the CASII.

   b. For initial evaluation youth with a score of 3-5 on the CASII also must meet one of the following criteria to be eligible based on their impaired functioning and service intensity level:
      
      i. Living in the community and
      
      • Be 6-21 years old and have 2 or more inpatient psychiatric hospitalizations or ER visits in the past 12 months or
      
      • Been in an RTC within the past 90 days
c. For initial evaluation youth who are younger than 6 years old who have a score of a 3-4 on the ECSII either must:
   i. Be referred directly from an inpatient or day hospital unit, PCP, outpatient psychiatric facility, ECMH Consultation Program in daycare, Head Start, Early Head Start, Judy Hoyer Centers, or home visiting programs; or
   ii. If living in the community, have one or more psychiatric inpatient or day hospitalizations, ER visits, exhibit severe aggression (i.e. hurting or threatening actions or words directed at infants, young siblings, killing a family pet, etc.), display dangerous behavior (i.e. impulsivity related to suicidal behavior), been suspended or expelled or at risk of expulsion from school or child care setting, display emotional and/or behavioral disturbance prohibiting their care by anyone other than their primary caregiver, at risk of out-of-home placement or placement disruption, have severe temper tantrums that place the child or family members at risk of harm, have trauma exposures and other adverse life events, or at risk of family related risk factors including safety, parent-child relational conflict, and poor health and developmental outcomes in the past 12 months.

2. Other Community Alternatives: The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the MDH or its designee.

3. Duplication of Services: The youth may not be enrolled in Adult Residential Program for Adults with Serious Mental Illness licensed under COMAR 1.63.01 and 10.63.04 or a Health Home while enrolled in HCBS benefit.

6. **Needs-based Institutional and Waiver Criteria.** (By checking this box the state assures that): There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. (Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):

<table>
<thead>
<tr>
<th>State plan HCBS needs-based eligibility criteria</th>
<th>NF (&amp; NF LOC** waivers)</th>
<th>ICF/IID (&amp; ICF/IID LOC waivers)</th>
<th>Applicable Hospital* (&amp; Hospital LOC waivers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A child or youth must demonstrate the following minimum requirements to be considered for 1915(i) services:</td>
<td>Maryland allows reimbursement to nursing homes for eligible persons who require hospital care, but who, because of their mental or</td>
<td>Md. Code Reg. 10.22.01.01 contains the following definitions: (2) “Alternative living unit (ALU)” means a residence</td>
<td>For inpatient hospital psychiatric emergency detention or involuntary admission, Md.</td>
</tr>
<tr>
<td>1) Impaired Functioning</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maryland allows reimbursement to nursing homes for eligible persons who require hospital care, but who, because of their mental or emotional disturbance prohibits their care by anyone other than their primary caregiver, at risk of out-of-home placement or placement disruption, have severe temper tantrums that place the child or family members at risk of harm, have trauma exposures and other adverse life events, or at risk of family related risk factors including safety, parent-child relational conflict, and poor health and developmental outcomes in the past 12 months.

For inpatient hospital psychiatric emergency detention or involuntary admission, Md.
& Service Intensity: A licensed mental health professional (including Psychiatrists, Nurse Psychotherapists (ARNP-PMH), Psychiatric Nurse Practitioners (CRNP-PMH), Licensed Clinical Social Workers, Licensed Clinical Professional Counselors, or a Psychologist) must complete or update a comprehensive psychosocial assessment within 30 days of the submission of the application to the ASO. The psychosocial assessment must outline how, due to the behavioral health disorder(s), the child or adolescent exhibits a significant impairment in functioning, representing potential serious harm to self or others, across settings, including the home, school, and/or community. The serious harm does not necessarily have to be of an imminent nature. The psychosocial assessment must support the completion of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-21.

- Youth must receive a score of 3, 4 or 5 on the ECSII, or 3, 4, 5 or 6 on the CASII.
- Youth with a score of 4 or less on the CASII also require skilled nursing care and related services, rehabilitation services, or, on a regular basis, health-related care and services (above the level of room and board) which can be made available to them only through institutional facilities. Md. Code Reg. 10.09.10.

Physical condition, requiring skilled nursing care and related services, rehabilitation services, or, on a regular basis, health-related care and services (above the level of room and board) which can be made available to them only through institutional facilities. Md. Code Reg. 10.09.10.

Health Gen. §§ 10-613 through 619 requires that: (1) the individual has a mental disorder; (2) the individual needs inpatient care or treatment; (3) The individual presents a danger to the life or safety of the individual or of others; (4) The individual is unable or unwilling to be admitted voluntarily; and; (5) There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.

For voluntary admission to a psychiatric hospital, the requirements of Md. Health Gen. §§ 10–609 and 10-610 for minors must be met, including a formal, written application. A facility may not admit an individual under this section unless: the (1) individual has a mental disorder; (2) The mental disorder is susceptible to care or treatment; (3) The individual understands the nature of the request for admission; (4) The individual is able to give
must meet one of the following criteria to be eligible based on their impaired functioning and service intensity level:

i. Living in the community and
   1. Be 6-21 years old and have 2 or more inpatient psychiatric hospitalizations or emergency room visits in the past 12 months, or
   2. Been in an RTC within the past 90 days.

c. Youth who are younger than 6 years old and have a score of a 3 or 4 on the ECSII either must be referred directly from an inpatient hospital or day hospital, PCP, outpatient psychiatric facility, ECMH Consultation Program in daycare, Head Start, Early Head Start, Judy Hoyer Centers, or home visiting programs unit or if living in the community, have two or more psychiatric inpatient hospitalizations in the past 12 months.

2) Other Community Alternatives: The accessibility and/or intensity of currently available community services are inadequate

(c) Is manifested in an individual younger than 22 years old;
(d) Results in an inability to live independently without external support or continuing and regular assistance; and
(e) Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are individually planned and coordinated for the individual.

continues assent to retention by the facility; and (5) The individual is able to ask for release
to meet these needs due to the severity of the impairment without the provision of one more of the service contained in the HCBS Benefit.

Duplication of Services: The youth may not be enrolled in an Adult Residential Program for Adults with Serious Mental Illness licensed under COMAR 10.21.22 or a Health Home while enrolled in the HCBS benefit.

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (Specify target group(s)):

This HCBS benefit is targeted to youth and young adults with serious emotional disturbances (SED) or co-occurring mental health and substance use disorders and their families.

1. Age: Youth must be under 18 years of age at the time of enrollment although they may continue in HCBS Benefit up to age 22.
2. Consent:
   a. Youth under 16 must have consent from the parent or legal guardian to participate; for young adults who are 16 or older and already enrolled, the young adult must consent to participate. Youth over 16 who are in the care and custody of the State, require consent from their legal guardian.
   b. The consent to participate includes information on the array and availability of services, data collection and information-sharing, and rights and responsibilities under Maryland Medical Assistance.
3. Behavioral Health Disorder:
   a. Youth must have a behavioral health disorder amenable to active clinical treatment.

There must be clinical evidence the child or adolescent has a serious emotional disturbance...
(SED) or co-occurring diagnosis and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment. Because of the clinical requirement that the young person have an SED in order to be covered under the Program, the State will require the young person to be actively involved in ongoing mental health treatment on a regular basis in order to receive 1915(i) services.

**Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

**Home and Community-Based Settings**

(By checking the following box the State assures that):

1. **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution.

(Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)
The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. This may include residence in:

1) a home or apartment with parents, family, or legal guardian or living independently, that is not owned, leased or controlled by a provider of any health-related treatment or support services; or

2) a home or apartment that is a licensed family foster care home or a licensed treatment foster care home. These settings are the private homes of foster parents who must meet a number of standard environmental and physical space dimensions of the home which are geared toward the individual needs of the children who live there. Foster home licensing also requires ongoing training for the foster parents, with more rigorous training, support, and consultation for treatment foster parents. These are not group homes with staff providing services. A group home that is not a therapeutic or high-intensity group home.

**Person-Centered Planning & Service Delivery**

*(By checking the following boxes the state assures that):

1. ✔ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ✔ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ✔ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual’s circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual’s Support Needs and Capabilities.**
   There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

   Care Coordinators will be responsible for conducting a face-to-face assessment of an individual’s and family’s support needs and capabilities. Care Coordinators are employed by the Care Coordination Organizations (CCOs) and have met all the requirements of being a care coordinator. Qualifications for Care Coordination Organizations (CCOs) are described in COMAR 10.09.90, and all 1915(i) participants are required to receive care coordination services under the same regulations. The State Plan Amendment pages for Care Coordination for Children and Youth include detailed requirements for CCOs. Care Coordinators employed by the CCO must demonstrate the following:
i. Bachelor's degree and has met the Department’s training requirements for care coordinators; or
ii. A high school diploma or equivalency and
   a. Is 21 years or older; and
   b. Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who received services from the public and child- and family-serving system; and
   c. Meets the training and certification requirements for care coordinators as set forth by the Department.
   d. Is employed by the CCO to provide care coordination services to participants; and
   e. Provides management of the POC and facilitation of the team meetings.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*
Participants in this State Plan HCBS benefit will participate in the Care Coordination model, facilitated by the CCO. Qualifications for Care Coordination Organizations (CCOs) are described in COMAR 10.09.90, and all 1915(i) participants are required to receive care coordination services under the same regulations. The State Plan Amendment pages for Care Coordination for Children and Youth include detailed requirements for CCOs. Care Coordinators employed by the CCO must demonstrate the following:

1. Bachelor's degree and has met the Department’s training requirements for care coordinators; or
2. A high school diploma or equivalency and
   a. Is 21 years or older; and
   b. Was a participant in, or is a direct caregiver, or was a direct caregiver of an individual who received services from the public and child- and family-serving system; and
   c. Meets the training and certification requirements for care coordinators as set forth by the Department.
   d. Is employed by the CCO to provide care coordination services to participants; and
   e. Provides management of the POC and facilitation of the team meetings.
   f. Care Coordinators may not be related by blood or marriage to the individual, or any paid caregiver of the individual, to whom they deliver care coordination services.

The Clinical Director, a licensed mental health professional, will supervise the development and ongoing implementation of the POC and review and approve the POC.

A core element of the Care Coordination model is the team approach. This team includes the CCO, child or youth (as appropriate), caregiver(s), support persons identified by the family (paid and unpaid), and service providers, including the youth’s treating clinician as available. The team should meet regularly and revisit the POC during meetings.

There are a variety of assessments used to develop the POC, including information collected during the application process, and all life domains are incorporated into the POC. The Child and Adolescent Needs and Strengths (CANS) is administered every 90 days by the CCO supervisor to support identification of strengths and needs for care planning. Information from the family and their identified supports is incorporated as a part of the process.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. (Specify: (a) the supports and information made available, and (b) the participant’s authority to determine who is included in the process):

   The child's/youth's family is informed verbally and in writing about overall services available in the State Plan HCBS benefit at the time they make the choice to enroll. One of the key philosophies in the Care Coordination process is family-determined care. This means that parent(s) or legal guardian, youth and family members are the primary decision makers in the care of their family. The CCO is responsible for working with the participant, family, and team to develop the Plan of Care through the process outlined below.
Within 72 hours of notification of enrollment, the Care Coordination Organization (CCO) contacts the participant and family to schedule a face-to-face meeting. At the first meeting between the CCO, participant, and family after enrollment, the CCO will:

(a) Administer the appropriate assessments, as designated by the Behavioral Health Administration (BHA);
(b) Work with the participant and family to develop an initial crisis plan that includes response to immediate service needs;
(c) Provide an overview of the Care Coordination process; and
(d) Facilitate the family sharing their story.

The CCO will, with the participant and family: identify needs to work on in the planning process; determine team meeting attendees; contact potential team members, provide them with an overview of the Care Coordination process, and discuss expectations for the first team meeting; conduct a strengths-based initial assessment of the participant, their family members and potential team members. Within 30 days of notification of enrollment, the CCO will offer the participant and family the opportunity to determine whether and how to use peer support in the development and implementation of the POC.

The team, which includes the participant and his or her family and informal and formal supports will determine the family vision which will guide the planning process; identify strengths of the entire team; determine the needs that the team will be working on; determine outcome statements for meeting identified needs; determine the specific services and supports required in order to achieve the goals identified in the POC; create a mission statement that the team generates and commits to following; identify the responsible person(s) for each of the strategies in the POC; review and update the crisis plan; and, meet at least every 45 days to coordinate the implementation of the POC and update the POC as necessary.

Before the provision of services in the POC, BHA or its designee shall review and authorize the services designated in the POC. The CCO in collaboration with the team shall reevaluate the POC at least every 45 days with re-administration of BHA-approved assessments as appropriate. During the development of the plan of care, family members and other supports identified by the family also participate as a part of the team. These participants may change as the child's or youth's needs change particularly as he/she is transitioning out of the formal care coordination services. The participant/family will sign and date a document that is part of the POC next to the statement that reads, “My family had voice and choice in the selection of services, providers and interventions, when possible, in the Care Coordination process of building my family's Plan of Care.”

7. Informed Choice of Providers. (Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):

BHA or its designee will have and maintain a database and/or directory available to the CCO and the family from which to choose providers to implement the plan of care. Providers are selected by team with the support of the CCO. Participants are active members who will, depending on age and/or cognitive development, assist in the selection of providers based on the POC and the expertise of the team members. There will be an ongoing enrollment of providers to ensure the capacity is available.
8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.  
(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):

Care Coordination is a team-level decision making process. The team determines the various supports and services that need to be in place for the family with the family and youth driving the process. The team is responsible to hold each other accountable in ensuring the implementation of high quality services for the family. The Care Coordination Organization (CCO) will manage the Plan of Care (POC). The Clinical Director, a licensed mental health professional employed by the CCO, will supervise the development and ongoing implementation of the POC and review and approve the POC. Prior to the provision of services in the POC, BHA or its designee will review and authorize the services designated in the POC based on medical necessity criteria for all Medicaid services. The POC will be provided to BHA or its designee to ensure that services that are authorized are consistent with the POC.

Families have access to services made available in the 1915(i) and public mental health system that will address their individualized needs, as long as they meet medical necessity criteria. Families have the primary decision making responsibility around provider selection. If a family is dissatisfied with a provider, there is an internal process within the CCO to address these needs and mediate as well as transition to another provider when needed. This includes dissatisfaction with CCos and any other providers. The POC process is designed to identify and address the individualized needs of each family. If a plan is not working for the family, the plan is revisited and redesigned to better meet the needs of the family. The team shares the philosophy that “the family doesn’t fail, the plan fails” and in turn needs to be re-developed. Families’ needs and strengths will be identified in part through the CANS as mentioned in the prior questions.

The CCO is responsible for monitoring the implementation of plans of care by service providers. BHA will sample plans of care, review participant records, and track and trend the results of quality management activities as part of the quality assurance plan outlined below. BHA will document the results of ongoing monitoring activities on an as needed basis for reportable events reports, and annual reports, according to the quality improvement strategies, that are provided to the Medicaid Agency. The Medicaid Agency will review the quarterly and annual reports that are prepared by BHA. To address any service deficiencies, the Medicaid Agency will work in collaboration with BHA to implement any necessary changes to a participant’s plan of care, prepare letters to providers that document deficiencies, and impose provider sanctions as needed.

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (check each that applies):

<table>
<thead>
<tr>
<th></th>
<th>Medicaid agency</th>
<th>Operating agency</th>
<th>Case manager</th>
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<tbody>
<tr>
<td>☑️</td>
<td>Other (specify):</td>
<td>Care Coordination Organization</td>
<td></td>
</tr>
</tbody>
</table>

1. State plan HCBS.  
(Complete the following table for each service. Copy table as needed):

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):
**Service Title:** Intensive In-Home Services

**Service Definition (Scope):**

Intensive In-Home Services (IIHS) is a strengths-based intervention with the child and his or her identified family (which may include biological family members, foster family members, treatment foster family members, or other individuals with whom the youth resides). When approved for this service, the IIHS provider sees the family and/or youth at least once each week. The IIHS includes a series of components, including functional assessments and treatment planning, individualized interventions, transition support, and in some cases, crisis response and intervention.

IIHS may be provided to the child alone, to other family members, and to the child and family members together. The services provided to other family members are essential to the positive course of treatment of the youth enrolled in the program. Examples of this include strengthening a caregiver’s ability to manage challenging child behaviors, developing skills in setting appropriate boundaries with the child, and developing de-escalation skills that are necessary to stabilize the young person and the home setting. The IIHS treatment plan must be integrated with the overall POC, and the IIHS providers must work with the team and family to transition out of the intensive service.

IIHS is intended to support a child to remain in his or her home and reduce hospitalizations and out-of-home placements or changes of living arrangements through focused interventions in the home and community. Examples of situations in which IIHS may be used include at the start of a child’s enrollment in the HCBS benefit, upon discharge from a hospital or residential treatment center, or to prevent or stabilize after a crisis situation.

IIHS includes a crisis service component, with IIHS providers immediately available 24 hours per day, 7 days each week to provide services as needed to prevent, respond to, or mitigate a crisis situation. If the crisis cannot be defused, the IIHS provider is responsible for assisting the family in accessing emergency services immediately for that child.

**Additional needs-based criteria for receiving the service, if applicable (specify):**

N/A

**Specify limits (if any) on the amount, duration, or scope of this service.** Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

*Choose each that applies:*

- **Categorically needy (specify limits):**
  
  The service is automatically authorized for 60 days for any individual meeting the eligibility criteria of this 1915(i) State Plan Amendment. Thereafter, the services will be authorized in six month increments. IIHS may not be billed on the same day as Mobile Crisis Response Services (MCRS), Mobile Treatment Services (MTS), partial hospitalization (day treatment), family therapy (not including individual therapy, medication management, or group therapy), an admission to an inpatient hospital or residential treatment center, or therapeutic behavioral services. The services provided under IIHS may not be duplicative of other Public Mental Health System or HCBS benefit services.

- **Medically needy (specify limits):**
Service limits are the same as those for the categorically needy.

**Provider Qualifications** *(For each type of provider. Copy rows as needed):*

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>License</th>
<th>Certification</th>
<th>Other Standard</th>
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<tbody>
<tr>
<td>Intensive In-Home</td>
<td>Health Occupations Article,</td>
<td>Certificate from national or intermediate purveyor</td>
<td>All providers must have a certificate or letter</td>
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<td>Annotated Code of Maryland</td>
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<td>from the national or intermediate purveyor or</td>
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<td>and COMAR 10.63.04</td>
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<td>developer of the particular evidence-based practice</td>
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<td>or promising practice or from MDH to demonstrate</td>
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<td>that the provider meets all requirements</td>
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<td>for the specific type of Intensive In-Home Service,</td>
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<td>for quality assurance, auditing, monitoring, data</td>
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<td>collection and reporting, fidelity monitoring,</td>
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<td>participation in outcomes evaluation, training,</td>
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<td>and staffing, as outlined in regulation.</td>
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<td>MDH will maintain a publicly available list of</td>
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<td>practices that meet the criteria for intensive</td>
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<td>in-home services, including but not limited to</td>
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<td>Family Centered Therapy (FCT) and Intervention</td>
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<td>Program For Children (IHIP-C).</td>
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<td>Providers of Intensive In-Home Services must</td>
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<td>1) There are Clinical Leads, Supervisors, and</td>
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<td>Therapists on staff who are responsible for</td>
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<td>creating, implementing and managing the treatment</td>
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<td>plan with the child and family; and</td>
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<td>2) For IIHS models including an on-call and crisis</td>
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<td>intervention element, these services are:</td>
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<td>i) Provided by a licensed mental health professional</td>
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<td>(psychiatrist, psychologist, nurse psychotherapist</td>
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<td>(APRN-PMH), psychiatric nurse practitioner (CRNP-PMH)</td>
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<td>LCSW-C, LCSW, or</td>
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</table>
LCPC) trained in the intervention; and,

ii) Available 24-hours per day, 7 days per week, during the hours the provider is not open to the individual enrolled in the treatment; and, iii) The program complies with staffing, supervision, training, data collection and fidelity monitoring requirements set forth by the purveyor, developer, or MDH and approved by the Department.

3) Clinical Leads and Supervisors must:
   a) Have a current license as either a licensed certified social worker-clinical (LCSW-C), licensed clinical professional counselor (LCPC), psychologist, psychiatrist, nurse psychotherapists, or advanced practice registered nurse/psychiatric mental health (APRN/PMH) under the Health Occupations Article, Annotated Code of Maryland; and,
   b) Have at least three years of experience in providing mental health treatment to children and families.

4) Therapists must:
   a) Have either a current license as a licensed certified social worker (LCSW), LCSW-C, LCPC, psychologist, psychiatrist, nurse psychotherapist, or APRN/PMH under the Health Occupations Article, Annotated Code of Maryland; and
   b) Be supervised by a Clinical Lead or Supervisor; and
c) See the child in-person at least once in a seven (7) day period

5) In-home stabilizers
   a) Support the implementation of the treatment plan
   b) Must be at least 21 years old;
   c) Must have at least a high school diploma or equivalency; and
   d) Must have completed relevant, comprehensive, appropriate training prior to providing services, as outlined by the purveyor, developer, or MDH and approved by MDH.

Licensed mental health providers are subject to all the rules and regulations in the Maryland Health Occupations Article and to the oversight of their respective licensing boards. The IIHS provider may be a provider of Mobile Treatment Services, an Outpatient Mental Health Clinic, or a Psychiatric Rehabilitation Program for Minors

### Verification of Provider Qualifications

*For each provider type listed above. Copy rows as needed:*

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Entity Responsible for Verification</th>
<th>Frequency of Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive In-Home Services</td>
<td>BHA verifies provider approvals such as PRP, OMHC if applicable. BHA certifies programs not approved by BHA through its Administrative Service Organization</td>
<td>At the time of application, and through a representative sample on an annual basis</td>
</tr>
</tbody>
</table>

### Service Delivery Method

*Check each that applies:*

- [ ] Participant-directed
- [x] Provider managed

### Service Specifications

*(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

**Service Title:** Community-Based Respite Care

**Service Definition (Scope):**

Community-Based Respite Services are temporary care services arranged on a planned or unplanned basis. Respite provides stabilization and relieves a caregiver from the stress of care giving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help
mitigate a potential crisis situation. These services may be provided in the home or the community. Community-based respite services are consistent with existing State of Maryland regulations for in-home respite care which is paid for using State-only dollars (COMAR 10.63.03.15).

Respite care services are those that are:

(1) Provided on a short-term basis in a community-based setting; and
(2) Designed to support an individual to remain in the individual’s home by:
   (a) Providing the individual with enhanced support or a temporary alternative living situation, or
   (b) Assisting the individual’s home caregiver by temporarily freeing the caregiver from the responsibility of caring for the individual. Additionally, the respite services are designed to fit the needs of the individuals served and their caregivers. A program may provide respite care services as needed for an individual based on the Child/Youth and Family Team’s Plan of Care (POC). The specific treatment plan for the community-based respite care should outline the duration, frequency, and location and be designed with a planned conclusion.

<table>
<thead>
<tr>
<th>Additional needs-based criteria for receiving the service, if applicable (specify):</th>
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<tbody>
<tr>
<td>N/A</td>
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</table>

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):
- Categorically needy (specify limits): ☑
Community-based respite services are available to children receiving the HCBS benefit who are residing in his or her family home (biological or kin), legal guardian’s home, pre-adoptive/adoptive, or foster home. Community-based respite services do not include on-going day care or before or after school programs. Community-based respite services are not available to children residing in residential child care facilities (COMAR 14.31.05-.07) or treatment foster homes.

The service is automatically authorized for 60 days for any individual meeting the eligibility criteria of this 1915(i) State Plan Amendment. Thereafter, the services will be authorized in six month increments. A minimum of one hour of the service must be provided to bill, up to a maximum of six hours per day. The services provided under Community-Based Respite Care may not be duplicative of other Public Mental Health System or HCBS benefit services, and will not be paid on the same day as therapeutic behavioral services (COMAR 10.09.34) or any other public mental health system respite services.

The limit may be exceeded only by determination of need in accordance with the person-centered service plan and the participant directed budget. Individuals who may require services beyond the stated limit may work with their care coordinator and service provider to request additional service authorization by the ASO. The ASO will review the request for medical necessity and demonstrated need to extend the service beyond the limit, based on criteria developed by the Department.

The limit on community-based respite is six hourly units allowed in a given day. Thus service provision that might exceed this daily limit may be a situation better suited to use of the out-of-home respite service which can cover up to a 24 hour period. The two respite care services are treated as a continuum of options for providing caregivers with a break.

Medically needy (specify limits):
Service limits are the same as those for the categorically needy.

Provider Qualifications (For each type of provider: Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>License (Specify):</th>
<th>Certification (Specify):</th>
<th>Other Standard (Specify):</th>
</tr>
</thead>
</table>
| Community-Based Respite Care | Health Occupations Article, Annotated Code of Maryland and COMAR 10.63.04 | Certificate from national or intermediate purveyor | Community Based Respite Care Providers Must:  
A. Meet the in-home respite care requirements of COMAR 10.63.03.15, as determined by the Maryland Department of Health;  
B. Ensure that respite care staff are:  
a. 21 years old or older and have a high school diploma or other high
school equivalency; or
b. When providing services to participants under age 13, at least 18 years old and enrolled in or in possession of at least an associate or bachelor’s degree from an accredited school in a human service field.

C. Ensure that community-based respite services are provided in the participant’s home or other community-based setting; and,

D. Follow the program model requirements outlined in COMAR 10.21.27.04-.08 for screening, assessment, staff training and expertise, provision of care, and conclusion of respite episode.

Providers are approved by the Maryland Department of Health.

### Verification of Provider Qualifications

(For each provider type listed above. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>Entity Responsible for Verification (Specify):</th>
<th>Frequency of Verification (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-Based Respite Care</td>
<td>Administrative Service Organization on behalf of the Department</td>
<td>BHA: At the time of enrollment and at least every three years ASO: At the time of enrollment and through a representative sample annually</td>
</tr>
</tbody>
</table>

### Service Delivery Method

(Check each that applies):

- [ ] Participant-directed
- [x] Provider managed

### Service Specifications

(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Out-of-Home Respite</th>
</tr>
</thead>
</table>

Out-of-Home Respite Services are temporary care which is arranged on a planned or unplanned basis. Respite provides stabilization and relieves a caregiver from the stress of care-giving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help mitigate a potential crisis situation. Out-of-home respite is provided in community-based alternative living arrangements that are appropriately licensed, registered, or approved, based on the age of individuals receiving services, and whether the respite has capacity to do overnight services. Out-of-home respite
services may not be provided in an institutional setting or on a hospital or residential facility campus. The services provided under Out-of-Home Respite Care may not be duplicative of other Public Mental Health System or HCBS benefit services.

Additional needs-based criteria for receiving the service, if applicable (specify):

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy (specify limits):

Out-of-Home respite services only are available to children receiving the HCBS benefit who are residing in his or her family home (biological or kin), legal guardian’s home, pre-adoptive/adoptive, or foster home. Out-of-home respite services are not available to children residing in residential child care facilities (COMAR 14.31.05-.07) or treatment foster homes. Out-of-home respite services do not include ongoing day care or before or after school programs.

The service is automatically authorized for a 60 day period after enrollment for any individual meeting the eligibility criteria of this 1915(i) State Plan Amendment. This is not to say that the Out-of-home respite episode would be 60 days in duration, as it is generally offered as a single overnight or in some cases, as a weekend of respite care for a family. After this initial 60-day period, the services will be authorized in six month increments. Out-of-home respite must be provided in a community-based alternative living arrangement outside of the child’s home and must be provided for a minimum of twelve hours overnight in order to bill. Participants may receive a maximum of 24 overnight units of out-of-home respite services annually. This limit is based on the framework of up to one weekend of respite care in a given month, or similar reasonable configuration.

The limit may be exceeded only by determination of need in accordance with the person-centered service plan and the participant directed budget. Individuals who may require services beyond the stated limit may work with their care coordinator and service provider to request additional service authorization by the ASO. The ASO will review the request for medical necessity and demonstrated need to extend the service beyond the limit, based on criteria developed by the Department.

☑ Medically needy (specify limits):

Service limits are the same as those for the categorically needy.

Provider Qualifications (For each type of provider. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify)</th>
<th>License (Specify)</th>
<th>Certification (Specify)</th>
<th>Other Standard (Specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Home Respite</td>
<td>Health Occupations Article, Annotated Code</td>
<td>Certificate from national or intermediate purveyor</td>
<td>Out-of-Home Respite Care Providers must: A. Meet the out-of-home respite care requirements of COMAR 10.63.03, as determined by</td>
</tr>
</tbody>
</table>
of Maryland and COMAR 10.63.04

the Maryland Department of Health.

B. Ensure that respite care staff are:
   a. 21 years old or older and have a high school diploma or other high school equivalency; or
   b. When providing services to participants under age 13, at least 18 years old and enrolled in an accredited post-secondary educational institution or in possession of at least an associate or bachelor's degree from an accredited school in a human services field.

C. Ensure that out-of-home respite services are provided in a community-based alternative living arrangement outside the participant’s home, in accordance with COMAR 14.31.05-.07, where applicable.

D. Follow the program model requirements outlined in COMAR 10.63.04.15 for screening, assessment, staff training and expertise, provision of care, and conclusion of respite episode.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed)*:

<table>
<thead>
<tr>
<th>Provider Type <em>Specify:</em></th>
<th>Entity Responsible for Verification <em>(Specify):</em></th>
<th>Frequency of Verification <em>(Specify):</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Home Respite Care</td>
<td>BHA initial verification of license or approval Administrative Service Organization on behalf of the Department</td>
<td>BHA: At the time of enrollment and at least every three years ASO: At the time of enrollment and</td>
</tr>
</tbody>
</table>
**Service Delivery Method.** *(Check each that applies):*

- [ ] Participant-directed
- [x] Provider managed

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

**Service Title:** Family Peer Support

**Service Definition (Scope):**

Family Peer Support is delivered on an individualized basis by a Peer Support Partner with lived experience who will do some or all of the following, depending on the Plan of Care developed by the CCO, Care Coordinator, and family. These services are specifically supportive of parents and caregivers rather than the child in need and contribute to the overall POC implementation. These services designed to assist families who would otherwise have difficulty engaging the care coordination/treatment process due to a history of accumulated negative experiences with the system which act as a barrier to engagement. The family peer support specialist employed by the Family Support Organization (FSO):

- Participate as a member of the Child/Youth Family Team meetings
- Explain role and function of the FSO to newly enrolled families and at the direction of the CCO linkages to other peers and supports in the community
- Work with the family to identify and articulate their concerns, needs, and vision for the future of their child; and ensure family opinions and perspectives are incorporated into Child/Youth Family Team process and Plan of Care through communication with CCO and Team Members
- Attend Child/Youth Family Team meetings with the family to support family decision making and choice of options
- Listen to the family express needs and concerns from peer perspective and offer suggestions for engagement in the care coordination process
- Provide ongoing emotional support, modeling and mentoring during all phases of the Child/Youth Family Team process
- Help family identify and engage its own natural support system
- Facilitate the family attending peer support groups and other FSO activities throughout POC process
- Work with the family to organize, and prepare for meetings in order to maximize the family’s participation in meetings
- Inform the family about options and possible outcomes in selecting services and supports so they are able to make informed decisions for their child and family
- Support the family in meetings at school and other locations in the community and during court hearings
- Empower the family to make choices to achieve desired outcomes for their child or youth, as well as the family
- Through one-to-one training, help the family acquire the skills and knowledge needed to attain greater self-sufficiency and maximum autonomy.
- Assist the family in developing the skills and confidence to independently identify, seek out and access resources that will assist in managing and mitigating the child/youth’s behavioral
health condition(s), preventing the development of secondary or other chronic conditions, promoting optimal physical and behavioral health, and addressing and encouraging activities related to health and wellness

- Assist in identifying and securing formal and informal resources for the family
- Assist the family in organizing and completing paperwork to secure needed resources
- Educate the family on how to navigate systems of care for their children
- Conduct an assessment related to the need for peer support (including projected frequency and duration) communicate with CCO and other team members

Additional needs-based criteria for receiving the service, if applicable (specify):

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

- Categorically needy (specify limits):
  
The service is automatically authorized for one year for any individual meeting the eligibility criteria of this 1915(i) State Plan Amendment. Thereafter, the services will be authorized in six month increments. The services provided under Family Peer Support may not be duplicative of other Public Mental Health System or HCBS benefit services. Family peer support may be provided, and billed, for meeting with the family in-person as well as for communicating with the family over the phone. Family peer support may not be billed for telephonic communications with other providers or resources. Service limits for peer support as follows: Face to face family support limited to 11 hours per month and telephonic peer support limited to 16 hrs monthly, unless specially approved by BHA for higher levels.

- Medically needy (specify limits):
  
  Service limits are the same as those for the categorically needy.

Provider Qualifications (For each type of provider: Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>License (Specify)</th>
<th>Certification (Specify)</th>
<th>Other Standard (Specify)</th>
</tr>
</thead>
</table>
| Family Peer Support | N/A | The National Certification for Parent Family Peers. The provider may have the certificate, be in the process of obtaining it or under the supervision of an individual | Family peer support must be provided by a Family Support Organization (FSO). To be eligible to provide services as an FSO, the organization must:
  1. Be a private, non-profit entity designated under 501(c)(3) of the Internal Revenue Service Code, and submit copies of the certificate of incorporation and Internal Revenue Service designation;
  2. Submit a list of members of the |
who has the certification.

board of directors with identification that at least 50% meet the following criteria:

a) Are caregivers with a current or previous primary daily responsibility for raising a child or youth with behavioral health challenges; and/or

b) Are individuals who have experience with State or local services and systems as a consumer who has or had behavioral health challenges

(3) Establish hiring practices that give preference to current or previous caregivers of youth with behavioral health challenges and/or individuals who have experience with State or local services and systems as a consumer who has or had behavioral health challenges, and submit a copy of the organization’s personnel policy that sets forth this preferred employment criteria;

(4) Employ a staff that is comprised of at least 75% individuals who are current or previous caregivers of youth with behavioral health challenges, or are individuals who have experience with State or local services and systems as a consumer who has or had emotional, behavioral health challenges, and submit a list of staff and positions held with identification of those who fit the experienced caregiver and consumer criteria; and

(5) Maintain general liability insurance to provide family peer support, the peer support provider shall:

(1) Be employed by a Family Support Organization;

(2) Be at least 18 years old;

(3) Receive supervision from an individual who is at least 21 years old and has at least three years of
experience providing family peer support or working with children with serious behavioral health challenges and their families;
(4) Have current or prior experience as a caregiver of a child with behavioral health challenges or be an individual with experience with State or local services and systems as a consumer who has or had behavioral health challenges; and

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Entity Responsible for Verification</th>
<th>Frequency of Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Peer Support</td>
<td>Administrative Service Organization on behalf of the Department</td>
<td>BHA: At the time of enrollment and at least every three years ASO</td>
</tr>
</tbody>
</table>

Service Delivery Method. (Check each that applies):
- [ ] Participant-directed
- [x] Provider managed

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Expressive and Experiential Behavioral Services</th>
</tr>
</thead>
</table>

Service Definition (Scope):
Expressive and Experiential Behavioral Services are adjunct therapeutic modalities to support individualized goals as part of the plan of care. These services involve action on the part of the provider and the participant. The aim of creative therapeutic modalities is to help participants find a form of expression beyond words or traditional therapy. They include techniques that can be used for self-expression and personal growth and aid in the healing and therapeutic process.

Experiential and Expressive Therapeutic Services include the following, and may include other specific service types if they meet MDH’s standards for training, certification, and accountability:
- Art Behavioral Services
- Dance/Movement Behavioral Services
- Equine-Assisted Behavioral Services
- Horticultural Behavioral Services
- Music Behavioral Services
- Drama Behavioral Services

Additional needs-based criteria for receiving the service, if applicable (specify):
N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any
individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. 

(Choose each that applies):

- **Categorically needy (specify limits):**
  
  Expressive and Experiential Behavioral Service Providers must receive prior authorization from the Administrative Service Organization for these services before providing them to participants. Participants may receive a maximum of two different expressive and experiential behavioral services on the same day.

- **Medically needy (specify limits):**
  
  Service limits are the same as those for the categorically needy.

**Provider Qualifications (For each type of provider. Copy rows as needed):**

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>License (Specify):</th>
<th>Certification (Specify):</th>
<th>Other Standard (Specify):</th>
</tr>
</thead>
</table>
| Expressive and Experiential Behavioral Service Providers | N/A | Board Certified Therapeutic Provider per specific therapeutic discipline | Programs are approved by the Maryland Department of Health. Licensed mental health providers are subject to all the rules and regulations in the Maryland Health Occupations Article and to the oversight of their respective licensing boards. 
To provide a particular expressive and experiential behavioral service, an individual shall have: 
(a) A bachelor’s or master’s degree from an accredited college or university; and 
(b) Current registration in the applicable certification body. 
The Department of Health and Mental Hygiene will maintain a publicly available list of Certification Bodies. 
The provider organization must maintain general liability insurance |

**Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):**

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>Entity Responsible for Verification (Specify):</th>
<th>Frequency of Verification (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressive and Experiential Behavioral Service</td>
<td>Administrative Service Organization on behalf of the Department</td>
<td>At the time of application and annually</td>
</tr>
</tbody>
</table>

**Service Delivery Method. (Check each that applies):**

- [ ] Participant-directed
- [ ] Provider managed
2. **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state’s strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*
Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (Select one):
   - The state does not offer opportunity for participant-direction of State plan HCBS.
   - Every participant in State plan HCBS (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
   - Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. (Specify criteria):

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

3. Limited Implementation of Participant-Direction. (Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):
   - Participant direction is available in all geographic areas in which State plan HCBS are available.
   - Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit’s standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (Specify the areas of the state affected by this option):

4. Participant-Directed Services. (Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):

<table>
<thead>
<tr>
<th>Participant-Directed Service</th>
<th>Employer Authority</th>
<th>Budget Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

5. Financial Management. (Select one):
   - Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
   - Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.
6.  □ Participant–Directed Person-Centered Service Plan. (By checking this box the state assures that):

Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.
7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual’s transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. **Opportunities for Participant-Direction**
   a. **Participant–Employer Authority** *(individual can select, manage, and dismiss State plan HCBS providers). *(Select one):*

   - The state does not offer opportunity for participant-employer authority.
   - Participants may elect participant-employer Authority *(Check each that applies):*
     - **Participant/Co-Employer.** The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
     - **Participant/Common Law Employer.** The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

   b. **Participant–Budget Authority** *(individual directs a budget that does not result in payment for medical assistance to the individual). *(Select one):*

   - The state does not offer opportunity for participants to direct a budget.
   - Participants may elect Participant–Budget Authority.

     **Participant-Directed Budget.** *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan):*

     **Expenditure Safeguards.** *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards)*
Quality Improvement Strategy

Quality Measures

(Describe the state’s quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

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

2. 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 state plan 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 state plan for 1915(i) HCBS.

3. Providers meet required qualifications.

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

5. The SMA retains authority and responsibility for program operations and oversight.

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

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Discovery Evidence (Performance Measures)</th>
<th>Discovery Activity (Source of Data &amp; sample size)</th>
<th>Monitoring Responsibilities (agency or entity that conducts discovery activities)</th>
<th>Frequency</th>
<th>Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</th>
<th>Frequency of Analysis and Aggregation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Service plans address</td>
<td></td>
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<tr>
<td>a) assessed needs of 1915(i) participants,</td>
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<tr>
<td>b) are updated annually, and</td>
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<tr>
<td>c) document choice of services and providers.</td>
<td>a) % of participants who had a team meeting at least every 45 days</td>
<td>1. Defensible sample of case files (electronic or paper) of participants who were enrolled during the time period under review</td>
<td>1. MDH/BHA, with CSAs/LBHAs</td>
<td>1. Every 12 months</td>
<td>1. MDH/BHA with CSAs/LBHAs</td>
<td>If a performance improvement plan is needed, a program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to BHA, ASO, and CSA, as applicable, within 30 working days of notice of program deficiencies. The CSA will follow up with the program 3 months after the final implementation of the performance improvement plan.</td>
</tr>
<tr>
<td></td>
<td>b) % of participants whose plan of care (POC) was updated to include change in progress, services or other areas within ten (10) days of the team meeting</td>
<td>2. Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review</td>
<td>2. MDH/BHA with CSAs/LBHAs</td>
<td>2. Every 12 months</td>
<td>2. MDH/BHA with CSAs/LBHAs</td>
<td></td>
</tr>
<tr>
<td>3. Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review</td>
<td>3. MDH/BHA with CSAs/LBHAs</td>
<td>3. Every 12 months</td>
<td>3. MDH/BHA with CSAs/LBHAs</td>
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<tr>
<td>c) % of participants whose POC indicates they were afforded choice in the selection of services and providers</td>
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</tbody>
</table>
### 3) Providers meet required qualifications.

<p>| a) % of providers who have submitted 1915(i) HCBS claims who are approved as providers by Maryland Medicaid | 1 &amp; 2. Defensible sampling strategy of provider files and related documentation. The sample will be drawn from providers who filed claims for services provided under the HCBS benefit during the time period under review. | 1 &amp; 2. ASO | Annually | MDH/BHA | If a performance improvement plan is needed, a program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to BHA within 30 working days of notice of program deficiencies. The CSA will follow up with the program 3 months after the final implementation of the performance improvement plan. |
| 4) Settings meet the home and community-based setting requirements as specified in this SPA. | 1. % of youth who are dis-enrolled as a result of moving to a setting that is not authorized in this SPA. | 1. Semi-annual sampling of entire enrolled roster | 1. MDH/BHA with the CSAs/LBHAs | Semi-Annually | MDH/BHA | Based on the findings, OHS and BHA will create a performance improvement plan within 30 working days of identification of deficiencies |</p>
<table>
<thead>
<tr>
<th>5) The SMA retains authority and responsibility for program operations and oversight.</th>
<th>a) % of quarterly progress reports submitted to MDH/Office of Health Services</th>
<th>1. Quarterly reports are provided to OHS by BHA</th>
<th>1&amp;2. MDH/BHA</th>
<th>Annually</th>
<th>MDH/BHA &amp; MDH/OHS</th>
<th>Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) % of enrollment census updates distributed to OHS</td>
<td>2. Review of distribution list for census updates issued by BHA</td>
<td>3. Review CASII/CONS documentation</td>
<td>3. ASO/BHA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Medical Eligibility/enrollment Oversight</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

<table>
<thead>
<tr>
<th>% of HCBS benefit service claims processed appropriately against fund source, authorization history, service limitations, and coding.</th>
<th>Defensible sampling strategy; point in time review of services received.</th>
<th>MDH/ASO</th>
<th>Annually</th>
<th>MDH/BHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. % of participants with completed financial eligibility reviews in accordance with policy at initial and redetermination (to include Medical Assistance eligibility and Level of Intensity documentation).</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

If a performance improvement plan is needed, a program director must submit a proposal within 10 working days. The final performance improvement plan must be submitted to BHA within 30 working days of notice of program deficiencies. The CSA will follow up with the program 3 months after the final implementation of the performance improvement plan. The Office of Compliance is a unit within the BHA responsible for identifying fraud and abuse, educating providers about compliance issues, and ensuring consistency with State and federal regulations. BHA may direct the ASO to retract paid claims, and may refer noncompliant providers to the Office of the Inspector General or Medicaid Fraud Unit with the Attorney General’s Office. BHA participates with the Office of Inspector General to identify provider outliers for investigation of potential fraud and abuse.
<table>
<thead>
<tr>
<th>7) The state identifies, addresses and seeks to prevent incidents of abuse, neglect, exploitation, including the use of restraints, and unexplained deaths.</th>
<th>% of reportable events involving abuse, neglect, exploitation, and/or unexplained deaths reported that are resolved according to policy</th>
<th>All reportable event forms are reviewed for compliance.</th>
<th>MDH/BHA</th>
<th>Annually, and continuously, as needed when a complaint/incident is received.</th>
<th>MDH/BHA</th>
<th>MDH will investigate if a performance improvement plan is needed. If necessary, the program director must submit a proposal within 10 working days.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) 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;</td>
<td>Utilization review of services on POC in conjunction with provider authorization and claims data</td>
<td>Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review</td>
<td>ASO</td>
<td>Semi-Annually</td>
<td>MDH/BHA with ASO &amp; CSAs</td>
<td>Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.</td>
</tr>
<tr>
<td>b) The process and instruments the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately, and</td>
<td>Number of participants who meet all eligibility criteria.</td>
<td>Review of all POC and referral forms uploaded into the ASO’s system during identified time period for a defensible sample of participants who were enrolled in the service.</td>
<td>ASO</td>
<td>Semi-Annually</td>
<td>MDH/BHA with ASO &amp; CSAs</td>
<td>Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.</td>
</tr>
<tr>
<td>c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the state plan for 1915(i) HCBS.</td>
<td>Percent of participants who were re-evaluated for eligibility after one year.</td>
<td>Review authorization data for participants who were continually enrolled for one year from the sample.</td>
<td>ASO</td>
<td>Semi-annually</td>
<td>MDH</td>
<td>Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.</td>
</tr>
</tbody>
</table>
**System Improvement**
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

<table>
<thead>
<tr>
<th>Methods for Analyzing Data and Prioritizing Need for System Improvement</th>
<th>Roles and Responsibilities</th>
<th>Frequency</th>
<th>Method for Evaluating Effectiveness of System Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>When data analysis reveals the need for system change, recommendations may be made along with a prioritization of design changes. Plans developed as a result of this process will be shared with stakeholders. All issues related to health, welfare, and safety will be prioritized above all else. Some issues may be monitored for a period of time if they do not threaten the health, welfare, or safety of participants and do not impede the State’s ability to receive federal financial participation.</td>
<td>MDH, BHA, in conjunction with the ASO and the CSAs, will gather and analyze the data and identify areas for quality improvement.</td>
<td>Annually</td>
<td>The Department or its designee will examine prior year data and examine data, to the extent it is available, on the functional outcomes of youth served through the HCBS Benefit, particularly with regard to remaining in or returning to a family-living environment, attending school or work, and not having future involvement with the juvenile justice or adult corrections systems. There will also be a focus on the comprehensive cost of care for youth enrolled in the HCBS benefit and served by the CCOs, as well as the psychotropic medication prescribing for these youth and their access to physical and oral health care services.</td>
</tr>
</tbody>
</table>
Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

| ☑ | HCBS Respite Care |
| ☐ | HCBS Case Management |
| ☐ | HCBS Homemaker |
| ☐ | HCBS Home Health Aide |
| ☐ | HCBS Personal Care |
| ☐ | HCBS Adult Day Health |
| ☐ | HCBS Habilitation |
COMMUNITY-BASED RESPITE CARE

Community-based respite services are provided for a minimum of one hour and a maximum of six hours per day, and may not be billed on the same day as out of home respite. These are paid using a service unit of one hour.

Assumptions
68% billable time
Respite Care worker has caseload of 15
Hourly rate is added to hourly pay for respite care worker of $13/hour Additional $1 youth activity fee per hour is added to total

Payment for Community Based Respite Care service as outlined per Attachment 3.1-i page 24-25 and is reimbursed at an hourly unit of service. Community Based Respite Care providers are defined per Attachment 3.1-i page 25-26.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services

<table>
<thead>
<tr>
<th>Annual Amount or Rate</th>
<th>% FT</th>
<th>Salary Cost</th>
<th>Fringe Benefits (30%)</th>
<th>Salary + Fringe Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite Supervisor</td>
<td>0.10</td>
<td>$5,000.00</td>
<td>$1,500.00</td>
<td>$6,500.00</td>
</tr>
<tr>
<td>Admin. Support</td>
<td>0.05</td>
<td>$1,750.00</td>
<td>$525.00</td>
<td>$2,275.00</td>
</tr>
<tr>
<td>Total</td>
<td>0.15</td>
<td>$6,750.00</td>
<td>$2,025.00</td>
<td>$8,775.00</td>
</tr>
</tbody>
</table>

Other Costs (based on FTE)
Rent (144 Square Feet @ $15 per square foot per FTE) $324.00
Cellular Phone, Internet & Communications (@$110/month per FTE) $198.00
Mileage (10,000 miles per year @ $0.555/mile) $5,550.00
Insurance (general liability, professional liability) @$1,000 per FTE $150.00
Indirect Cost (7% of salaries) $472.50
Total cost for 1 FTE respite care worker $15,469.50
Hourly Rate--Not Including Respite Care Worker (Based on 1386 hours) $11.16
Hourly Rate for Administration + Respite Care Worker + $1 Activity Fee $25.16

State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the schedule are published at the above website address.
OUT OF HOME RESPITE CARE

Out of Home respite services are provided on an overnight basis for a minimum of 12 hours, and are reimbursed using a flat per diem rate. The service has a maximum of 24 units per year, subject to medical necessity criteria override. The service may not be billed on the same day as community-based respite.

<table>
<thead>
<tr>
<th>Out-of-Home Respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median per diem rate for 109 &quot;preferred&quot; programs</td>
</tr>
<tr>
<td>10% Administrative Charge</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

The rate development is based on the Fiscal Year 2012 Maryland Interagency Rates Committee (IRC) rates for residential child care facilities and child placement agencies. The IRC is charged with developing and operating a rate process for residential child care and child placement agency programs that is fair, equitable and predictable, and is comprised of representatives from the Department of Budget and Management, Maryland Department of Health Administration/Behavioral Health Administration, Department of Human Resources/Social Services Administration, Department of Juvenile Services, Governor's Office for Children and the Maryland State Department of Education (http://www.marylandpublicschools.org/MSDE/divisions/earlyinterv/IRC).

The IRC identifies programs as "preferred" or "non-preferred." For this rate development, only preferred provider rates were incorporated. Additionally, only the per diem rates for group homes, therapeutic group homes, and treatment foster care providers were included.

The fiscal model identified in the August 2006 Real Choice Systems Change Grants for Community Living: A Feasibility Study to Consider Respite Services for Children with Disabilities in Maryland prepared by The Hilltop Institute (formerly the Center for Health Program Development and Management) at UMBC included a 10% administrative cost for training, family support, outreach and provider recruitment that was specific to the youth at the highest levels of care. A similar finding of a need for additional administrative funds was identified by the Respite Care Committee under the Maryland Blueprint for Children's Mental Health Committee.

Payment for Out Of Home Respite Care service as outlined per Attachment 3.1-i page 24-25 and is reimbursed at an hourly unit of service. Out Of Home Respite Care providers are defined per Attachment 3.1-i page 25-26.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-Children,-Youth-and-Families.aspx State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.
For Individuals with Chronic Mental Illness, the following services:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HCBS Psychosocial Rehabilitation</td>
</tr>
</tbody>
</table>

HCBS Day Treatment or Other Partial Hospitalization Services
## Intensive In-Home Services (IIHS) – EBP

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Annual Amount or Rate</th>
<th>% FT E</th>
<th>Salary Cost</th>
<th>Fringe Benefits (25%)</th>
<th>Salary + Fringe Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist</td>
<td>$ 50,000</td>
<td>1</td>
<td>$ 50,000</td>
<td>$ 12,500</td>
<td>$ 62,500.00</td>
</tr>
<tr>
<td>Supervisor/Clinical Lead</td>
<td>$ 75,000</td>
<td>0.20</td>
<td>$ 15,000</td>
<td>$ 3,750</td>
<td>$ 18,750.00</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>$ 100,000</td>
<td>0.09</td>
<td>$ 9,000</td>
<td>$ 2,250</td>
<td>$ 11,250.00</td>
</tr>
<tr>
<td>Quality Assurance/Management Info. Systems Director</td>
<td>$ 90,000</td>
<td>0.09</td>
<td>$ 8,100</td>
<td>$ 2,025</td>
<td>$ 10,125.00</td>
</tr>
<tr>
<td>Admin. Assistant</td>
<td>$ 35,000</td>
<td>0.25</td>
<td>$ 8,750</td>
<td>$ 2,188</td>
<td>$ 10,937.50</td>
</tr>
<tr>
<td>Billing Support Specialist</td>
<td>$ 35,000</td>
<td>0.05</td>
<td>$ 1,750</td>
<td>$ 438</td>
<td>$ 2,187.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1.68</td>
<td></td>
<td>$ 92,600</td>
<td>$ 23,150</td>
<td>$ 115,750</td>
</tr>
</tbody>
</table>

Rent ($15/sq ft, 144 sq ft per FTE)  
Office supplies and maintenance (paper, postage, pens, printing, copier/fax) @ $750 per FTE  
Mileage (20,000 miles per year @ $0.555/mile)  
Management Information System @ $150 per FTE  
Insurance (general liability, professional liability) @ $1,000 per FTE  
Indirect Cost (7% of salaries)  
**Total Cost for 1 FTE Therapist**  
**Weekly rate (Total Cost/52 weeks/11 clients)**

### Assumptions:
- Supervisor caseload of 5 therapists
- Maximum length of service is 16 weeks

Intensive In-Home Services (IIHS) providers may be reimbursed at a regular weekly rate of service. The approved IIHS providers will bill the Maryland Department of Health directly for the services rendered. No more than one unit of service may be billed for services delivered at the same time by the same staff. Private and public IIHS providers will be reimbursed at the same rate.

The rate development adheres to the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in current IIHS program. Cost estimates conform to our
experience with programs similar to IIHS in Maryland, including the salaries paid.

An IIHS provider may bill for a week only if an IIHS activity occurred for the covered youth on at least one day of the billable week. A minimum of one (1) face-to-face contact is required per week. At least fifty percent (50%) of therapist’s contacts with the youth and/or family must be face-to-face. A minimum of fifty percent (50%) of the therapist’s time must be spent working outside the agency and in the youth’s home or community, as documented in the case notes. An individual can only receive IIHS services from one provider at a time. Partial hospitalization/day treatment, mobile crisis response services (MCRS), and other family therapies cannot be charged at the same time. IIHS providers are expected to provide crisis response services for the youth on their caseload.

An evidence-based practice (EBP) is defined as a program, intervention or service that:

1. is recognized by MDH as an EBP for youth;
   a. are derived from rigorous, scientifically controlled research; and
   b. can be applied in community settings with a defined clinical population;
2. has a consistent training and service delivery model;
3. utilizes a treatment manual; and
4. has demonstrated evidence that successful program implementation results in improved, measureable outcomes for recipients of the service intervention.

The rate is higher for those programs that are identified as an EBP, in keeping with the established practice of different reimbursement rates for an EBP versus non-EBP service (e.g., Mobile Treatment Services and Assertive Community Treatment).

The weekly rate for the IIHS-EBP program is based on the cost of a therapist with a maximum caseload of 11 and a maximum length of stay in the program of 16 weeks. The supervisor caseload is a ratio of 1:5. The rate includes other costs, including mileage costs (at least 50% of face-to-face contacts must be in the home or community, and the therapist must see the youth and family face-to-face at least once each week), rent, and communications costs.

Payment for Intensive In-Home service as outlined per Attachment 3.1-i page 15-16 and is reimbursed a weekly unit of service. Intensive In-Home providers are defined per Attachment 3.1-i page 16-19.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-Children,-Youth-and-Families.aspx State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

**Intensive In-Home Services (IIHS)- NON EBP**
### Personnel

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Annual Amount or Rate</th>
<th>% FTE</th>
<th>Salary Cost</th>
<th>Fringe Benefits (25%)</th>
<th>Salary + Fringe Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist</td>
<td>$50,000</td>
<td>0.50</td>
<td>$25,000</td>
<td>$6,250</td>
<td>$31,250.00</td>
</tr>
<tr>
<td>Supervisor/Clinical Lead</td>
<td>$75,000</td>
<td>0.20</td>
<td>$15,000</td>
<td>$3,750</td>
<td>$18,750.00</td>
</tr>
<tr>
<td>In-Home Stabilizer</td>
<td>$40,000</td>
<td>0.50</td>
<td>$20,000</td>
<td>$5,000</td>
<td>$25,000.00</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>$100,000</td>
<td>0.08</td>
<td>$8,000</td>
<td>$2,000</td>
<td>$10,000.00</td>
</tr>
<tr>
<td>Admin. Assistant</td>
<td>$35,000</td>
<td>0.25</td>
<td>$8,750</td>
<td>$2,188</td>
<td>$10,937.50</td>
</tr>
<tr>
<td>Billing Support Specialist</td>
<td>$35,000</td>
<td>0.05</td>
<td>$1,750</td>
<td>$438</td>
<td>$2,187.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1.58</strong></td>
<td></td>
<td><strong>$78,500</strong></td>
<td><strong>$19,625</strong></td>
<td><strong>$98,125</strong></td>
</tr>
</tbody>
</table>

### Other Costs

<table>
<thead>
<tr>
<th>Cost Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent ($15/sq ft, 144 sq ft per FTE)</td>
<td>$3,412.80</td>
</tr>
<tr>
<td>Cellular Phone, Internet &amp; Communications (@$110/month per FTE)</td>
<td>$2,085.60</td>
</tr>
<tr>
<td>Office supplies &amp; maintenance (paper, postage, pens, printing, copier/fax) @ $750 per FTE</td>
<td>$1,185.00</td>
</tr>
<tr>
<td>Mileage (20,000 miles per year @ $0.555/mile)</td>
<td>$11,100.00</td>
</tr>
<tr>
<td>Management Information System @$150 per FTE</td>
<td>$237.00</td>
</tr>
<tr>
<td>Insurance (general liability, professional liability) @$1,000 per FTE</td>
<td>$1,580.00</td>
</tr>
<tr>
<td>Indirect Cost (7% of salaries)</td>
<td>$5,495.00</td>
</tr>
<tr>
<td><strong>Total Cost FTE</strong></td>
<td><strong>$123,220.40</strong></td>
</tr>
</tbody>
</table>

### Weekly rate (total cost/(52*12))

| Weekly rate (total cost/(52*12)) | $197.47 |

### Assumptions:
- Caseload of 12 clients
- Supervisor caseload of 5 therapists
- Youth may stay in for a year
- Clients are supported by .5 FTE therapist, .5 FTE in-home stabilizer, .2 supervisor/clinical lead, and .08 clinical director

Intensive In-Home Services (IIHS) providers may be reimbursed at a regular weekly rate of service. The approved IIHS providers will bill the Maryland Department of Health directly for the services rendered. No more than one unit of service may be billed for services delivered at the same time by the same staff. Private and public IIHS providers will be reimbursed at the same rate.

The rate development adheres to the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in current IIHS program. Cost estimates conform to our experience with programs similar to IIHS in Maryland, including the salaries paid.
An IIHS provider may bill for a week only if an IIHS activity occurred for the covered youth on at least one day of the billable week. A minimum of one (1) face-to-face contact is required per week. At least fifty percent (50%) of therapist’s contacts with the youth and/or family must be face-to-face. A minimum of fifty percent (50%) of the therapist’s time must be spent working outside the agency and in the youth’s home or community, as documented in the case notes. An individual can only receive IIHS services from one provider at a time. Partial hospitalization/day treatment, mobile crisis response services (MCRS), and other family therapies cannot be charged at the same time. IIHS providers are expected to provide crisis response services for the youth on their caseload.

The weekly rate for the IIHS program is based on the cost of a therapist (.5 FTE) and in-home stabilizer (.5 FTE) with a shared caseload of 1:12. An in-home stabilizer provides some of the face-to-face services. The supervisor caseload is a ratio of 1:5. The rate includes other costs, such as rent, communications (phone, internet), and mileage.

Payment for Intensive In-Home service as outlined per Attachment 3.1-i page 15-16 and is reimbursed a weekly unit of service. Intensive In-Home providers are defined per Attachment 3.1-i page 16-19.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-Children,-Youth-and-Families.aspx State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

EXPRESSIVE AND EXPERIENTIAL BEHAVIORAL SERVICES

<table>
<thead>
<tr>
<th>Proposed Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressive Therapies--Individual, LMHP</td>
</tr>
<tr>
<td>45-50 minutes</td>
</tr>
<tr>
<td>$68.41</td>
</tr>
<tr>
<td>Expressive Therapies--Individual, LMHP</td>
</tr>
<tr>
<td>75-80 minutes</td>
</tr>
<tr>
<td>$89.62</td>
</tr>
<tr>
<td>Expressive Therapies--Individual, non LMHP</td>
</tr>
<tr>
<td>45-50 minutes</td>
</tr>
<tr>
<td>$62.19</td>
</tr>
<tr>
<td>Expressive Therapies--Individual, non LMHP</td>
</tr>
<tr>
<td>75-80 minutes</td>
</tr>
<tr>
<td>$80.85</td>
</tr>
<tr>
<td>Expressive Therapies--Group, LMHP</td>
</tr>
<tr>
<td>45-60 minutes</td>
</tr>
<tr>
<td>$24.16</td>
</tr>
<tr>
<td>Expressive Therapies--Group, LMHP</td>
</tr>
<tr>
<td>75-90 minutes</td>
</tr>
<tr>
<td>$31.41</td>
</tr>
<tr>
<td>Expressive Therapies--Group, non LMHP</td>
</tr>
<tr>
<td>45-60 minutes</td>
</tr>
<tr>
<td>$27.20</td>
</tr>
<tr>
<td>Expressive Therapies--Group, non LMHP</td>
</tr>
<tr>
<td>75-90 minutes</td>
</tr>
<tr>
<td>$35.36</td>
</tr>
</tbody>
</table>

LMHP = Licensed Mental Health Practitioner

Rates from FY13 PMHS:

<table>
<thead>
<tr>
<th>Rate Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-50 minute rate for an individual clinician in PMHS, FY 13</td>
<td>62.19</td>
</tr>
<tr>
<td>75-80 minute rate for C&amp;A Prolonged Psychotherapy</td>
<td>80.85</td>
</tr>
<tr>
<td>45-60 minute rate for C&amp;A group psychotherapy</td>
<td>27.2</td>
</tr>
<tr>
<td>Prolonged rate for C&amp;A Group Psychotherapy</td>
<td>35.36</td>
</tr>
</tbody>
</table>

The approved expressive & experiential behavioral therapy providers will bill the Maryland Department of Health directly for the services rendered. No more than
one unit of service may be billed for services delivered at the same time by the same staff. Private and public expressive and experiential behavioral therapy providers will be reimbursed at the same rate.

Rate development: The following details the rate development for expressive and experiential behavioral therapy services. Expressive and Experiential Behavioral Therapy Services Providers must have a) A bachelor's or master's degree from an accredited college or university; and (b) Current registration in the applicable association. The applicable registrations and associations include the following:

- Dance Therapist Registered or Academy of Dance Therapists Registered in The American Dance Therapy Association
- Certified by The Equine Assisted Growth and Learning Association (EAGALA) to provide services under the EAGALA model or The North American Handic
- Horticultural Therapist Registered by The American Horticultural Therapy Association
- Music Therapist-Board Certified by the Board for Music Therapists, Inc in the American Association for Music Therapy, Inc.
- Registered Drama Therapist or Board Certified Trainer in the National Association for Drama Therapy

These associations, registrations and certifications were identified as having comprehensive standards, continuing education requirements, and examinations. As such, the rate for this service has been aligned with the Medicaid rate for individual practitioners (licensed certified social worker-clinical, nurse psychotherapist, licensed clinical professional counselor, licensed clinical marriage and family therapist, and certified registered nurse practitioner-psychiatric) for 45-50 minutes of individual therapy with a child or adolescent ($62.19/hour). These rates were set by the State of Maryland at approximately 70% of the Medicare rate for individual therapy provided by practitioners of a similar skill level.

Expressive and experiential behavioral therapy service providers who are licensed mental health professionals (licensed certified social worker-clinical, nurse psychotherapist, licensed clinical professional counselor, licensed clinical marriage and family therapist, and certified registered nurse practitioner-psychiatric) are reimbursed for this service at a rate that is 10% greater than the standard rate for non-mental health licensed professionals providing the same service. A differential was selected based on the additional costs to providers to obtain and maintain their license and the cost of and time required to obtain continuing education credits.

In the 1915(c) PRTF Demonstration Waiver (RTC Waiver), it was difficult to 1) Ascertain how many of the expressive and experiential behavioral service providers were also licensed mental health clinicians and 2) encourage licensed mental health clinicians who were already Public Mental Health System providers to enroll to provide the additional service (a necessary step in helping families and youth to identify the most appropriate provider to address their needs). As a result, the high rate was developed to address both of these issues through a mechanism to encourage provider enrollment and more accurately track provider utilization. The group rates were set based on
the C&A Group Psychotherapy Rates.

Payment for Expressive and Experiential Behavioral service as outlined per Attachment 3.1-i page 29-30 and is reimbursed either a 45-50 unit of service or a 75-80 unit of service. Expressive and Experiential Behavioral providers are defined as per Attachment 3.1-i page 27-29.

The agency's fee schedule was set as of October 1, 2014 and is effective for service provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-

State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.

### FAMILY PEER SUPPORT

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Annual Amount or Rate</th>
<th>% FT</th>
<th>Salary Cost</th>
<th>Fringe Benefits (25%)</th>
<th>Salary + Fringe Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Support Partner</td>
<td>$36,000</td>
<td>1</td>
<td>$36,000</td>
<td>$9,000</td>
<td>$45,000.00</td>
</tr>
<tr>
<td>Family Support Partner Supervisor</td>
<td>$58,500</td>
<td>0.10</td>
<td>$5,850</td>
<td>$1,463</td>
<td>$7,312.50</td>
</tr>
<tr>
<td>Administrative Assistant</td>
<td>$35,000</td>
<td>0.25</td>
<td>$8,750</td>
<td>$2,188</td>
<td>$10,937.50</td>
</tr>
<tr>
<td>Billing Support Specialist</td>
<td>$35,000</td>
<td>0.05</td>
<td>$1,750</td>
<td>$438</td>
<td>$2,187.50</td>
</tr>
<tr>
<td>Administrator</td>
<td>$55,000</td>
<td>0.05</td>
<td>$2,750</td>
<td>$688</td>
<td>$3,437.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>1.45</td>
<td>$55,100</td>
<td>$13,775</td>
<td>$68,875.00</td>
</tr>
</tbody>
</table>

**Billable Time**

<table>
<thead>
<tr>
<th>Personnel</th>
<th>Total work hours per year (8 hour day * 260)</th>
<th>Vacation, sick &amp; holiday leave: 20 days@8</th>
<th>Training: 16 days @8 hours per day</th>
<th>Travel (not with client): 10 hours per week</th>
<th>Total Non-Billable Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Support Partner</td>
<td>2080</td>
<td>Vacation, sick &amp; holiday leave: 20 days@8</td>
<td>Training: 16 days @8 hours per day</td>
<td>Travel (not with client): 10 hours per week</td>
<td>1352</td>
</tr>
<tr>
<td>Family Support Partner Supervisor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Assistant</td>
<td>160</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Billing Support Specialist</td>
<td>128</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrator</td>
<td>440</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>728</td>
<td></td>
<td></td>
<td></td>
<td>1352</td>
</tr>
</tbody>
</table>

0.35 % Non-Billable
Other Costs

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent ($15/sq ft, 144 sq ft per FTEs)</td>
<td>$3,132.00</td>
</tr>
<tr>
<td>Cellular Phone, Internet &amp; Communications (@$110/month per FTE)</td>
<td>$1,914.00</td>
</tr>
<tr>
<td>Mileage (10,500 miles per year @ $0.555/mile)</td>
<td>$5,827.50</td>
</tr>
<tr>
<td>Office supplies &amp; maintenance (printing, copier/fax, etc) @ $750 per FTE</td>
<td>$1,088</td>
</tr>
<tr>
<td>Management Information System User Fees (@$150/FTE)</td>
<td>$218</td>
</tr>
<tr>
<td>Insurance (general liability, professional liability) @ $1,000 per FTE</td>
<td>$1,450</td>
</tr>
<tr>
<td>Indirect Cost (7% of salaries)</td>
<td>$3,857</td>
</tr>
<tr>
<td><strong>Total Cost FTE</strong></td>
<td><strong>$86,360.50</strong></td>
</tr>
</tbody>
</table>

**Hourly rate** $63.88  
**30 minute rate** $31.94  
**15 minute rate** $15.97  
**15 minute telephonic/non-face-to-face rate** $7.98

Assumptions:
*Supervisor: FSP ratio is 1:10

The rate development adheres to the CMS-accepted methodology for cost-based rates, which includes salary, fringe benefits, indirect costs, and transportation costs based on an average of the mileage experience in current peer support programs. Cost estimates conform to our experience with peer support in Maryland.

The 15-minute rate was calculated as the cost for one family support partner for 12 months divided by 1,352 billable service hours. This was based on the amount of time that is spent traveling (without the family present), completing documentation, participating in training (including the Care Coordination Practitioners Certificate Program), and leave time. Indirect costs were calculated at the standard 10% of salaries.

The telephonic rate is established at 50% of the regular rate.

Payment for Family Peer Support service as outlined per Attachment 3.1-i page 26-27 and is reimbursed a fifteen minute unit of service. Family Peer Support providers are defined per Attachment 3.1-i page 27-29.

The agency's fee schedule was set as of October 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-Children,-Youth-and-Families.aspx State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the above website address.
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Notwithstanding anything else in this State plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

A. The State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42 CFR §441.510. To receive CFC services and supports under this section, an individual must meet the following requirements:

1. Be eligible for medical assistance under the State plan;
2. As determined annually --
   a. Be in an eligibility group under the State plan that includes nursing facility services;
   or
   b. If in an eligibility group under the State plan that does not include such nursing facility services, and which the state has elected to make CFC services available (if not otherwise required), have an income that is at or below 150 percent of the Federal poverty level (FPL); and
3. Receive a determination, at least annually, that in the absence of the home and community-based personal assistance services and supports, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan.
4. Individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915 (c) requirements and receive at least one home and community-based waiver service per month.
5. Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term services and supports through other Medicaid State plan, waiver, grant, or demonstration authorities.

B. During the five-year period that begins January 1, 2014, spousal impoverishment rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community-based services provided under 1915(k).
ii. Service Delivery Models

- **X** Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.

- Self-Directed Model with service budget – This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

- Direct Cash

- Vouchers

- Financial Management Services in accordance with 441.545(b)(1).

- Other Service Delivery Model as described below:

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iii. Service Package
A. The following are included CFC services (in addition to service descriptions, please include any service limitations):
   1.1 Assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), health related tasks through hands on assistance, supervision, and/or cueing, which will be provided under the Personal Assistance (formerly named personal care) Services.
      a. Personal Assistance Services means hands-on assistance, supervision, and/or cueing specific to the functional needs of a participant with a chronic illness, medical condition, or disability and includes assistance with ADLs, IADLs and health related tasks as prescribed by§441.520(a)(1). Personal assistance services may include the performance of some delegated nursing functions.
         i. Personal Assistance services will be based on Resource Utilization Groups (RUGs) or other case mix, identified through the interRAI assessment or other assessment process for determining budgets. The highest RUG grouping budget is $78,269 annually.
         ii. There will be a maximum budget for personal assistance services based on RUGs, or other case mix strategy, grouping that will help inform supports planners and participants in developing the POS.
         iii. There will be an exceptions process, based on medical necessity, for the participants requesting personal assistance services and/or hours above and beyond the recommended budget allotment.

   The State will claim an enhanced match for the Personal Assistance Service.

   b. Nurse Monitoring - Nurse monitors will evaluate the outcome of the provision of personal assistance services.

      The State will claim the enhanced match for nurse monitoring that will be provided by the local health departments.

1.2 Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks.
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a. Consumer training—
   i. The topics covered by consumer training may include, but are not limited to money management and budgeting, independent living and meal planning. These activities are to be targeted to the individualized needs of the participant receiving the training; and sensitive of the educational background, culture, and general environment of the participant receiving the training.
   ii. To participate in the Program as a provider of consumer training, a provider shall: be a self-employed trainer or an agency that employs qualified trainers, have demonstrated experience with the skill being taught, and be willing to meet at the participant’s home to provide services.

The State will claim an enhanced match on this service.

b. Personal Assistance as described in A.1. Through personal assistance, the participant may work on activities that aid in the acquisition, maintenance, and enhancement of skills.

The State will claim an enhanced match on this service.

c. Items that increase independence or substitute for human assistance as described in B.1. Participants will have access to items that allow for the individual to acquire, maintain, or enhance skills to the extent that expenditures would otherwise be made for the human assistance.

The State will claim the enhanced match for such items that increase independence or substitute for human assistance.

2. Back-up systems or mechanisms to ensure continuity of services and supports.
   a. A personal emergency response system (PERS) is an electronic device, piece of equipment or system which, upon activation, enables a participant to secure help in an emergency, 24 hours per day, seven days per week. There are a variety of devices and systems available to meet individual needs and preferences of CFC participants choosing this service.
   i. This service may include any or all of the following components: purchase/installation and monthly maintenance/monitoring of a PERS device. There are different rates established for each of the two components of the PERS service.

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ii. There is a one unit maximum per installation and there is a one unit maximum per month for PERS maintenance/monitoring. Units for each type of service are identified separately in the participant's plan of service; units submitted for payment may not exceed what is approved in the participant's POS. There is no lifetime limit on the number of installation fees, but each additional installation will need to be approved in the participant’s Plan of Service. The State will claim the enhanced match on this service.

3. Voluntary training on how to select, manage, and dismiss attendants.
   a. The State will develop materials and technical assistance to supports planners who provide training to participants.
      i. Supports planners must meet minimum qualifications established through a solicitation process. Current standards can be found on the Department’s website.
   b. This training will be provided to participants when requested. The Supports Planner will advise the participant of their training options. Even when an individual chooses to waive supports planning, they will still be assigned a supports planner in the tracking system in the event they need assistance or would like to request training.
   c. The State will develop and maintain a training manual and other materials which can be presented in many formats including: individually, in groups, and by webinar if requested.
   d. Manuals for the training will be provided to participants upon delivery of training and will also be posted on the Department’s website.
   e. Participants can choose to be referred for training multiple times to enhance their skills.

4. Support System Activities
   a. Under CFC, the Area Agencies on Aging and supports planning providers identified through a competitive solicitation will engage participants in a person-centered planning process that identifies the goals, strengths, risks, and preferences of the participant. Supports Planners shall coordinate community services and supports from various programs and payment sources to aid applicants and participants in developing a comprehensive plan for community
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living. Supports planners shall support applicants in locating and accessing housing options, identifying housing barriers such as past credit, eviction, and criminal histories, and in resolving the identified barriers. Supports planners shall assist the applicant in developing a comprehensive POS that includes both State and local community resources; coordinate the transition from an institution to the community, and maintain community supports throughout the individual’s participation in services.

b. In accordance with §441.555 of the CFR, the Supports Planner will:
   i. Appropriately assess and counsel an individual before enrollment; and
   ii. Provide the appropriate information, counseling, training, and assistance to ensure that an individual is able to manage their services and budgets.
   iii. This information must be communicated to the individual in a manner and language understandable by the individual. To ensure the information is communicated in an accessible manner, information should be communicated in plain language and needed auxiliary aids and services should be provided.

c. Also in accordance with §441.555 of the CFR, the POS will include:
   i. Person-centered planning and how it is applied.
   ii. Range and scope of individual choices and options.
   iii. Process for changing the person-centered service plan.
   iv. Grievance process.
   v. Information on the ability to freely choose from available home and community-based personal assistance providers.
   vi. Individual rights, including appeal rights.
   vii. Reassessment and review schedules.
   viii. Goals, needs, and preferences of CFC services and supports.
   ix. Identifying and accessing services, supports, and resources.
   x. Risk management agreements.
   xi. A personalized backup plan.
   xii. Information on how to recognize and report critical events.
   xiii. Information about how an individual can access a Maryland-based advocate or advocacy system.

The State will claim the enhanced match on this service.

B. The State elects to include the following CFC permissible service(s):

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1. Expenditures relating to a need identified in an individual's person-centered POS that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.

a. The following will be services permissible under CFC in the category of items that substitute for human assistance:
   i. Home delivered meals
      1. The service can only be provided by a facility or food preparation site that has a food license issued by the local health department, in accordance with COMAR 10.15.03, or an appropriate license from the state in which the site is located.
      2. This service will be provided as it substitutes for human assistance and, along with personal assistance, is limited by the RUG allocated budget and there will be the same exceptions process for participants requesting services over the budget.
   ii. Environmental Assessments
      1. Service must provided by be a licensed occupational therapist, or agency or professional group employing a licensed occupational therapist.
      2. The evaluation can be used to determine: the presence and likely progression of a disability or a chronic illness or condition in a participant; environmental factors in the facility or home; the participant's ability to perform activities of daily living; the participant's strength, range of motion, and endurance; and the participant's need for assistive devices and equipment. All of this can be used in the determination of service on the plan of service.
   iii. Technology that substitutes for human assistance
      1. To participate as a provider of assistive devices, equipment, or technology services, the provider shall be either a Program provider of disposable medical supplies and durable medical equipment under COMAR 10.09.12 or the store, vendor, organization, or company which sells or rents the equipment or system, subject to Department approval during the plan of service review.
      2. A unit is equal to one piece of equipment or item.
      3. Assistive technology is a device or appliance that empowers a participant to live in the community and/or participate in community activities.

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4. Technology may include a variety of environmental controls for the home or automobile, personal computers, software or accessories, maintenance or repair of technology devices, augmentative communication devices, and self-help aids that assist with activities of daily living and/or instrumental activities of daily living. Additionally, assessments and training may be included as costs under the Technology service.

5. In order to qualify for payment, each piece of technology shall meet applicable standards of manufacture, design, usage, and installation. Experimental technology or equipment is excluded.

6. Supports Planners are required to obtain multiple quotes from enrolled providers for individual units of service that exceed $1,000. Technology services may not be approved for durable medical equipment or items that are otherwise covered by private insurance, Medicare, or the Medicaid State plan. When multiple quotes are obtained, the individual shall be permitted to choose the functionality of the technology that best meets the needs as identified in the person-centered service plan.

7. This expense will be combined with adaptations and together be capped at $15,000 for every three year period per participant.

8. CFC may approve services that exceed this cost cap under circumstances when there is documentation that the additional services will reduce the on-going cost of care or avert institutional care. Units of service may not exceed what is approved in the participant's POS.

iv. Accessibility adaptations

1. Accessibility adaptations empower a participant to live in the community and/or participate in community activities.

2. Adaptations may include wheelchair ramps or lifts, stairglides, widening doorways, roll-in showers, roll-under sinks, pull-down cabinetry, and other barrier removal.

3. Each adaptation shall:
   a. Be preauthorized in the participant’s plan of service as necessary to prevent the participant’s institutionalization;
   b. Ensure the participant’s health, safety, and independence;
   c. Specifically relate to ADLs or IADLs within the approved plan of service;

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d. Meet necessary standards of manufacture, design, usage, and installation, if applicable;
e. Be provided in accordance with State and local building codes and pass required inspections, if applicable; and
f. Not be provided primarily for comfort or convenience
4. Excluded from coverage are adaptations or improvements to the home which:
a. Are of general maintenance, such as carpeting, roof repair, and central air conditioning;
b. Are not of direct medical or remedial benefit to the participant;
c. Add to the home’s total square footage; or
d. Modify the exterior of the home, other than the provision of ramps or lifts.
5. This expense will be combined with technology and together be capped at $15,000 for every three year period per participant.
6. CFC only covers items not covered under the state plan home health benefit.

The State will claim the enhanced match on these services.

2. Expenditures for transition costs such as rent and utility deposits, first month’s rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities to a community-based home setting where the individual resides.
   a. This service will be covered as part of CFC. The State will begin covering transition services as part of the fiscal intermediary contract. Transition service will be covered when it is identified based on assessment of need and listed as a needed service in the participant’s Recommended Plan of Care.
      i. May not include televisions, television access, or gaming units
      ii. CFC transition funds may be administered via the supports planning agency up to 60 calendar days post transition.
   iii. Transition services are limited to $3,000 per transition.

The State will claim the enhanced match on these services.
iv. Use of Direct Cash Payments

A. 1. ___ The State elects to disburse cash prospectively to CFC participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

2. ___X___ The State elects not to disburse cash prospectively to CFC participants.

v. Assurances

(A) The State assures that any individual meeting the eligibility criteria for CFC will receive CFC services.

(B) The State assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for CFC services.

(C) The State assures the provision of consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual’s needs, and without regard to the individual’s age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.

(D) With respect to expenditures during the first twelve month period in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section...
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1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.

(E) The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports.

(F) The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.
(ii) The number of individuals that received such services and supports during the preceding fiscal year.
(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.
(iv) Data regarding how the State provides Community First Choice and other home and community-based services.
(v) The cost of providing Community First Choice and other home and community-based services and supports
(vi) The specific number of individuals that have been previously served under any other home and community based services program under the State plan or under a waiver.
(vii) Data regarding the impact of Community First Choice services and supports on the physical and emotional health of individuals.
(viii) Data regarding how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to receive home and community-based services in lieu of institutional care.

(G) The State assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws and all applicable provisions of Federal and State laws as described in 42 CFR 441.570(d) regarding the following:

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(i) Withholding and payment of Federal and State income and payroll taxes.
(ii) The provision of unemployment and workers compensation insurance.
(iii) Maintenance of general liability insurance.
(iv) Occupational health and safety.
(v) Any other employment or tax related requirements.

(H) The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of consumers who are individuals with disabilities, elderly individuals and their representatives.

(I) The State assures that service budgets follow the requirements of 42 CFR 441.560.

vi. Assessment and Service Plan
Describe the assessment process or processes the state will use to obtain information concerning the individual’s needs, strengths, preferences, goals, and other factors relevant to the need for services:

A. The participant has an initial and an annual assessment done by the local health department or contractor using a standardized assessment of need.
   1. The assessment will be performed face-to-face by a nurse and/or social worker. The assessment is entered in the Long Term Service and Supports (LTSS) tracking system.
   2. The POS will be completed by a Supports Planner chosen by the applicant/participant.
   3. The state establishes conflict of interest standards for the assessments of functional need and the person-centered service plan development process in accordance with 42 CFR 441.555(c).

The State will not claim an enhanced match for these services.

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Indicate who is responsible for completing the assessment prior to developing the Community First Choice person-centered service plan. Please provide the frequency the assessment of need will be conducted.

B. The initial and annual assessments will be conducted by the Local Health Departments or a State contractor. Assessments will be completed upon application to the program to determine initial eligibility and annually to maintain eligibility. A standardized assessment is used to determine service needs.

Describe the reassessment process the State will use when there is a change in the individual’s needs or the individual requests a reassessment. Indicate if this process is conducted in the same manner and by the same entity as the initial assessment process or if different procedures are followed:

C. A reassessment based on a change in the individual’s needs will be conducted in the same manner and by the same entity as the initial and annual assessment. An assessment for significant change can be requested at any time during a participant’s enrolled status in CFC. Per 42 CFR 441.535(c) and 441.540(c), the participant may also request an assessment at any time.

Person-Centered Service Plan Development Process: Describe the process that is used to develop the person-centered service plan, including: Indicate how the service plan development process ensures that the person-centered service plan addresses the individual’s goals, needs (including health care needs), and preferences, by offering choices regarding the services and supports they receive and from whom.

D. Several entities are involved in the development of the POS with the applicant or participant, including the supports planner and the local health department (LHD) evaluators. After receiving a referral, LHD staff schedule an on-site visit with the applicant to conduct a comprehensive evaluation, including the completion of the standardized assessment instrument. Recommendations in the form of a Recommended Plan of Care are made based on the comprehensive evaluation/assessment.

E. Per 42 CFR 441.540(a)(1), a participant may select from any available supports planner in the jurisdiction. All applicants for Community First Choice will be mailed a package with brochures of available supports planning agencies for their jurisdiction. The applicant or participant will be able to call the Department, the supports planning agency or the local health department to select, which can be then be indicated in the tracking
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system. The Supports Planner then schedules and completes a face-to-face meeting with the applicant/participant and their identified representatives to explore the applicant/participant's needs, preferences, strengths, risks, and goals through a person-centered planning process. This will be done by a supports planning agency that has demonstrated the ability to be culturally sensitive in all business practices and effectively relates to the cultural/ethnic diversity of participants. The person-centered planning process shall include people chosen by the individual applicant or participant. The participant can choose a new supports planning agency in the event that they are unsatisfied with their current selection.

F. The Supports Planner will use the tracking system and have access to the clinical assessors’ Recommended Plans of Care. With that information along with input from the participant, a Supports Planner will help create a proposed plan of service. Supports Planners will assist the participant in identifying enrolled providers and make referrals for voluntary training on self-direction, when needed.

G. Supports Planners shall coordinate community services and supports from various programs and payment sources to aid applicants and participants in developing a comprehensive plan for community living. Person-Centered Planning is essential to assure that the participant’s personal strengths, goals, risks, and preferences are incorporated into service planning and reflected on the POS. Supports Planners engage every applicant and participant in a person-centered planning process designed to offer the participant choice and control over the process and resulting plan.

H. Risk mitigation strategies, including back-up plans that are based on the unique needs of the individual must ensure health and safety while affording an individual the dignity of risk. Individualized risk mitigation strategies are incorporated directly into the POS and are done in a manner sensitive to the individual's preferences. The POS will need to contain a reasonably designed back-up system for emergencies, including situations in which a scheduled provider does not show up to provide services. Strategies may include individual, family, and staff training, assistive technology, back-up staffing, etc. The proposed POS becomes effective upon approval by the Department.

I. Per 42 CFR 441.530(a)(1)(ii) the setting options are identified and documented in the person-centered service plan and are based on the individual’s needs, preferences, and for residential settings, resources available for room and board.

All actions of the aforementioned person centered planning process will comport with 42 CFR 441.540 (b).
A description of the timing of the person-centered service plan to assure the individual has access to services as quickly as possible, frequency of review, how and when it is updated, mechanisms to address changing circumstances and needs or at the request of the individual.

J. The first day of the process begins when an applicant expresses interest in the CFC program. The referral to the local health department occurs and within 15 calendar days the assessment and Recommended Plan of Care are completed.

K. Supports Planner selection begins when the medical and financial eligibility processes have been completed. A Supports Planning selection packet will be mailed to the applicant at the same time that the referral for medical assessment is made. A person has 21 calendar days to select a Supports Planner or one will be automatically assigned via the LTSS tracking system. The participant may choose at any time to switch to a different available supports planning agency. They can do this by calling the Department, the existing supports planning agency, the supports planning agency of their choice, or the local health department. The Supports Planner has 20 days to submit the POS.

L. Supports Planners and participants will have access to the POS and will have the ability to update and request changes based on significant change or upon request of the individual at any time.

A description of the strategies used for resolving conflict or disagreement within the process, including the conflict of interest standards for assessment of need and the person-centered service plan development process that apply to all individuals and entities, public or private.

M. The process begins with the nurse and/or social worker performing a standardized assessment. The development of the POS is then done by another entity, the Area Agency on Aging or other provider identified through a competitive solicitation. There is a separation of duties such that the same entity will not be performing the assessments and completing the plan of service with the participant.

N. Supports planning entities that have responsibility for service plan development may not provide other direct services to the participant unless there are administrative separations in place to prevent and monitor potential conflicts of interest.

O. Plans of service are reviewed by the Department prior to implementation to assure that there are no conflicts of interest.

vii. Home and Community-based Settings
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CFC services will be provided in a home or community setting, which does not include a nursing facility, institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital providing long-term care services, or any other locations that have qualities of an institutional setting.

Please specify the settings CFC services will be provided.

A. CFC services are available and provided to individuals residing in settings that meet the federal regulatory requirements for a home and community-based setting and include, but are not limited to, single family homes, duplexes, apartments, and congregate settings serving three or fewer unrelated individuals. Settings criteria will meet the requirements of 42 CFR 441.530. CFC participants may receive services in the workplace or other community settings.

viii. Qualifications of Providers of CFC Services

A. In accordance with CFR 441.565 (a)(1)-(3):
   1. An individual retains the right to train attendant care providers in the specific areas of attendant care needed by the individual, and to have the attendant care provider perform the needed assistance in a manner that comports with the individual's personal, cultural, and/or religious preferences.
   2. An individual retains the right to establish additional staff qualifications based on the individual's needs and preferences.
   3. Individuals also have the right to access other training provided by or through the State so that their attendant care provider(s) can meet any additional qualifications required or desired by individuals.

B. Provider qualifications have been designed to ensure necessary safeguards to protect the health and welfare of participants. Personal Assistance agencies may include providers certified by the Office of Health Care Quality as a residential services agency (RSA).
   1. Agency-based personal assistants are required to be certified in the performance of CPR.

TN # 15-0011 Approval Date January 7, 2016 Effective Date October 1, 2015
Supersedes TN # 13-17
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Community First Choice State Plan Option

2. Agency-based personal assistants must receive instruction, training and assessment from the delegating nurse regarding all services identified in the plan of services.
3. Certified Nursing Assistant status may be required for activities that would normally be delegated by a nurse; or, if required to administer medications, be either a certified medicine aide in accordance with COMAR 10.39.03; or a Medication technician in accordance with COMAR 10.39.04.
4. Agencies are required to verify that all personal assistants have complied with criminal background check requirements.
5. All CFC services providers must meet the "general requirements" for participation located at COMAR 10.09.84.05.
6. Enrolled personal assistance agencies are required to ensure that their assistants meet the applicable standards prior to working with CFC participants.
7. To participate as a provider of accessibility adaptations a provider must have a current license with the Maryland Home Improvement Commission and be approved by the Department.

C. Per 42 CFR 441.540(a)(1), the person-centered planning process shall include representatives chosen by the individual.

Approval Date: March 13, 2017
Effective Date: April 1, 2017

TN # 16-0012
Supersedes TN # 15-0011
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ix. Quality Assurance and Improvement Plan

Provide a description of the State's Community First Choice quality assurance system. Please include the following information:

• How the State will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement;

A. Community First Choice will adopt the waiver Quality Management Strategy where appropriate.

B. CFC will have a Quality Management Strategy designed to review operations on an ongoing basis, discover issues with operations, remediate those issues, and develop quality improvement initiatives to prevent the repeat of operational problems. The State Medicaid Agency oversees a cross-agency quality committee called the Quality Council. The Quality Council meets regularly to address quality issues through data analysis, share program experiences and information, and further refine the quality management systems.
C. Regular reporting and communication among the Office of Health Services, providers, the utilization control agent and other stakeholders, including the Community Options Advisory Council, and Quality Council, facilitates ongoing discovery and remediation. The Office of Health Services is the lead entity responsible for trending, prioritizing and determining system improvements based on the data analysis and the formulation of recommendations for system improvements. Partners include, but are not limited to, the Office of Health Care Quality (OHCQ), providers, participants, family, Community Options Advisory Council, and the Quality Council. A plan to work on significant problem areas may result in the establishment of a specific task group or groups, which may include stakeholders.

D. When program data are received, it is documented by OHS staff. Data sources include, but are not limited to, provider enrollment documents, provider and participant audits, the provider database, the tracking system, reportable events submissions and other reporting. Data are assigned to appropriate staff to be reviewed, prioritized and recorded in the appropriate trends and anomalies that may need immediate attention. Plans developed as a result of this process will be shared with stakeholders for review and recommendation for remediation.

E. In accordance with the Department’s Reportable Events Policy, all entities associated with Community First Choice are required to report alleged or actual Reportable Events. All Reportable Events shall be reported in full on the Department’s Reportable Events form in the tracking system to analyze trends and identify areas in need of improvement.

F. Any person who believes that an individual has been subjected to abuse, neglect, or exploitation in the community or an assisted living facility is required to report the alleged abuse, neglect, or exploitation immediately to an Adult Protective Services (APS) or Child Protective Services (CPS) office and, within 24 hours, the Office of Health Services.

G. The supports planners will have access to a check list for any residents in congregate settings in order to ensure the setting meets HCBS settings requirements. The supports planner will be able to utilize this form during any of their quarterly visits with participants where there is a residence change or there is a change in living situation of the current residence. They will be required to submit this form in the tracking system to the State. The State will be responsible for oversight during Plan of Service review.
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Community First Choice State Plan Option

- The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

H. Performance Measures:
1. The standardized assessment instrument for CFC captures information about support needs and along with the tracking system, maintains a database of all applicants and participants. All historical data can be retrieved easily by ad hoc reporting. Reports are available on measures such as number of applicants receiving an annual assessment, number of participants in each RUG or case mix category, and other measures which can be sorted by time frame, assessor, by jurisdiction, and other criteria. The Department can evaluate the timeliness of the completion of the assessments, the Utilization Control Agent in completing their reviews, and of various tasks of the Supports Planners.
2. The Department will work to increase the overall scope and effectiveness of the program. The Department has included measures in LTSSMaryland to track quality indicators of providers and will expand the quality review process to include participant-indicators.
3. The Department has added a Reportable Events module to LTSSMaryland to enhance and coordinate reviews of incidents and track information in one uniform system.

I. Outcomes Measures
Another benefit to utilizing the standardized assessment tool is access to quality data reports to track long term changes in medical status and needs of participants. The interRAI tool is equipped to track data across years and report based on aggregate data by jurisdiction or program as well as tracking individual participant outcomes and changes throughout time. The Department will also use Resource Utilization Groups (RUGs) based on the interRAI assessment to identify level of need and track improvement over time.

J. Satisfaction Measures
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The State has chosen to implement the Money Follows the Person (MFP) Quality of Life survey amended with several questions from the Participant Experience Survey (PES). These questions will be asked directly to participants to determine level of satisfaction with the CFC program. The State will utilize the services of an independent contractor to perform these surveys with CFC participants, thus avoiding conflict of interest.

- Describe how the State’s quality assurance system will measure individual outcomes associated with the receipt of community-based attendant services and supports.

K. Administering CFC and quality staff will continuously evaluate the effectiveness and relevance of the quality improvement strategy with input from participants, providers, and other stakeholders. Through the continuous process of discovery, vital information will be presented to the Department through various sources, such as the Reportable Events listed above, provider licensure, complaint surveys/reports, and provider audits. In addition to that list, the Department will also utilize interRAI quality data reports to track long term changes. The interRAI tool is equipped to track data across years and report based on needs. Clinical Assessment Protocols will help enhance service plans and ensure necessary services are provided and coordinated properly. The Department will also use Resource Utilization Groups (RUGs) to identify level of need and track improvement over time.

L. The State will utilize the tracking system to monitor participants’ service plans in order to ensure that services are delivered in accordance with the service plan.

M. Included on the POS are the participant’s strengths and goals. Progress on individual goals will be monitored and reported by the Supports Planner during quarterly and annual visits. Tracking system reports will allow data to be aggregated and analyzed.

- Describe the system(s) for mandatory reporting, investigation and resolution of allegations of neglect, abuse, and exploitation in connection with the provision of CFC services and supports.

N. In the case of suspected neglect, abuse, or exploitation in the CFC program, the Department maintains the same procedure as has been documented in the Reportable Events (RE) Policy used by the home and community-based waivers. “Any person who believes that an individual has been subjected to abuse, neglect, or exploitation in the community or an assisted living facility is required to report the alleged abuse, neglect, or exploitation immediately to an Adult Protective Services (APS) or Child Protective Services (CPS) office and, within 24 hours, the Office of Health Services.”

TN # 13-17
Supersedes TN # NEW

Approval Date APR 02 2014
Effective Date JAN 01 2014
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determined by the RE Policy, all reportable events that are suspected neglect, abuse, or exploitation would be considered cases of Immediate Jeopardy (IJ). In addition to being reported to the appropriate agency, these cases are monitored by the Office of Health Services to meet timely resolution. Each case will be reviewed by OHS staff. The Department also maintains a web-based tracking system for many long-term supports and services. This system tracks all CFC activities and is called the LTSSMaryland tracking system. Supports planning providers, nurse monitors, the fiscal intermediary contractor, and the utilization control agent will all use the system to document aspects of their work. The tracking system will be used to document activities, complete forms such as monthly contacts and reportable events, and enter other data used for reporting.

- Describe the State's standards for all service delivery models for training, appeals for denials and reconsideration procedures for an individual's person-centered service plan.

O. The supports planning provider shall meet with the participant in-person at least once every 90 days to monitor the implementation of the POS and identify any unmet needs. These minimum contact standards may be waived by the participant and therefore the participant may identify unmet needs in their POS via a consumer portal to the tracking system. If there is a needed or requested change in the POS, the provider or participant shall follow Departmental guidelines to submit a POS modification request and assist the participant in changing his or her services.

P. Participants who are denied services receive a letter, including Notice of Fair Hearing and Appeal Rights, from the State. The letter lists the reason(s) for the denial and provides detailed information about steps for the individual/representative to follow, as well as time frames, to request an appeal. The letter includes information regarding procedures to follow to assure continuance of benefits while the appeal process is underway. The letter is mailed to the applicant and their representative, if designated, by the State. The independent Office of Administrative Hearings (OAH) sends the appellant/representative information regarding the date and time of the hearing. An information sheet is enclosed with the hearing notice which explains the nature of administrative hearing and what to expect, what documents an individual may want to bring, how to access the OAH law library and the right to be represented by a friend, relative or an attorney (information on obtaining legal representation for low income individuals is provided). Additionally, this information sheet instructs the appellant on how to obtain special accommodations such as an interpreter, and conditions under which an appellant may request a postponement.
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Q. Participants and/or their representatives may request assistance applying for a Fair Hearing from a provider, supports planner or other individual of their choosing. Information sent with the adverse action notice also includes contact information related to Legal Aid and the Maryland Disability Law Center, the State’s Protection and Advocacy Agency.

- **Describe the quality assurance system's methods that maximize consumer independence and control and provide information about the provisions of quality improvement and assurance to each individual receiving such services and supports.**

R. Voluntary training on self-direction will be offered to participants through their supports planners using materials and guidance from the Maryland Department of Disabilities. This training will be available when a participant requests assistance.

S. Supports Planning will also educate participants about consumer independence and control and provide information about the provisions of quality improvement and assurance as described above in iii. Service Package, A.4 Support System. Supports Planners will assist the participants in accessing training on self-direction, selecting providers of consumer training services, and in learning how to navigate the Consumer portal of the LTSS tracking system. Participants may monitor provider time keeping, view reports, and access and update their POS through the tracking system.

T. In-Home Supports Assurance System (ISAS) – A telephonic time keeping system that will track personal assistance hours and use a landline phone or one-time password device to ensure that a provider is in the participant’s home when clocking in and out. Participants may view and monitor the time keeping of their providers in this system.

U. The CFC Implementation Council will remain to be a consumer-majority committee that will advise the State Medicaid Agency on ongoing issues and procedures of the CFC program.

- **Describe how the State will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit.**

V. The State will continue to have a consumer-majority advisory council. The council will have the opportunity to meet at least quarterly. The State welcomes other stakeholders and advocates to attend these meetings either in person or via conference call/webinar format.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- **The methods used to continuously monitor the health and welfare of Community First Choice individuals**

  W. The health and welfare of CFC individuals will be monitored by all of the previously mentioned standards in performance and outcome measurements including via nurse monitoring visits, Supports Planning contacts, and Reportable Events. The State will use all available information in the standardized assessment and reporting capabilities of the tracking system to monitor health services for participants.

- **The methods for assuring that individuals are given a choice between institutional and community-based services.**

  X. A person-centered planning process will begin before the choice of an identified supports planner. Materials will be mailed to applicants on all available supports planning agencies by jurisdiction. This will include information on all resources and services available. Upon entrance into the Program, the participant will be able to select their Supports Planner. It will be the responsibility of supports planners to counsel an individual on their choice between receiving institutional and community-based services. Activities of the Supports Planner will be entered in the tracking system and monitored via automated reports.
Alternative Benefit Plan

State Name: Maryland
Transmittal Number: MD - 18-0012

Alternative Benefit Plan Populations

Identify and define the population that will participate in the Alternative Benefit Plan.


Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

<table>
<thead>
<tr>
<th>Eligibility Group:</th>
<th>Enrollment is mandatory or voluntary?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Group</td>
<td>Mandatory</td>
</tr>
</tbody>
</table>

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state’s approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state’s approved Medicaid state plan that is not subject to 1937 requirements.

The State chose the largest plan in any of the three largest small group insurance products in Maryland's small group market as its base-benchmark plan (CareFirst Small Group Plan). The existing State Plan package fully aligns with the essential health benefits covered under the CareFirst Small Group Plan. The Adult Group covered under this ABP will receive one additional service - audiology prostheses (hearing aids, cochlear implants). Audiology prostheses are not a covered benefit under the CareFirst Small Group Plan for adults (see form ABP5 for details).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1830.
Alternative Benefit Plan

Select one of the following:

- The state/territory is amending one existing benefit package for the population defined in Section 1.
- The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: State Plan Adult Benefit

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- State employee coverage that is offered and generally available to state employees (State Employee Coverage).
- A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO).
- Secretary-Approved Coverage.

- The state/territory offers benefits based on the approved state plan.
- The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
- The state/territory offers the benefits provided in the approved state plan.
- Benefits include all those provided in the approved state plan plus additional benefits.
- Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
- The state/territory offers only a partial list of benefits provided in the approved state plan.
- The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

The State chose the largest plan in any of the three largest small group insurance products in Maryland's small group market as its base-benchmark plan (CareFirst Small Group Plan). The existing State Plan package fully aligns with the essential health benefits covered under the CareFirst Small Group Plan. The Adult Group covered under this ABP will receive one additional service - audiology prostheses (hearing aids, cochlear implants). Hearing aids and cochlear implants are/are not a covered benefit under the CareFirst Small Group Plan for adults (see form ABP5 for details).
Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option: [No]

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- Any of the largest three state employee health benefit plans by enrollment.
- Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- Largest insured commercial non-Medicaid HMO.

Plan name: CareFirst Small Group Plan

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

1. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
2. The state assures the accuracy of all information in ABP5 depicting amount, duration, and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-20-05, Baltimore, Maryland 21244-1850.
Alternative Benefit Plan

State Name: Maryland
Transmittal Number: MD - 18 - 0012

Alternative Benefit Plan Cost-Sharing

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722
## Alternative Benefit Plan

### 1. Essential Health Benefit: Ambulatory patient services

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

#### Authorization:
- Prior Authorization

#### Provider Qualifications:
- Medicaid State Plan

#### Amount Limit:
- None

#### Duration Limit:
- None

#### Scope Limit:
- None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physician services are not prior-authorized under the Medicaid FFS program, except for transplant services or plastic surgery services. Two Medicaid MCOs prior-authorize specialty physician services (non-primary care). One Medicaid MCO prior-authorizes specialty physician services in hospital space. Most Medicaid MCOs prior-authorize out-of-network physician services.

### Benefit Provided:
- Medical Care by Other Licensed Practitioners

<table>
<thead>
<tr>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

#### Authorization:
- None

#### Provider Qualifications:
- Medicaid State Plan

#### Amount Limit:
- None

#### Duration Limit:
- None

#### Scope Limit:
- None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Other Licensed Practitioners included nurse practitioners and nurse anesthetists

### Benefit Provided:
- Outpatient Hospital Services

<table>
<thead>
<tr>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

#### Authorization:
- Prior Authorization

#### Provider Qualifications:
- Medicaid State Plan

#### Amount Limit:
- None

#### Duration Limit:
- None

#### Scope Limit:
- None
### Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient hospital services are not prior-authorized in the FFS program. All Medicaid MCOs use prior authorization requirements outpatient hospital services. Some focus on all outpatient services and others focus on certain diagnoses or procedures, such as endoscopic procedures or all outpatient diagnostics procedures.

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
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</thead>
<tbody>
<tr>
<td>Clinic Services</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td><strong>Authorization:</strong> None</td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td><strong>Amount Limit:</strong> None</td>
<td><strong>Duration Limit:</strong> None</td>
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<td><strong>Scope Limit:</strong> None</td>
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Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
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<tbody>
<tr>
<td>Home Health Care Services: Nursing &amp; Aide Services</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td><strong>Authorization:</strong> Prior Authorization</td>
<td>Provider Qualifications: Medicaid State Plan</td>
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<tr>
<td><strong>Amount Limit:</strong> None</td>
<td><strong>Duration Limit:</strong> None</td>
</tr>
<tr>
<td><strong>Scope Limit:</strong> None</td>
<td></td>
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</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Preauthorization is required for more than one visit per type of service per day; any service or combination of services rendered during any 30-day period for which the provider anticipates payments from the program in excess of the Medicaid average nursing facility rate; four or more hours of care per day whether the 4-hour limit is reached in one visit or in several visits in one day; or any instances in which home health aide services without skilled nursing services are provided.

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
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</thead>
<tbody>
<tr>
<td>Personal Care Services</td>
<td>State Plan 1905(a)</td>
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<tr>
<td><strong>Authorization:</strong> Prior Authorization</td>
<td>Provider Qualifications: Medicaid State Plan</td>
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# Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
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<tbody>
<tr>
<td>Community First Choice</td>
<td>State Plan 1915(k)</td>
</tr>
<tr>
<td>Federally-Qualified Health Services</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td>Hospice Care- in home/ambulatory setting</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization</th>
<th>Provider Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit</th>
<th>Duration Limit</th>
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<tr>
<td>None</td>
<td>None</td>
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<td>None</td>
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<td>None</td>
<td>None</td>
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</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
## Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Scope Limit:</td>
<td></td>
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<tr>
<td>None</td>
<td></td>
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</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Doctor certifies individual has six months or less to live. Maryland continues to provide medically-necessary curative services, even after election of the hospice benefit by or on behalf of children receiving services. This is consistent with federal rules.

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions-Hyde Compliant</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
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<tbody>
<tr>
<td>Prior Authorization</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Scope Limit:</td>
<td></td>
</tr>
<tr>
<td>None - These are abortions that comply with the Hyde Amendment</td>
<td></td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
## 2. Essential Health Benefit: Emergency services

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital: Emergency Hospital Services</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td><strong>Authorization:</strong></td>
<td><strong>Provider Qualifications:</strong></td>
</tr>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td><strong>Amount Limit:</strong></td>
<td><strong>Duration Limit:</strong></td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Scope Limit:</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Other Medical Care: Em. Transportation</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td><strong>Authorization:</strong></td>
<td><strong>Provider Qualifications:</strong></td>
</tr>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td><strong>Amount Limit:</strong></td>
<td><strong>Duration Limit:</strong></td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Scope Limit:</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
### 3. Essential Health Benefit: Hospitalization

**Benefit Provided:** Inpatient Hospital Services - Including Transplant  
**Source:** State Plan 1905(a)

- **Authorization:** Concurrent Authorization  
- **Provider Qualifications:** Medicaid State Plan  
- **Amount Limit:** None  
- **Duration Limit:** None  
- **Scope Limit:** None

**Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:**

All inpatient services are authorized both in the Medicaid FFS and MCO programs.

**Benefit Provided:** Physician Services - Inpatient  
**Source:** State Plan 1905(a)

- **Authorization:** Prior Authorization  
- **Provider Qualifications:** Medicaid State Plan  
- **Amount Limit:** None  
- **Duration Limit:** None  
- **Scope Limit:** None

**Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:**

Note: FFS Program requires authorization for physician services for certain inpatient services, such as Transplant Services and Plastic Surgery Services. Two MCOs prior-authorize specialty physician services. One MCO prior-authorizes specialty physician services in hospital space. Most MCOs prior-authorize out-of-network physician services.

**Benefit Provided:** Hospice Care - Inpatient Setting  
**Source:** State Plan 1905(a)

- **Authorization:** Other  
- **Provider Qualifications:** Medicaid State Plan  
- **Amount Limit:** None  
- **Duration Limit:** None  
- **Scope Limit:**

Doctor certifies individual has six months or less to live. Maryland continues to provide medically-necessary curative services, even after election of the hospice benefit by or on behalf of children receiving services.
Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add
## Alternative Benefit Plan

### 4. Essential Health Benefit: Maternity and newborn care

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Care- Maternity and Newborn</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
<tr>
<td>Authorization</td>
<td>Provider Qualifications</td>
<td></td>
</tr>
<tr>
<td>Concurrent Authorization</td>
<td>Medicaid State Plan</td>
<td></td>
</tr>
<tr>
<td>Amount Limit</td>
<td>Duration Limit</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Scope Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

All inpatient services are authorized

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services-Maternity and Newborn</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
<tr>
<td>Authorization</td>
<td>Provider Qualifications</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
<td></td>
</tr>
<tr>
<td>Amount Limit</td>
<td>Duration Limit</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Scope Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note- Program requires authorization for physician services for certain inpatient services, such as Transplant Services. There is not authorization for normal maternity care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Services- Maternity and Newborn</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
<tr>
<td>Authorization</td>
<td>Provider Qualifications</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
<td></td>
</tr>
<tr>
<td>Amount Limit</td>
<td>Duration Limit</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Scope Limit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services furnished by Nurse Midwife</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization:</th>
<th>Provider Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital Services-Mental Health/Subs</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization</th>
<th>Provider Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The state assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services-Mental Health/Sub</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization</th>
<th>Provider Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount Limit:</th>
<th>Duration Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The state assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Services-Mental Health</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorization</th>
<th>Provider Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization</td>
<td>Medicaid State Plan</td>
</tr>
</tbody>
</table>

## Alternative Benefit Plan

### Benefit Provided: Medical Care Furnished by Licensed Practitioners
- **Source:** State Plan 1905(a)
- **Authorization:** Prior Authorization
- **Amount Limit:** None
- **Scope Limit:** None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The state assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

### Benefit Provided: Inpatient Hospital Services - MH/SUD
- **Source:** State Plan 1905(a)
- **Authorization:** Concurrent Authorization
- **Amount Limit:** None
- **Scope Limit:** None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Other Licensed Practitioners include certified registered nurse practitioners with a specialty in psychiatry, certified advanced practice registered nurse/psychiatric mental health, clinical professional counselors, psychologists, and clinical social workers.

The state assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These services are not provided in IMDs.

The state assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
6. Essential Health Benefit: Prescription drugs

**Benefit Provided:**
Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

**Prescription Drug Limits (Check all that apply):**
- [x] Limit on days supply
- [x] Limit on number of prescriptions
- [x] Limit on brand drugs
- [x] Other coverage limits
- [x] Preferred drug list

**Authorization:** Yes

**Provider Qualifications:** State licensed

**Coverage that exceeds the minimum requirements or other:**
The State of Maryland's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.
7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Benefit Provided: Physical Therapy and Related Services-Rehab.

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The services provided include Physical Therapy, Occupational Therapy, Speech Therapy and Audiology services. All services available in hospital and outpatient departments and home health setting. Physical Therapy and Audiology is covered in an outpatient setting in the community. State Plan 3.1 1-A page 11 authorizes these services in a hospital outpatient setting.

All Medicaid MCOs prior-authorize therapy services. Some MCOs limit the prior-authorization to certain services and some require prior authorize after a certain number of visits (e.g., after 10 visits the service must be prior authorized).

Benefit Provided: Home Health Services - DME/DMS

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Durable Medical Equipment that costs $1,000 or more must be prior-authorized. Durable Medical Supplies that cost $500 or more must be prior-authorized.

The following services require prior-authorization: 1) all hearing aids; 2) certain hearing aid accessories; 3) repairs for hearing aid exceeding $500.

Benefit Provided: Nursing Facility Services: Rehabilitation Services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan
# Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Amount Limit</th>
<th>Duration Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>100 days or less per 12 month eligibility period</td>
</tr>
</tbody>
</table>

**Scope Limit:**
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Need to meet nursing level of care criteria. Services are limited to those required for short-term rehabilitation, not custodial care. Rehabilitation services is defined as services provided in the nursing home for 100 days or less.

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation Services - Physical Therapy and Other</td>
<td>State Plan Other</td>
</tr>
</tbody>
</table>

**Authorization:**
None

**Provider Qualifications:**
Medicaid State Plan

<table>
<thead>
<tr>
<th>Amount Limit</th>
<th>Duration Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Scope Limit:**
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This includes both acquisition and maintenance services. Services will only be provided to the adults covered under Section 1902 (a)(10)(A)(i)(VIII). Services provided will include Physical Therapy, Occupational Therapy, and Speech Therapy. All services will be provided in hospital inpatient and outpatient departments. Services will not be provided in a home setting. Physical therapy is covered in an outpatient setting in the community.

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic devices</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:**
Other

**Provider Qualifications:**
Medicaid State Plan

<table>
<thead>
<tr>
<th>Amount Limit</th>
<th>Duration Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Scope Limit:**

Devices include: artificial eyes; breast prostheses, including surgical brassiere; upper and lower extremity, full and partial, to include stump or harnesses where necessary; replacement of prostheses; cochlear implants and auditory osseointegrated devices

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior-authorization is required for certain cochlear implant devices and replacement components; all auditory osseointegrated devices; and repairs of cochlear implant devices and osseointegrated devices
exceeding $500.
## 8. Essential Health Benefit: Laboratory services

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Laboratory and X-Ray Services</td>
<td>State Plan 1905(a)</td>
</tr>
</tbody>
</table>

**Authorization:**
- None

**Provider Qualifications:**
- Medicaid State Plan

**Amount Limit:**
- None

**Duration Limit:**
- None

**Scope Limit:**
- None

**Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:**

[Add button]
### 9. Essential Health Benefit: Preventive and wellness services and chronic disease management

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td><strong>Authorization:</strong></td>
<td><strong>Provider Qualifications:</strong></td>
</tr>
<tr>
<td>None</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td><strong>Amount Limit:</strong></td>
<td><strong>Duration Limit:</strong></td>
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<tr>
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<td>None</td>
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<tr>
<td><strong>Scope Limit:</strong></td>
<td></td>
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<td>None</td>
<td></td>
</tr>
<tr>
<td>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Care by Other Licensed Practitioners</td>
<td>State Plan 1905(a)</td>
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<tr>
<td><strong>Authorization:</strong></td>
<td><strong>Provider Qualifications:</strong></td>
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<tr>
<td>None</td>
<td>Medicaid State Plan</td>
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<tr>
<td><strong>Amount Limit:</strong></td>
<td><strong>Duration Limit:</strong></td>
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<tr>
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<td>None</td>
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<tr>
<td><strong>Scope Limit:</strong></td>
<td></td>
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<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:</td>
<td>These providers include nurse practitioners and nutritionists/dietitians.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Provided</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care Services - DME/DMS - Diabetes</td>
<td>State Plan 1905(a)</td>
</tr>
<tr>
<td><strong>Authorization:</strong></td>
<td><strong>Provider Qualifications:</strong></td>
</tr>
<tr>
<td>Authorization required in excess of limitation</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td><strong>Amount Limit:</strong></td>
<td><strong>Duration Limit:</strong></td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
### Alternative Benefit Plan

**Scope Limit:**

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Durable Medical Equipment that costs $1,000 or more must be prior-authorized. Durable Medical Supplies that cost $500 or more must be prior-authorized.
### 10. Essential Health Benefit: Pediatric services including oral and vision care

<table>
<thead>
<tr>
<th>Benefit Provided:</th>
<th>Medicaid</th>
<th>State Plan EPSDT Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source:</td>
<td>State Plan 1905(a)</td>
<td></td>
</tr>
<tr>
<td>Authorization:</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Provider Qualifications:</td>
<td>Medicaid State Plan</td>
<td></td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Duration Limit:</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Scope Limit:</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

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TN No: MD 18-0012
Supercedes: MD 15-0007

Approval Date: November 15, 2018
Effective Date: July 1, 2018
<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Visit Duplication</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Primary Care Visits to treat injury or an illness were mapped with the 'ambulatory patient services' EHB category. The bundled services are a duplication of Physician Services and Other Licensed Providers from the existing state Medicaid plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist Visit-Duplication</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Specialists Visits were mapped with the 'ambulatory patient services' EHB category. The services are a duplication of Physician Services, Other Licensed Providers, and Clinic Services from the existing state Medicaid plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mastectomy Related Services-Duplication</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Mastectomy Related Services were mapped with the 'ambulatory patient services' EHB category. The services are a duplication of Physician, Home Health, and Outpatient Hospital Services in the existing State Plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Facility Fee-Duplication</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Outpatient Facility Fee was mapped with the 'ambulatory patient' EHB category. The services are a duplication of the Outpatient Hospital Services in the existing State Plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Facilities</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits: Urgent Care Facilities were mapped to the 'ambulatory patient' EHB category. The services are a duplication of outpatient hospital services in the existing State Plan.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin. of Injectable Prescrp. Drugs-Duplication</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Alternative Benefit Plan

**Explanation of Substitution or Duplication**

- **Base Benchmark Benefit that was Substituted:**
  - Routine Gynecological Care-Duplication
  -**Source:** Base Benchmark

  - **Explanation:** The routine gynecological care was substituted for the 'ambulatory patient' EHB category. The services are a duplication of physician services and medical care by other licensed providers in the existing State Plan.

- **Base Benchmark Benefit that was Substituted:**
  - Renal Dialysis-Duplication
  - **Source:** Base Benchmark

  - **Explanation:** Renal dialysis was mapped to the 'ambulatory patient' EHB category. The services are a duplication of physician services and outpatient hospital services in the existing State Plan.

- **Base Benchmark Benefit that was Substituted:**
  - Chemotherapy, Radiation, and Infus. -Duplication
  - **Source:** Base Benchmark

  - **Explanation:** Chemotherapy, radiation therapy, and infusion therapy are mapped to the 'ambulatory patient' EHB category. The services are a duplication of physician and outpatient hospital services in the existing State Plan.

- **Base Benchmark Benefit that was Substituted:**
  - Clinical Trial Patient Cost Services-Duplication
  - **Source:** Base Benchmark

  - **Explanation:** Clinical trial patient cost services were mapped to the 'prescription drugs' EHB category. The services are a duplication of the prescribed drugs in the existing State Plan.

- **Base Benchmark Benefit that was Substituted:**
  - Other Practitioner Office Visits-Duplication
  - **Source:** Base Benchmark

  - **Explanation:** Other practitioner office visits were mapped to 'ambulatory patient services' EHB category. The services are a duplication of medical care furnished by licensed practitioners within the scope of their practice in the existing State Plan.
## Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Services-Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
<tr>
<td><strong>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Services were mapped to 'Ambulatory Patient Services' EHB category. The services are a duplication of the Home Health Services in the existing State Plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Services-Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
<tr>
<td><strong>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Services were mapped to 'Emergency Room Services' EHB category. The services are a duplication of the Outpatient Hospital Services in the existing State Plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Transportation-Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
<tr>
<td><strong>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Services were mapped to 'Emergency Room Services' EHB category. The services are a duplication of the Any Other Medical Care in the existing State Plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services-Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
<tr>
<td><strong>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services were mapped with the 'Hospitalization' EHB category. The services are a duplication of the Inpatient Hospital Services in the existing State Plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Physician/Surgical Services-Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
<tr>
<td><strong>Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Physician and Surgical Services were mapped with the 'Hospitalization' EHB category. The services are a duplication of the Physician Services in the existing State Plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bariatric Surgery-Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

TN No: MD 18-0012
Supersedes: MD 15-0007

Approval Date: November 15, 2018
Effective Date: July 1, 2018
### Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

#### Bariatric Services
Bariatric Services were mapped with the 'Hospitalization' EHB category. The services are a duplication of the Inpatient Hospital and Physician Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Services-Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

#### Organ and Tissue Transplant
Organ and Tissue Transplant were mapped with the 'Hospitalization and Ambulatory' EHB category. The services are a duplication of the Organ Transplant Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organ and Tissue Transplant-Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

#### Prenatal and Postnatal Care
Prenatal and Postnatal Care were mapped with the 'Maternity and Newborn Care' EHB category. The services are a duplication of the Physician Services and Services Provided by a Nurse Midwife in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Postnatal Care-Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

#### Elective Abortions
Elective abortions were mapped with the 'Ambulatory Patient Services (Hyde Compliant Abortions)' EHB category.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Abortions-Hyde Compliant</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

#### Mental Health Outpatient Services
Mental Health Outpatient Services were mapped with the 'Mental Health and Substance Abuse Disorder' EHB category.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Outpatient Services-Duplication</td>
<td>Base Benchmark</td>
<td></td>
</tr>
</tbody>
</table>
## Alternative Benefit Plan

**Services' EHB category.** The services are a duplication of the Outpatient Hospital Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Inpatient Services-Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental Health Inpatient Services were mapped with the 'Mental Health and Substance Abuse Disorder Services' EHB category. The services are a duplication of the Hospital Inpatient Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorder Inpatient Services-Dupli</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance Use Disorder Inpatient Services were mapped with the 'Mental Health and Substance Abuse Disorder Services' EHB category. The services are a duplication of the Hospital Inpatient Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorder Outpatient Services-Dupli</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance Use Disorder Outpatient Services were mapped with the 'Mental Health and Substance Abuse Disorder Services' EHB category. The services are a duplication of the Hospital Outpatient Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profess. Services by Licensed Men. Sub Pract-Dup</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Professional Services by Licensed Mental Health and Substance Abuse Practitioners were mapped with the 'Mental Health and Substance Abuse Disorder Services' EHB category. The services are a duplication of the Physician, Medical Care Provided by Licens. Practitioners, Clinics and Rehabilitation in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic for Mental/Substance Disorders-Duplic</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Diagnostic for Mental/Substance Disorders were mapped with the 'Other Laboratory and X-Ray Services' EHB category. The services are a duplication of Other Laboratory in the existing State Plan.
### Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs-Duplication</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td>Preferred Drugs-Duplication</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td>Non-Preferred Drugs Brand-Duplication</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td>Specialty Drugs-Duplication</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td>Diagnostic Test (X-Ray and Lab Work) - Duplication</td>
<td>Base Benchmark</td>
</tr>
<tr>
<td>Imaging (CT/PET Scans, MRIs)- Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

**Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:**

- **Generic Drugs**: were mapped with the 'Prescription Drugs' EHB category. The services are a duplication of Prescribed Drugs in the existing State Plan.
- **Preferred Drugs**: were mapped with the 'Prescription Drugs' EHB category. The services are a duplication of Prescribed Drugs in the existing State Plan.
- **Non-Preferred Drugs**: were mapped with the 'Prescription Drugs' EHB category. The services are a duplication of Prescribed Drugs in the existing State Plan.
- **Specialty Drugs**: were mapped with the 'Prescription Drugs' EHB category. The services are a duplication of Prescribed Drugs in the existing State Plan.
- **Diagnostic Test (X-Ray and Lab Work)**: were mapped with the 'Laboratory Services' EHB category. The services are a duplication of Other Laboratory and X-Ray Services in the existing State Plan.
# Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

- Imaging (CT/PET Scans, MRIs) were mapped with the 'Laboratory Services' EHB category. The services are a duplication of Other Laboratory and X-Ray Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteoporosis Prevention-Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

- Osteoporosis Prevention was mapped with the 'Preventative and Wellness Services and Chronic Disease Management' EHB category. The services are a duplication of Physician Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Equipment, Sup. and Self Mana. -Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

- Diabetes Equipment, Supplies, and Self-Management was mapped with the 'Preventative and Wellness Services and Chronic Disease Management' EHB category. The services are a duplication of the Home Health Services DME/DMS in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Foods-Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

- Medical Foods were mapped with the 'Preventative and Wellness Services and Chronic Disease Management' EHB category. The services are a duplication of the Home Health Services DME/DMS in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Related Services-Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1927 benchmark benefit(s) included above under Essential Health Benefits:

- Allergy Related Services (care delivered in medical offices for treatment of illness or injury) were mapped with the 'Preventative and Wellness Services and Chronic Disease Management' EHB category. The services are a duplication of Physician Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Preventive and Routine Care-Duplication</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

- Child Preventive and Routine Care were mapped with the 'Pediatric Services, Including Oral and Vision'
## Alternative Benefit Plan

**EHB category.** The services are a duplication of Early and Periodic Screen, Diagnostic, and Treatment Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Glasses for Children-Duplication</strong></td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Eye Glasses for Children were mapped with the 'Pediatric Services, Including Oral and Vision' EHB category. The services are a duplication of Early and Periodic Screening, Diagnostic, and Treatment Services.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Check-Up for Children-Duplication</strong></td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Dental Check-Up for Children were mapped with the 'Pediatric Services, Including Oral and Vision' EHB category. The services are a duplication of Early and Periodic Screening, Diagnostic, and Treatment Services.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Rehabilitation Services-Duplication</strong></td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient Rehabilitation Services were mapped with the 'Rehabilitative and Habilitative Services and Devices' EHB category. The services are a duplication of Physical Therapy and Related Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable Medical Equipment-Duplication</strong></td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Durable Medical Equipment was mapped with the 'Rehabilitative and Habilitative Services and Devices' EHB category. The services are a duplication of Home Health Care Services-DME/DMS in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing-Duplication</strong></td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Skilled Nursing Services were mapped with the 'Rehabilitative and Habilitative Services and Devices' in the EHB category. The Essential Health Benefit limits nursing home services to 100 days. The services are a duplication of nursing facility services provided for rehabilitation purposes (100 days or less) in the
## Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Cardiac Rehabilitation-Duplication</strong></td>
<td>Base Benchmark</td>
</tr>
<tr>
<td><strong>Infertility Treatment Services-Substitution</strong></td>
<td>Base Benchmark</td>
</tr>
<tr>
<td><strong>Acupuncture and Chiropractic Care- Substitution</strong></td>
<td>Base Benchmark</td>
</tr>
<tr>
<td><strong>Preventive Care/Screening-Duplication</strong></td>
<td>Base Benchmark</td>
</tr>
<tr>
<td><strong>Immunizations-Duplication</strong></td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

### Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

- **Outpatient Cardiac Rehabilitation Services** were mapped with the 'Rehabilitative and Habilitative Services and Devices' in the EHB category. The services are a duplication of Outpatient Hospital Services in the existing State Plan.

- **IVF services** were mapped to the 'ambulatory patient services' category. Services not covered under this category include: in vitro fertilization, ovum transplants, and gamete intra-fallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures. Personal care and Community First Choice services from the existing State Plan were used for substitution purposes.

- **Acupuncture and Chiropractic Care** were mapped to the 'ambulatory patient services' category. Chiropractic services are limited to 20 visits per condition per contract year. Federally-Qualified Health Center Services from the existing State Plan were used for substitution purposes.

- The benefit is duplicative of the preventive services offered in EHB9.

- The benefit is duplicative of the preventive services offered in EHB9.
### Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Anesthesia and Ass. Dental Care-Duplicat</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

General Anesthesia was mapped with the 'Ambulatory Patient Services' EHB category. The services are a duplication of Physician and Outpatient Hospital Services in the existing State Plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit that was Substituted:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery Physician/Surgical Services</td>
<td>Base Benchmark</td>
</tr>
</tbody>
</table>

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient Surgery Physician/Surgical Services were mapped to the 'ambulatory patient' EHB category. The services are a duplication of the Physician Services in the existing State Plan.
### Alternative Benefit Plan

#### 13. Other Base Benchmark Benefits Not Covered

<table>
<thead>
<tr>
<th>Base Benchmark Benefit not Included in the Alternative Benefit Plan</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn hearing screen</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:**

The ABP is a benefit package for the new adults under 1902 (a)(10)(A)(i)(VIII). Children and newborns will not be enrolled in this benefit plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit not Included in the Alternative Benefit Plan</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion -outside of the Hyde Amendment</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:**

Maryland provides these services, but does not collect federal dollars for them.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit not Included in the Alternative Benefit Plan</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Eye Exam -Adults</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:**

Vision is not considered and an essential health benefit for purposes of Alternative Benefit Plans.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit not Included in the Alternative Benefit Plan</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Care</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:**

The ABP is a benefit package for the new adults under 1902 (a)(10)(A)(i)(VIII). Newborns will not be enrolled in this benefit plan.

<table>
<thead>
<tr>
<th>Base Benchmark Benefit not Included in the Alternative Benefit Plan</th>
<th>Source: Base Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumcision</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:**

The ABP is a benefit package for the new adults under 1902 (a)(10)(A)(i)(VIII). Newborns will not be enrolled in this benefit plan.
### 14. Other 1937 Covered Benefits that are not Essential Health Benefits

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Care by Other Licensed Pract. - Podiatrist</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
<td>(not applicable)</td>
</tr>
</tbody>
</table>

- **Authorization:**
  - Prior Authorization

- **Amount Limit:**
  - Chronic care is limited to 1 visit every 6 weeks

- **Scope Limit:**
  - None

- **Other:**
  - Preauthorization is required for more than five visits or care beyond 90 days.

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning Services and Supplies</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
<td>(not applicable)</td>
</tr>
</tbody>
</table>

- **Authorization:**
  - Other

- **Amount Limit:**
  - None

- **Scope Limit:**
  - None

- **Other:**
  - (not applicable)

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
<th>Remove</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling and Pharm. for Cessation of Tobacco</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
<td>(not applicable)</td>
</tr>
</tbody>
</table>

- **Authorization:**
  - Other

- **Amount Limit:**
  - None

- **Scope Limit:**
  - None

- **Other:**
  - (not applicable)
## Alternative Benefit Plan

### Other 1937 Benefit Provided:
- **Health Homes**

<table>
<thead>
<tr>
<th>Source:</th>
<th>Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorization:</strong></td>
<td>Other</td>
</tr>
<tr>
<td><strong>Provider Qualifications:</strong></td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td><strong>Amount Limit:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Duration Limit:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Scope Limit:</strong></td>
<td>As long as individuals meet the participation requirements and receives services from a qualified provider.</td>
</tr>
</tbody>
</table>

**Other:**

### Other 1937 Benefit Provided:
- **Non-Emergency Transportation**

<table>
<thead>
<tr>
<th>Source:</th>
<th>Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorization:</strong></td>
<td>Prior Authorization</td>
</tr>
<tr>
<td><strong>Provider Qualifications:</strong></td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td><strong>Amount Limit:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Duration Limit:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Scope Limit:</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Other:**

### Other 1937 Benefit Provided:
- **Optometrist Services**

<table>
<thead>
<tr>
<th>Source:</th>
<th>Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorization:</strong></td>
<td>Prior Authorization</td>
</tr>
<tr>
<td><strong>Provider Qualifications:</strong></td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td><strong>Amount Limit:</strong></td>
<td>Eye Examination Every Two Years</td>
</tr>
<tr>
<td><strong>Duration Limit:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Scope Limit:</strong></td>
<td>None</td>
</tr>
</tbody>
</table>
**Alternative Benefit Plan**

**Other:**
- Does not cover eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients 21 years old and older.

**Other 1937 Benefit Provided:**
- **Mobile Treatment**
  - **Source:** Section 1937 Coverage Option Benchmark Benefit Package
  - **Authorization:** Other
  - **Provider Qualifications:** Medicaid State Plan
  - **Amount Limit:** None
  - **Duration Limit:** None
  - **Scope Limit:** None

**Other:**
- Usually prior-authorization but in an emergency can provide services for a short period of time. It is an intensive integrated blend of outpatient and psychiatric rehabilitation services. Mobile Treatment provides assertive outreach, treatment and support to adults with Serious and Persistent Mental Illness (SPMI) who resist more traditional forms of outpatient treatment. Service provision is mobile and provided in the individual's natural environment.

**Other 1937 Benefit Provided:**
- **Psychiatric Rehabilitation Program-Not in IMD**
  - **Source:** Section 1937 Coverage Option Benchmark Benefit Package
  - **Authorization:** Prior Authorization
  - **Provider Qualifications:**
  - **Amount Limit:** None
  - **Duration Limit:** None
  - **Scope Limit:** None

**Other:**
- PRP services include: services to develop or restore self-care skills, social skills and independent living skills. Additionally, medication management and monitoring, health promotion and training, and psychiatric crisis services are covered.

**Other 1937 Benefit Provided:**
- **Outpatient Mental Health Clinic Serv. -Not in IMD**
  - **Source:** Section 1937 Coverage Option Benchmark Benefit Package
  - **Authorization:** Prior Authorization
  - **Provider Qualifications:** Medicaid State Plan
### Alternative Benefit Plan

**Amount Limit:** None  
**Duration Limit:** None

**Scope Limit:** None  
**Other:**

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home Custodial Care</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
</tr>
</tbody>
</table>

**Authorization:** Prior Authorization  
**Provider Qualifications:** Medicaid State Plan

**Amount Limit:** None  
**Duration Limit:** None

**Scope Limit:** None  
**Other:** Need to meet nursing level of care criteria. Note: Hospice care in nursing homes is also covered.

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Services Extended to Pregnant Women</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
</tr>
</tbody>
</table>

**Authorization:** Other  
**Provider Qualifications:** Medicaid State Plan

**Amount Limit:** None  
**Duration Limit:** None

**Scope Limit:** None  
**Other:** Risk assessment, enrich maternity services, high-risk nutritional counseling, and dental

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-Based Substance Abuse Services</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
</tr>
</tbody>
</table>
### Alternative Benefit Plan

#### Authorization:
- Other

#### Provider Qualifications:
- Medicaid State Plan

#### Amount Limit:
- See below in the Other Section

#### Duration Limit:
- None

#### Scope Limit:
- None

#### Other:
Services authorized include comprehensive substance use disorder assessments, group and individual substance use disorder counseling services, intensive outpatient services, partial hospitalization, opioid maintenance therapy and ambulatory withdrawal management. Services authorized are community-based and align with those detailed in the State Plan.

---

#### Other 1937 Benefit Provided:
- Program of All-Inclusive Care for the Elderly

#### Source:
- Section 1937 Coverage Option Benchmark Benefit Package

#### Authorization:
- Other

#### Provider Qualifications:
- Medicaid State Plan

#### Amount Limit:
- None

#### Duration Limit:
- None

#### Scope Limit:
- None

#### Other:

---

#### Other 1937 Benefit Provided:
- Rural Health Center Services

#### Source:
- Section 1937 Coverage Option Benchmark Benefit Package

#### Authorization:
- Other

#### Provider Qualifications:
- Medicaid State Plan

#### Amount Limit:
- None

#### Duration Limit:
- None

#### Scope Limit:
- None

#### Other:

## Alternative Benefit Plan

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Care Facilities-Intellectually Dis.</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
</tr>
<tr>
<td>Authorization:</td>
<td>Provider Qualifications:</td>
</tr>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Scope Limit:</td>
<td>None</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Recipient has been certified that he/she requires intermediate care facility services for the intellectually-disabled or persons with related conditions.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management-Mental Illness</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
</tr>
<tr>
<td>Authorization:</td>
<td>Provider Qualifications:</td>
</tr>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
</tr>
<tr>
<td>Yes-See below</td>
<td>None</td>
</tr>
<tr>
<td>Scope Limit:</td>
<td>None</td>
</tr>
<tr>
<td>Other:</td>
<td>Limited to individuals with serious emotional disturbance at risk of or needs continued treatment to prevent inpatient psychiatric treatment, treatment in an RTC or an out-of-home placement; prevent inpatient psych treat, homelessness or incarceration. #’s of units are based on severity of the condition in the plan of care. Individuals receiving Level I (general) Case Management Services are limited to 2 units of service per month. Individuals receiving Level II (intensive) Case Management Services are limited to 5 units of service per month. Level I and Level II individuals can receive an additional unit in the first month.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other 1937 Benefit Provided:</th>
<th>Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management-HIV</td>
<td>Section 1937 Coverage Option Benchmark Benefit Package</td>
</tr>
<tr>
<td>Authorization:</td>
<td>Provider Qualifications:</td>
</tr>
<tr>
<td>Other</td>
<td>Medicaid State Plan</td>
</tr>
<tr>
<td>Amount Limit:</td>
<td>Duration Limit:</td>
</tr>
<tr>
<td>Yes-See below</td>
<td>None</td>
</tr>
<tr>
<td>Scope Limit:</td>
<td>None</td>
</tr>
</tbody>
</table>
### Alternative Benefit Plan

**Other:**

Limited to individuals who are certified for and enrolled in the Maryland's Medical Assistance Program and diagnosed as HIV-infected. Case management services are covered when documented as appropriate and necessary. Individuals are limited to 96 units of service per year.

### Other 1937 Benefit Provided:

<table>
<thead>
<tr>
<th>Case Management-Developmental Disabilities</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorization:</strong></td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Authorization required in excess of limitation</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td><strong>Amount Limit:</strong></td>
<td></td>
</tr>
<tr>
<td>See below-No hard cap on the number of services</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td><strong>Scope Limit:</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

**Other:**

1. Individuals who are found eligible for funding from the Developmental Disabilities Administration (DDA) and are on the DDA waiting list. Case management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. #s of units are based on severity of the condition in the plan of care. There is no hard cap on the number of services. The target group does not include individuals between 22 and 64 who are in IMD or individuals who are inmates of public institutions.

2. Individuals who are found eligible for funding from the Developmental Disabilities Administration (DDA) and are transitioning to the community. Case management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. #s of units are based on severity of the condition in the plan of care. There is no hard cap on the number of services. The target group does not include individuals between 22 and 64 who are in IMD or individuals who are inmates of public institutions.

3. Individuals who are found eligible for funding from the Developmental Disabilities Administration (DDA) and are in comprehensive community services funded by the DDA. Case management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. #s of units are based on severity of the condition in the plan of care. There is no hard cap on the number of services. The target group does not include individuals between 22 and 64 who are in IMD or individuals who are inmates of public institutions.

### Other 1937/ Benefit Provided:

<table>
<thead>
<tr>
<th>Free Standing Birth Center Services</th>
<th>Source: Section 1937 Coverage Option Benchmark Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorization:</strong></td>
<td>Provider Qualifications: Medicaid State Plan</td>
</tr>
<tr>
<td>Other</td>
<td>Duration Limit: None</td>
</tr>
<tr>
<td><strong>Amount Limit:</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
Scope Limit:
None
Other:

Add
PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V 20160722
## Alternative Benefit Plan

### Benefits Assurances

<table>
<thead>
<tr>
<th>EPSDT Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).</td>
</tr>
<tr>
<td>The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.</td>
</tr>
<tr>
<td>Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:</td>
</tr>
<tr>
<td>Through an Alternative Benefit Plan.</td>
</tr>
<tr>
<td>Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).</td>
</tr>
</tbody>
</table>

Other Information regarding how EPSDT benefits will be provided to participants under 21 years of age (optional):

### Prescription Drug Coverage Assurances

| The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark. |
| The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered. |
| The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act. |
| The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act. |

### Other Benefit Assurances

| The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS. |
| The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act. |
| The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act. |
Alternative Benefit Plan

- The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

- The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

- The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

- The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

- The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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V 20130917
Alternative Benefit Plan

State Name: Maryland

Service Delivery Systems

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- Managed care.
  - Managed Care Organizations (MCO).
  - Prepaid Inpatient Health Plans (PIHP).
  - Prepaid Ambulatory Health Plans (PAHP).
  - Primary Care Case Management (PCCM).
- Fee-for-service.
- Other service delivery system.

Managed Care Options

Managed Care Assurance

☐ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The existing adult benefit package for our HealthChoice managed care organizations (MCOs) fully aligns with the ABP. The MCOs will be responsible for educating enrollees that this is a covered benefit.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program.

☐ Section 1915(a) voluntary managed care program.
☐ Section 1915(b) managed care waiver.
☐ Section 1932(a) mandatory managed care state plan amendment.
☐ Section 1115 demonstration.
☐ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: 12/26/2016
Alternative Benefit Plan

Describe program below:
There are currently nine MCOs participating in HealthChoice: Actna Better Health, Amerigroup Community Care, Jai Medical Systems, Kaiser Permanente, Maryland Physicians Care, MedStar Family Choice, Priority Partners, University of Maryland Health Partners and United Healthcare. Maryland enrolls families, children, pregnant women, foster care children, non-institutionalized SSI enrollees who are younger than 65 and not on Medicare and the new adults under the Section 1902(a)(10)(A)(i)(VIII).

Additional Information: MCO (Optional)
Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options
Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

☐ Traditional state-managed fee-for-service

☐ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service management models/non-risk, contractual incentives as well as the population served via this delivery system.

Until an enrollee selects an MCO, individuals will receive services on a fee-for-service basis. This period could be up to 30 days.

There are services carved-out of the MCO benefit package for adults. These include:
- Specialty mental health and substance use disorder benefits are provided by an ASO.
- Specialty mental health and HIV/AIDS prescription drugs are carved out of the MCO benefit package and provided on a fee-for-service basis.
- Personal care services are carved out of the MCO benefit package.
- Viral load testing services, genotypic, phenotypics or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS is carved out of the MCO benefit package and provided on a fee-for-service basis.

There are a few additional services carved-out of the MCO benefit package for children. These include:
- Health-related and targeted case management services provided to children when specific in a child's Individualized Education Plan or Individualized Family Service Plan
- Therapy services
- Dental

Dental services is a covered benefit for pregnant women.

Additional Information: Fee-For-Service (Optional)
Provide any additional details regarding this service delivery system (optional):

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Alternative Benefit Plan

Attachment 3.1-C-

Employer Sponsored Insurance and Payment of Premiums

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

No

The state/territory otherwise provides for payment of premiums.

No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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Alternative Benefit Plan

General Assurances

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services.

☑ Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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## Payment Methodology

### Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

**An attachment is submitted.**

### PRA Disclosure Statement

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V.20130917
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Maryland

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

The following method is used to provide the entire range of Maryland Medical Assistance Program benefits under Part B of title XVIII to the Group of Medicare-eligible individuals indicated:

A. Buy-in agreements with the Secretary of HHS. This agreement covers:

1. Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   ❑ Yes ❑ No

2. Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State’s approved title IV-A plan, who are categorically needy under the State’s approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   ❑ Yes ❑ No

3. All individuals eligible under the State’s approved title XIX plan.

B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups:

This relates only to comparability of devices - benefits under XVIII to what groups - not how XIX pays. ...if State has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group, e.g. does #1 for money payment receipts and #3 for non-$-receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment.

Revision: HCFA-PK-87-4 (BERC) MARCH 1987

Attachment 3.2-A OMB No.: 0938-0193

Approval Date JUL 15 1988 Effective Date JUL 01 1987
MARYLAND HBE – CMS ALTERNATE APPLICATION FOR HEALTH COVERAGE

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TN No: MD-13-0021-MM2

Maryland

Approval Date: 02/12/2014

Effective Date: 10/01/2013
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1 Section I – My Account

1.1 Create Account

1.1.1 Flow Charts

CHECK THE COST OF HEALTH PLANS

PURCHASE PLANS WITHOUT ASSISTANCE

PURCHASE PLANS WITH ASSISTANCE

MARYLAND HEALTH CONNECTION (MHC) LANDING PAGE

CHECK THE COST OF HEALTH PLANS

PURCHASE PLANS WITHOUT ASSISTANCE

PURCHASE PLANS WITH ASSISTANCE
1.1.2 MHC Landing Page

Apply For Assistance and Purchase Plans

GET STARTED
• What do I need to do? A plan?
• What is an excerpt?
• Is this the right plan?
• What is an excerpt?
• What is my eligibility for other programs?
• Apply for other programs

I NEED HELP
• Can I be a navigator?
• I am an employer
• Is this the right plan?

Log into your Account
1.1.3 Check the Cost of Health Plans: Getting Started

Getting Started

To get started, please choose one of the options below:

- Create an account. Creating your own account will let you save what you are doing and come back to it later.
- Log in if you already have an account.
- Continue without logging in. Continue without creating an account or logging in.

1.1.4 Purchase Plans With and Without Assistance: Getting Started

Getting Started

Before starting this process, you must create a new account or log in to an account that you already have.

To get started, please choose one of the options below:

- Create an account. Creating your own account will let you save your work and return to it later.
- Log in if you already have an account.

1.1.5 Create a User Account

Create a User Account

In order to set up a user account, please enter your details below. Your user account will let you save your application and come back to it later. You will also be able to check the status of your application after you submit it.

If you have questions about creating your user account, please call the Customer Service Center at 1-855-1-4323000.

Personal Details
First Name: Jane
Last Name: Doe
Email: jane@example.com

User Name and Password
Your User Name must be at least 6 characters. Your Password must be at least 6 characters and contain at least one number and/or one special character.

User Name: jane
Password: *required
Re-type Password: *required

Password Hint
If you forget your password, you can use your security question to get a new password. Please select your question and type your answer below.

Question: Mother's maiden name
Answer: Doe

Please check the box to let us know that you have read and agreed to the usage conditions.
1.1.6 Client Login

Client Login

Login to your account.

Your Login Details

Please enter your User Name and Password and click the Next button to continue.

User Name: ClientEll
Password: ********

Forgot your password?

1.1.7 Login from MHC Landing Page

Apply For Assistance and Purchase Plans

GET STARTED
- Apply for assistance with your Health Care
- Apply To Purchase Health Care Without Assistance
- Check the status of your plans
- Apply for an employer-sponsored health plan
- Apply for an exemption
- Check if you are eligible for other programs
- Apply for other purposes

NEED HELP?
- What do I need to see a plan?
- How do I make a claim?
- Can I be suspended?
- I'm an employer.
- Can I be a beneficiary?
- How do I call an assistant?

Log into your Account

1.1.8 Purchase Plans with Assistance: Getting Started with Application

Getting Started

- You and/or your dependents are eligible for assistance programs. First, you need to complete the application for coverage. Please select an option from below.

- lncome
- Home ownership
- Homeownership
- Additional income explanation
- Address
- Verification summary

PAGE 8 OF 66
2 Section II - Privacy

2.1 Flow Chart

2.2 For Myself and/or My Family

Before We Start

Please read the information below and check the box to show your agreement.

Household Information

We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health insurance or help paying for health insurance. We'll check your answers using information in our electronic databases and the databases of our partner agencies. If the information doesn't match, we may ask you to send us proof.

This application doesn't ask questions about the household medical history. Household members who don't want insurance won't be asked questions about citizenship and immigration.

Important: As part of the application process, we may need to retrieve information about the household from other government agencies like IRS, Social Security Administration and the Department of Homeland Security. We need this information to check the household eligibility for health insurance or help paying for health insurance.

Learn more about your data

View Privacy Act Statement

By checking this box you are confirming that the applicant has granted you permission to enter information on their behalf and that you will not disclose that information to anyone else without the applicant's permission.
2.3 Authorized Representative or Assistor

Before We Start

Please read the information below and check the box to show your agreement.

Household Information

We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health insurance or help paying for health insurance. We'll check your answers using information in our electronic databases and the databases of our partner agencies. If the information doesn't match, we may ask you to send us proof.

This application doesn't ask questions about the household medical history. Household members who don't want insurance won't be asked questions about citizenship and immigration.

Important: As part of the application process, we may need to retrieve information about the household from other government agencies like IRS, Social Security Administration and the Department of Homeland Security. We need this information to check the household eligibility for health insurance or help paying for health insurance.

Learn more about your data
Use Privacy Act Statement

By checking this box you are confirming that the applicant has granted you permission to enter information on their behalf and that you will not disclose that information to anyone else without the applicant's permission.

2.4 Privacy Act Statement

MARYLAND HEALTH BENEFIT EXCHANGE PRIVACY STATEMENT

Thank you for visiting a website published and managed by the Maryland Health Benefit Exchange (MHBE), a public corporation and unit of State government. This statement applies specifically to www.marylandhealthconnection.gov.

Information Collected and Stored Automatically

When you browse this website, read pages, or download information, certain information about your visit is automatically gathered and stored. This information does not identify you personally, and includes the following:

- The Internet domain (example: aol.com) and the IP address (the number automatically assigned to your computer when surfing the Web) from which you access our portal,
- The type of browser and operating system used to access our site,
- The date and time you access our site,
- The pages you visit,
- The address from which you linked to our website.

This information is used to make this website more useful to visitors, to learn about the number of visitors to our site, and the types of technology our visitors use. We do not track or record identifying information about individuals and their visits.

Cookies

This website uses "temporary cookies" to track user navigation in order to make the portal experience more useful. A temporary cookie is erased when the user closes the web browser. The "temporary cookie", also called a session cookie, is stored in temporary memory in the form of a text file on your computer, and is erased after the browser session is ended. No identifying user information is collected and stored on other computers anywhere. We store no personal information based on your visit to our website.

General Privacy Policy

It is our policy to preserve the privacy of personal records and to protect confidential or privileged information. Such information will be disclosed publicly only as required by the Public Information Act or as necessary or permissible to carry out official duties. Under State law, these policies do not apply to information gathered for certain specified purposes, such as the investigation of a possible violation of the law. If you have any questions about these privacy policies, please e-mail them to TBD.

Privacy Policy Changes

Changes to our websites may necessitate changes to our privacy statement. Notification will be posted on this website in the Privacy Notice link. The information contained in this privacy statement applies only to www.marylandhealthconnection.gov.
3 Section III - Getting Started

3.1 Contact Information

3.1.1 Flow Chart

3.1.2 Authorized Representative Contact Information

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner</td>
<td></td>
</tr>
<tr>
<td>Let's get started with your application</td>
<td></td>
</tr>
<tr>
<td>In order to evaluate the eligibility for insurance</td>
<td></td>
</tr>
<tr>
<td>assistance an application is required to be completed</td>
<td></td>
</tr>
<tr>
<td>and submitted. Information on who is applying for</td>
<td></td>
</tr>
<tr>
<td>coverage determines how the application information is</td>
<td></td>
</tr>
<tr>
<td>captured on subsequent pages. Please select an option</td>
<td></td>
</tr>
<tr>
<td>from below which will be used to drive the information</td>
<td></td>
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<tr>
<td>capture.</td>
<td></td>
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<tr>
<td>I am applying</td>
<td>For myself and/or my</td>
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<td></td>
<td>family</td>
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<td></td>
<td>As an individual acting</td>
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<td>responsibly on behalf of</td>
</tr>
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<td></td>
<td>someone else</td>
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<tr>
<td></td>
<td>As an authorized</td>
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<td></td>
<td>representative</td>
</tr>
<tr>
<td>Cluster Name: Application Filer Details</td>
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</tr>
<tr>
<td>You have indicated that you are applying as</td>
<td></td>
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<tr>
<td>an authorized representative and not yourself. Before</td>
<td></td>
</tr>
<tr>
<td>we ask for their information we need to know about</td>
<td></td>
</tr>
<tr>
<td>some basic details about you.</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Dr.</td>
</tr>
<tr>
<td></td>
<td>Miss</td>
</tr>
<tr>
<td></td>
<td>Mr.</td>
</tr>
<tr>
<td></td>
<td>Mrs.</td>
</tr>
<tr>
<td></td>
<td>Ms.</td>
</tr>
<tr>
<td></td>
<td>Prof.</td>
</tr>
<tr>
<td>Getting Started</td>
<td>Values (if applicable)</td>
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<td>Suffix</td>
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<td>Junior</td>
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<td>Senior</td>
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<td>Second</td>
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<td>Fourth</td>
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<td></td>
<td>Fifth</td>
</tr>
<tr>
<td>First Name</td>
<td></td>
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<tr>
<td>Middle Name</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td><strong>Cluster Name: Your Address</strong></td>
<td></td>
</tr>
<tr>
<td>Apt/Suite</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Alabama ** Wyoming</td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td>List of all the counties by state wise</td>
</tr>
<tr>
<td><strong>Cluster Name: Other Contact Information</strong></td>
<td></td>
</tr>
<tr>
<td>Preferred Contact Method</td>
<td>Email</td>
</tr>
<tr>
<td></td>
<td>Post/Mail</td>
</tr>
<tr>
<td>Home Phone Number</td>
<td></td>
</tr>
<tr>
<td>Work Phone Number</td>
<td></td>
</tr>
<tr>
<td>Cell Phone Number</td>
<td></td>
</tr>
<tr>
<td>E-mail Address</td>
<td></td>
</tr>
<tr>
<td><strong>Cluster: Authorization Information</strong></td>
<td></td>
</tr>
<tr>
<td>Enter the date the applicant authorized you to apply for coverage on their behalf.</td>
<td></td>
</tr>
<tr>
<td>Enter the name of the applicant that authorized you</td>
<td></td>
</tr>
<tr>
<td>What has the applicant authorized you to do?</td>
<td></td>
</tr>
<tr>
<td>Complete and submit renewals</td>
<td></td>
</tr>
<tr>
<td>Sign the application on the applicant's behalf</td>
<td></td>
</tr>
<tr>
<td>Receive copies of all notices and communications</td>
<td></td>
</tr>
<tr>
<td>Act on behalf of the applicant on all other matters</td>
<td></td>
</tr>
<tr>
<td>Do you belong to an organization?</td>
<td>No</td>
</tr>
<tr>
<td>(If the dropdown value for the field 'Do you belong to an organization?' is 'YES' the following field(s) appear)</td>
<td></td>
</tr>
<tr>
<td>Please enter the organizational details</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Identification Number</td>
<td></td>
</tr>
<tr>
<td>Getting Started</td>
<td>Values (If applicable)</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Phone Number</td>
<td></td>
</tr>
<tr>
<td>E-mail Address</td>
<td></td>
</tr>
<tr>
<td>By checking this box you are agreeing that</td>
<td>By checking this box you are confirming that the</td>
</tr>
<tr>
<td>you will adhere to all relevant State and</td>
<td>applicant has granted your permission to enter  information on their behalf, that you</td>
</tr>
<tr>
<td>Federal laws concerning conflicts of interest</td>
<td>acknowledge you are responsible for providing information and communicating to the same</td>
</tr>
<tr>
<td>and confidentiality of information,</td>
<td>extent as the applicant would be for the tasks you checked above, and that you will</td>
</tr>
<tr>
<td>including the following provisions in the</td>
<td>not disclose that information to anyone else without the applicant's permission.</td>
</tr>
<tr>
<td>Code of Federal Regulations: Chapter 42,</td>
<td></td>
</tr>
<tr>
<td>part 431, subpart F; 42 C.F.R. 447.10; and</td>
<td></td>
</tr>
<tr>
<td>45 C.F.R. 155.260(f).</td>
<td></td>
</tr>
</tbody>
</table>

By checking this box you are agreeing that you will adhere to all relevant State and Federal laws concerning conflicts of interest and confidentiality of information, including the following provisions in the Code of Federal Regulations: Chapter 42, part 431, subpart F; 42 C.F.R. 447.10; and 45 C.F.R. 155.260(f).

By checking this box you are confirming that the applicant has granted your permission to enter information on their behalf, that you acknowledge you are responsible for providing information and communicating to the same extent as the applicant would be for the tasks you checked above, and that you will not disclose that information to anyone else without the applicant's permission.
3.1.3 Assistor Contact Information

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner</td>
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</tbody>
</table>

S94 Maryland - HBE CMS Alternate Application For Health Coverage

TN No: MD-13-0021-MM2

Approval Date: 02/12/2014
Effective Date: 10/01/2013
In order to evaluate the eligibility for insurance assistance an application is required to be completed and submitted. Information on who is applying for coverage determines how the application information is captured on subsequent pages. Please select an option from below which will be used to drive the information capture.

<table>
<thead>
<tr>
<th>Getting Started</th>
<th>Values (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Let's get started with your application</td>
<td>For myself and/or my family</td>
</tr>
<tr>
<td>In order to evaluate the eligibility for insurance assistance an application is required to be completed and submitted. Information on who is applying for coverage determines how the application information is captured on subsequent pages. Please select an option from below which will be used to drive the information capture.</td>
<td>As an individual acting responsibly on behalf of someone else</td>
</tr>
<tr>
<td></td>
<td>As an authorized representative</td>
</tr>
</tbody>
</table>

**Cluster Name: Application Filer Details**

You have indicated that you are applying on behalf of someone else and not yourself but before we ask for their information we need to know some basic details about you.

<table>
<thead>
<tr>
<th>Title</th>
<th>Dr. Miss Mr. Mrs. Ms. Prof.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffix</td>
<td>Esquire Junior Senior First Second Third Fourth Fifth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle Name</td>
<td></td>
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<tr>
<td>Last Name</td>
<td></td>
</tr>
</tbody>
</table>

**Cluster Name: Your Address**

<table>
<thead>
<tr>
<th>Apt/Suite</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Alabama ~ Wyoming</td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td>List of all the counties by state wise</td>
</tr>
</tbody>
</table>

**Cluster Name: Preferred Method of Communication**

<table>
<thead>
<tr>
<th>Communication Preference</th>
<th>Email Post/Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone Number</td>
<td></td>
</tr>
<tr>
<td>Work Phone Number</td>
<td></td>
</tr>
</tbody>
</table>
Getting Started

<table>
<thead>
<tr>
<th>Cell Phone Number</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-mail Address</td>
<td></td>
</tr>
</tbody>
</table>

By checking this box you are confirming that the applicant has granted your permission to enter information on their behalf and that you will not disclose that information to anyone else without the applicant's permission.

Getting Started

I am applying:
- [ ] For myself and my family.
- [ ] As an individual acting separately on behalf of someone else.
- [ ] As an authorized representative.

Application File Details

You have indicated that you are applying on behalf of someone else and not yourself and whether you need to leave some basic details blank.

**Yes:** Please select

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Last Name</th>
</tr>
</thead>
</table>

Your Address

<table>
<thead>
<tr>
<th>Address 1</th>
<th>Address 2</th>
<th>Address 3</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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</table>

Other Contact Information

<table>
<thead>
<tr>
<th>Preferred Contact Method</th>
<th>Home Phone Number</th>
<th>Work Phone Number</th>
<th>Cell Phone Number</th>
<th>E-Mail ID</th>
</tr>
</thead>
</table>

By checking this box you are confirming that the applicant has granted you permission to enter information on their behalf and that you will not disclose that information to anyone else without the applicant's permission.

3.1.4 For Myself and/or My Family Contact Information – Primary Applicant

<table>
<thead>
<tr>
<th>Information About You</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner</td>
<td></td>
</tr>
</tbody>
</table>

Please provide some information about yourself.
Please enter your personal details below. You will be designated as the primary contact for the application. If you choose to include yourself in the application for coverage, the information you provide will be used to verify your identity, income and citizenship status. You will also be designated as the primary applicant.

### Cluster Name: Your Details

<table>
<thead>
<tr>
<th>Details</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
<td>Dr. Miss Mr. Mrs. Ms. Prof.</td>
</tr>
<tr>
<td><strong>Suffix</strong></td>
<td>Esquire Junior Senior First Second Third Fourth Fifth</td>
</tr>
<tr>
<td><strong>First Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Middle Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Last Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>Female Male</td>
</tr>
</tbody>
</table>

### Cluster: Your Home Address

Your address is required in order to determine your eligibility to use Maryland Health Connection and also so that we can contact you with regard to any decisions we make about your eligibility.

Do you have a fixed address? No Yes

(If the dropdown value for the Fixed Address field is 'NO', the following questions display)

Are you a Maryland resident? No Yes

If you do not have a fixed address, please choose a local health department based on the county you spend the most time in.

<table>
<thead>
<tr>
<th>County</th>
<th>List of all the counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Health Department/Organization</td>
<td>List of all the county Health Depts.</td>
</tr>
</tbody>
</table>
### Information About You

<table>
<thead>
<tr>
<th>Question</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a mailing address?</td>
<td>No</td>
</tr>
<tr>
<td>(If the dropdown value for the mailing address is 'YES', the following field(s) appear)</td>
<td></td>
</tr>
<tr>
<td>Address Line 1</td>
<td></td>
</tr>
<tr>
<td>Address Line 2</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Alabama ~ Wyoming</td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td></td>
</tr>
<tr>
<td>(If the dropdown value for the fixed address is 'YES', the following field(s) appear)</td>
<td></td>
</tr>
<tr>
<td>Address Line 1</td>
<td></td>
</tr>
<tr>
<td>Address Line 2</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Alabama ~ Wyoming</td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td></td>
</tr>
</tbody>
</table>

If the State does not = Maryland then this displays.

### Cluster: Temporarily Absent from State?

<table>
<thead>
<tr>
<th>Question</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you living outside the state temporarily and have intentions to return to the state?</td>
<td>No</td>
</tr>
<tr>
<td>Clusters: Your Mailing Address</td>
<td></td>
</tr>
<tr>
<td>Is the mailing address the same as your home address?</td>
<td>No</td>
</tr>
<tr>
<td>(If the dropdown value for the Mailing Address field is 'NO', the following field(s) appear)</td>
<td></td>
</tr>
<tr>
<td>Address Line 1</td>
<td></td>
</tr>
<tr>
<td>Address Line 2</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Alabama ~ Wyoming</td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td></td>
</tr>
</tbody>
</table>

### Cluster: Other Contact Information

We need to know the best way to contact you about this application. You may receive notifications by mail, email or phone

<table>
<thead>
<tr>
<th>Preferred Contact Method</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Email</td>
</tr>
<tr>
<td></td>
<td>Text</td>
</tr>
<tr>
<td></td>
<td>Mail</td>
</tr>
<tr>
<td>Information About You</td>
<td>Values (If applicable)</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Preferred Language</td>
<td>American Sign</td>
</tr>
<tr>
<td></td>
<td>Apache</td>
</tr>
<tr>
<td></td>
<td>Brazilian Portugese</td>
</tr>
<tr>
<td></td>
<td>Cambodian</td>
</tr>
<tr>
<td></td>
<td>Cantonese</td>
</tr>
<tr>
<td></td>
<td>English</td>
</tr>
<tr>
<td></td>
<td>French</td>
</tr>
<tr>
<td></td>
<td>German</td>
</tr>
<tr>
<td></td>
<td>Irish</td>
</tr>
<tr>
<td></td>
<td>Italian</td>
</tr>
<tr>
<td></td>
<td>Japanese</td>
</tr>
<tr>
<td></td>
<td>Korean</td>
</tr>
<tr>
<td></td>
<td>Lao</td>
</tr>
<tr>
<td></td>
<td>Navajo</td>
</tr>
<tr>
<td></td>
<td>Russian</td>
</tr>
<tr>
<td></td>
<td>Simplified Chinese</td>
</tr>
<tr>
<td></td>
<td>Spanish</td>
</tr>
<tr>
<td></td>
<td>Traditional Chinese</td>
</tr>
<tr>
<td></td>
<td>Vietnamese</td>
</tr>
</tbody>
</table>

| Phone Number          | Business               |
|                       | Fax                    |
|                       | Mobile                 |
|                       | Other                  |
|                       | Pager                  |
|                       | Personal               |

| Alternate Phone Number| Business               |
|                       | Fax                    |
|                       | Mobile                 |
|                       | Other                  |
|                       | Pager                  |
|                       | Personal               |

| E-mail Address        |                        |

<table>
<thead>
<tr>
<th>Cluster: Help paying for your health benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you want to find out if you can get help paying for your own health insurance and health benefits?</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>
Information About You

Provide profile some information about you:

Your Details
First name: John
Middle name: Smith
Last name: Doe
Suffix: Jr.
Date of Birth:
State:
City:

Your Home Address
Your address is required in order to determine your eligibility in your Maryland health connection and are so that we can contact you with regard to any decisions we make about your eligibility.
Do you have a local address:

Are you a Maryland resident:

Temporarily Absent from State?
Are you living outside the state temporarily and have reasons to return to the Maryland:

Your Mailing Address
Do you have a mailing address:

Other Contact Information
We need to know the best way to contact you about this application. You may receive communications by mail, email, or phone.
Preferred Contact Name:
Preferred English Language:
Alternate Phone Number:
Alternate English Language:
Alternate Mailing Address:

Help paying for your health benefits
Do you want to know if you can get help paying for your health insurance and health benefits:

Approval Date: 02/12/2014
Effective Date: 10/01/2013
4 Section IV – Assistance with completing the application

5 Section V – Help Paying for Coverage

5.1 Flow Chart

5.1.1 Pre-Screening Calculator

Estimate how the Health Reform Act may affect you or your household

<table>
<thead>
<tr>
<th>Adults in household</th>
<th>6</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Children under 19 in household</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total annual household income</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>Is anyone in the household pregnant?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Based on your annual household income and household size, you may be eligible for Medicaid.

Based on your annual household income and household size, your children younger than 19 years old may be eligible for Medicaid.

*Your available health options are subject to change based on the accuracy of the information you entered.
5.1.2 Tax Filer Information

<table>
<thead>
<tr>
<th>Tax Filer Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner</td>
</tr>
<tr>
<td>Please choose the tax filers in your household</td>
</tr>
</tbody>
</table>

We need to know who in your household is a 'tax filer' so we can figure out whether you qualify for help in paying for coverage. We've listed the members of your household below. Please indicate which of them will be filing taxes.

INCLUDE yourself if you plan to file taxes, your spouse if he/she will be filing jointly with you OR will be filing his/her own form, your children IF they will have to file their own taxes, and any other dependents IF they will have to file their own taxes.

DO NOT INCLUDE your children if they will not need to file their own taxes or any other dependents if they will not need to file their own taxes.

If anyone in your household expects to file taxes this year, please select them below:

1. Jerry
2. Mary

Save & Exit
6 Section VI – Tell us how many people are applying for health coverage

6.1 Flow Chart

6.2 Other Household Members

In order to properly determine your eligibility, we need to know about any other people in the household.

- Include your spouse, your children under 21 who live with you, your unmarried partner who needs health coverage, anyone you include on your tax return, even if they don’t live with you and/or anyone else under 21 who you take care of and live with you. Don’t include your unmarried partner who doesn’t need health coverage, your unmarried partner’s children, your parents who live with you, but file their own tax return (if you’re over 21) and/or other adult relatives who file their own tax return.

Is there anyone else in the household? *

---Please Select---

- Yes
- No

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Maryland

Approval Date: 02/12/2014
Effective Date: 10/01/2013
6.3 Household Member Details

<table>
<thead>
<tr>
<th>Household Member Details</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner</td>
<td></td>
</tr>
<tr>
<td>Please provide details of the next household member</td>
<td></td>
</tr>
<tr>
<td>Please tell us about the next person in your household by filling in the information below. You may be asked more questions about this person on the next screen depending on whether you wish to find out whether you can get help paying for this person's health insurance and health benefits.</td>
<td></td>
</tr>
<tr>
<td><strong>Cluster: Details</strong></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Dr. Miss Mr. Mrs. Ms. Prof.</td>
</tr>
<tr>
<td>Suffix</td>
<td>Esquire Junior Senior First Second Third Fourth Fifth</td>
</tr>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Middle Name</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Female Male</td>
</tr>
<tr>
<td>Does this person live with you?</td>
<td>No Yes</td>
</tr>
<tr>
<td>(If the dropdown value for the Live with you is 'NO', the following field(s) appear)</td>
<td></td>
</tr>
<tr>
<td>Does this person have a fixed address?</td>
<td>No Yes</td>
</tr>
<tr>
<td>(If the dropdown value for the Fixed Address field is 'NO', the following field(s) appear)</td>
<td></td>
</tr>
<tr>
<td>Is this person a Maryland resident?</td>
<td>No Yes</td>
</tr>
<tr>
<td>Household Member Details</td>
<td>Values (If applicable)</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>(If the dropdown value for the state resident is 'YES', the following field(s) appear)</td>
<td></td>
</tr>
<tr>
<td>If this person does not have a fixed address, please choose a local health department based on the county this person spends the most time in.</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td>List of all the counties by state wise</td>
</tr>
<tr>
<td>Local Health Department/Organization</td>
<td>List of all the county Health Depts.</td>
</tr>
<tr>
<td>(If the dropdown value for the Fixed Address field is 'YES', the following field(s) appear)</td>
<td></td>
</tr>
<tr>
<td>Apt/Suite</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Alabama ~ Wyoming</td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td>List of all the counties</td>
</tr>
<tr>
<td>If the State does not = Maryland then this displays.</td>
<td></td>
</tr>
<tr>
<td><strong>Cluster: Temporarily Absent from State?</strong></td>
<td></td>
</tr>
<tr>
<td>Is living outside the state temporarily and has intentions to return?</td>
<td>No</td>
</tr>
<tr>
<td>Do you want to find out if you can get help paying for health insurance and health benefits for this person?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
Household Member Details

Please provide details of the next household member.

Details

Title
First Name *
Last Name *
Sex *
Does this person live with you? *
Does this person have a fixed address? *
Address *
City
Zip Code *

Do you want to find out if you can get help paying for health insurance and health benefits for this person? *

6.4 Relationships

<table>
<thead>
<tr>
<th>Relationships</th>
<th>Values (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please provide information about household member's relationships</td>
<td></td>
</tr>
<tr>
<td>In order to determine eligibility for medical insurance assistance, we need to know the relationships of all individuals in the household. Please select the most appropriate description of the relationship between each individual.</td>
<td></td>
</tr>
<tr>
<td>Relationships</td>
<td>Values (If applicable)</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Are they also a non-parent caretaker of this person?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Relationships</td>
<td>Is Unrelated to Is the Appointee of Is the Appointer of Is the Aunt of Is the Child of Is the Cousin of Is the Foster Child of Is the Foster Parent of Is the Grand Child of Is the Grandparent of Is the Great Aunt of Is the Great Grand Child of Is the Great Grandparent of Is the Great Nephew of Is the Great Niece of Is the Great Uncle of Is the Guardian of Is the Live in Attend of Is the Nephew of Is the Niece of Is the Orphan of Is the Parent of Is the Person Cared for by Is the Sibling of Is the Spouse of Is the Uncle of</td>
</tr>
</tbody>
</table>
7 Section VII – Tell us about each person

7.1 Flow Chart

7.2 Primary Applicant – Applying for Coverage
The information gathered in this screen is the same information that is gathered for all household members who are applying for coverage.

<table>
<thead>
<tr>
<th>More About You</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Banner</strong></td>
<td></td>
</tr>
<tr>
<td>Please provide some more information about yourself to help with your application</td>
<td></td>
</tr>
<tr>
<td><strong>Cluster: Race and Ethnicity (Optional)</strong></td>
<td></td>
</tr>
<tr>
<td>Please select options from below that best describe you. Providing this information won’t impact your eligibility for health coverage, your health plan options, or your costs in any way</td>
<td></td>
</tr>
<tr>
<td>If Hispanic/Latino ethnicity check all that apply</td>
<td>Mexican</td>
</tr>
</tbody>
</table>
We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If someone doesn’t have an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1 800 325 0778.

Do you have an SSN?  

<table>
<thead>
<tr>
<th>More About You</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexican American</td>
<td></td>
</tr>
<tr>
<td>Chicano/a</td>
<td></td>
</tr>
<tr>
<td>Puerto Rican</td>
<td></td>
</tr>
<tr>
<td>Cuban</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td></td>
</tr>
<tr>
<td>Asian Indian</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td></td>
</tr>
<tr>
<td>Filipino</td>
<td></td>
</tr>
<tr>
<td>Japanese</td>
<td></td>
</tr>
<tr>
<td>Korean</td>
<td></td>
</tr>
<tr>
<td>Vietnamese</td>
<td></td>
</tr>
<tr>
<td>Other Asian</td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td></td>
</tr>
<tr>
<td>Guamanian or Chamorro</td>
<td></td>
</tr>
<tr>
<td>Samoan</td>
<td></td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>Are you an American Indian or an Alaskan Native?</td>
<td>No</td>
</tr>
<tr>
<td>(If the dropdown value for American Indian/Alaskan Native field is 'YES' the following field(s) appear)</td>
<td></td>
</tr>
<tr>
<td>Tribal Identification Number</td>
<td></td>
</tr>
<tr>
<td>Cluster: Additional Information</td>
<td></td>
</tr>
<tr>
<td>We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If someone doesn’t have an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1 800 325 0778. Do you have an SSN?</td>
<td></td>
</tr>
<tr>
<td>(If the dropdown value for Do you have an SSN? is 'No' the following field(s) appear) Have you applied for SSN?</td>
<td></td>
</tr>
<tr>
<td>(If the dropdown value for Have you applied for SSN? is 'No' the following field(s) appear) Reason why you don’t have an SSN</td>
<td></td>
</tr>
<tr>
<td>Apply for Social Security Number</td>
<td>Links to ssa.gov</td>
</tr>
<tr>
<td>(If the dropdown value for the field SSN is 'YES' the following field(s) appear) SSN</td>
<td></td>
</tr>
<tr>
<td>Approval Date: 02/12/2014</td>
<td></td>
</tr>
<tr>
<td>Effective Date: 10/01/2013</td>
<td></td>
</tr>
<tr>
<td>More About You</td>
<td>Values (If applicable)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Are you a US Citizen?</td>
<td>No</td>
</tr>
<tr>
<td>(If the dropdown value for the field US Citizen is 'NO' the following field(s)</td>
<td>appear)</td>
</tr>
<tr>
<td>Are you a US National?</td>
<td>No</td>
</tr>
<tr>
<td>(If the dropdown value for the field US National is 'NO' the following field(s)</td>
<td>appear)</td>
</tr>
<tr>
<td>Are you lawfully present in the United States?</td>
<td>No</td>
</tr>
<tr>
<td>(If the dropdown value for the field Lawfully present is 'YES' the following field(s)</td>
<td>appear)</td>
</tr>
<tr>
<td>Date of Entry</td>
<td></td>
</tr>
<tr>
<td>Supporting Document</td>
<td>See screenshot below</td>
</tr>
<tr>
<td>(If the dropdown value for the field National is 'YES' the following field(s)</td>
<td>appear)</td>
</tr>
<tr>
<td>Supporting Document</td>
<td>Certificate of Citizenship</td>
</tr>
<tr>
<td></td>
<td>I-551 (Permanent Resident Card)</td>
</tr>
<tr>
<td></td>
<td>Naturalization Certificate</td>
</tr>
<tr>
<td></td>
<td>Passport</td>
</tr>
<tr>
<td>If the household member is a female over the age of 13 regardless of whether</td>
<td></td>
</tr>
<tr>
<td>they are an applicant or not the following questions appear.</td>
<td></td>
</tr>
<tr>
<td>Is &lt;name&gt; currently pregnant or gave birth in the last 3 months?</td>
<td>No</td>
</tr>
<tr>
<td>(If the dropdown value for the field pregnancy is 'YES' the following field(s)</td>
<td>appear)</td>
</tr>
<tr>
<td>Cluster: Pregnancy Information</td>
<td></td>
</tr>
<tr>
<td>How many children is &lt;name&gt; expecting?</td>
<td>Numeric</td>
</tr>
<tr>
<td>If &lt;name&gt; is currently pregnant, please enter the due date.</td>
<td></td>
</tr>
<tr>
<td>If &lt;name&gt; was currently pregnant, please enter the date the pregnancy ended.</td>
<td></td>
</tr>
<tr>
<td>If the household member is a between the ages of 18 and 26 and is applying for health insurance the following questions appear.</td>
<td></td>
</tr>
<tr>
<td>Was &lt;name&gt; ever in foster care?</td>
<td>No</td>
</tr>
<tr>
<td>(If the dropdown value for the field foster care is 'YES' the following field(s)</td>
<td>appear)</td>
</tr>
<tr>
<td>Cluster: Foster Care</td>
<td></td>
</tr>
<tr>
<td>Select the State in which &lt;name&gt; was in the foster care system.</td>
<td>Alabama ~ Wyoming</td>
</tr>
<tr>
<td>Was &lt;name&gt; in foster care on their 18th birthday?</td>
<td>No</td>
</tr>
<tr>
<td>(If the household member is a between the ages of 18 and 22 and is applying for health insurance the following questions appear.</td>
<td></td>
</tr>
</tbody>
</table>

TN No: MD-13-0021-MM2
Maryland

Approval Date: 02/12/2014
Effective Date: 10/01/2013
### More About You

Please provide some more information about yourself to help with your application.

#### Race and Ethnicity (Optional)

Please select options from below that best describe you. Providing this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way.

If Hispanic/Latino ethnicity, check all that apply:
- [ ] Mexican
- [ ] Mexican American
- [ ] Chicana/o
- [ ] White
- [ ] Black or African American
- [ ] American Indian or Alaska Native
- [ ] Asian Indian
- [ ] Chinese
- [ ] Filipino
- [ ] Japanese
- [ ] Korean

Are you an American Indian or an Alaskan Native? *  

---Please Select---

### Additional Information

We need Social Security Numbers (SSNs) for anyone who needs coverage. We use SSNs to verify citizenship. If someone doesn't have an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1-800-325-0778.

Do you have an SSN? *  

---Please Select---

Are you a US Citizen? *  

---Please Select---

---Save & Exit---

---Next---
7.2.1 Document Types

--Please Select--
Certificate of Citizenship
DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)
I-20 (Certificate of Eligibility for Non Immigrant (F-1) Student Status)
I-94 (Arrival/Departure Record)
I-327 (Reentry Permit)
I-551 (Permanent Resident Card)
I-571 (Refugee Travel Document)
I-688 (Temporary Resident Card)
I-688A (Employment Authorization Card)
I-688B (Employment Authorization Document)
I-766 (Employment Authorization Card)
Immigrant Visa (Temporary Resident Card)
Naturalization Certificate
Temporary I-551 Stamp
Unexpired Foreign Passport
WTWB Admission Stamp in Unexpired Foreign Passport
Other

7.3 Primary Applicant – Not Applying for Coverage

<table>
<thead>
<tr>
<th>More About You</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the applicant did not answer 'YES' to 'Do you want to find out if you can get help paying for your own health insurance and health benefits?' on S06 Information About You then the following page displays</td>
<td></td>
</tr>
<tr>
<td>Please provide some more information about yourself to help with your application</td>
<td></td>
</tr>
</tbody>
</table>

Cluster: Additional Information

Because you aren't applying for health insurance, you may provide a Social Security number (SSN) if you have one. It's optional. We'll use this SSN to check your income. This can speed up the decision about whether household members get help paying for assistance.

SSN
7.4 Existing Coverage

<table>
<thead>
<tr>
<th>Cluster: Existing Coverage Found</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Name</strong></td>
</tr>
<tr>
<td><strong>Source of Coverage</strong></td>
</tr>
<tr>
<td><strong>Start Date</strong></td>
</tr>
<tr>
<td><strong>End Date</strong></td>
</tr>
</tbody>
</table>

If you feel this information is incorrect, you may continue this application, and then you will need to contact your Local Health Department.

If you are an existing Medicaid or MCHIP client and would like to submit your renewal, please exit the application and click the link that allows you to link to your existing case on your account home page.

---

7.5 Supporting Documents

<table>
<thead>
<tr>
<th>Supporting Document Details</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Banner</strong></td>
<td></td>
</tr>
<tr>
<td>Naturalization Certificate has been selected to be the supporting document for the status of being a U.S National. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.</td>
<td>(This supporting document about 'Naturalization Certificate' appears, when the user selects any option for the field 'Supporting Document', which is under the primary field 'Are you a US National?')</td>
</tr>
<tr>
<td>Alien Number</td>
<td>Mandatory</td>
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<tr>
<td>First Name</td>
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<td>Middle Name</td>
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<td>Last Name</td>
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<tr>
<td>Date of Birth</td>
<td>Calendar option</td>
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<td>Cluster Name: Additional Information</td>
<td>Text box</td>
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<td>Banner</td>
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S94 Maryland - HBE CMS Alternate Application For Health Coverage
<table>
<thead>
<tr>
<th>Supporting Document Details</th>
<th>Comments</th>
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<tbody>
<tr>
<td>I-94 (Arrival/Departure Record) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.</td>
<td>(This banner text and the related fields appear, when the user selects the option I-94 for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')</td>
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<tr>
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<td>Document Expiration Date</td>
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<td>Certificate of Citizenship has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.</td>
<td>(This banner text and the related fields appear, when the user selects the option 'Certificate of Citizenship' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')</td>
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<td>DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.</td>
<td>(This banner text and the related fields appear, when the user selects the option 'DS2019 Certificate' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')</td>
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<tr>
<td>SEVIS ID</td>
<td>Mandatory</td>
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<td>Document Expiration Date</td>
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<td>Supporting Document Details</td>
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<td>Banner</td>
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<tr>
<td>I-20 (Certificate of Eligibility for Non immigrant (F-1) Student Status) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.</td>
<td>(This banner text and the related fields appear, when the user selects the option 'I-20 Certificate of Eligibility for F1' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')</td>
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| Banner                      |          |
| I-327 (Reentry Permit) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information. | (This banner text and the related fields appear, when the user selects the option 'I-327 (Reentry Permit)' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?') |
| Alien Number                | Mandatory |
| Document Expiration Date    | Calendar option |
| First Name                  |          |
| Middle Name                 |          |
| Last Name                   |          |
| Date of Birth               | Calendar option |
| Text box                    |          |

<p>| Banner                      |          |
| I-551 (Permanent Resident Card) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information. | (This banner text and the related fields appear, when the user selects the option 'I 551(Permanent Resident Card)' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?') |
| Alien Number                | Mandatory |
| Card Number                 | Mandatory |
| Document Expiration Date    | Calendar option |
| First Name                  |          |
| Middle Name                 |          |
| Last Name                   |          |
| Date of Birth               | Calendar option |
| Text box                    |          |</p>
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<th>Comments</th>
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<tbody>
<tr>
<td><strong>I-571 (Refugee Travel Document)</strong> has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.</td>
<td><em>(This banner text and the related fields appear, when the user selects the option 'I-571 (Refugee Travel Document)' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')</em></td>
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<td><strong>Calendar option</strong></td>
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<td><strong>Last Name</strong></td>
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<td><strong>Date of Birth</strong></td>
<td><strong>Calendar option</strong></td>
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<td><strong>Text box</strong></td>
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</table>

| **I-688 (Temporary Resident Card)** has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information. | *(This banner text and the related fields appear, when the user selects the option 'I-688 (Temporary Resident Card)' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')* |
| **Alien Number** | **Mandatory** |
| **Document Expiration Date** | **Calendar option** |
| **First Name** | |
| **Middle Name** | |
| **Last Name** | |
| **Date of Birth** | **Calendar option** |
| **Text box** | |

<p>| <strong>I-688A (Employment Authorization Card)</strong> has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information. | <em>(This banner text and the related fields appear, when the user selects the option 'I-688A (Employment Authorization Card)' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')</em> |
| <strong>Alien Number</strong> | <strong>Mandatory</strong> |
| <strong>Document Expiration Date</strong> | <strong>Mandatory + Calendar option</strong> |
| <strong>First Name</strong> | |
| <strong>Middle Name</strong> | |
| <strong>Last Name</strong> | |
| <strong>Date of Birth</strong> | <strong>Calendar option</strong> |
| <strong>Text box</strong> | |</p>
<table>
<thead>
<tr>
<th>Supporting Document Details</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-6888 (Employment Authorization Document) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.</td>
<td>(This banner text and the related fields appear, when the user selects the option 'I-6888 (Employment Authorization Document)' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')</td>
</tr>
<tr>
<td>I-6888 (Employment Authorization Document) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.</td>
<td></td>
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<tr>
<td>Alien Number</td>
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<td>Document Expiration Date</td>
<td>Mandatory + Calendar option</td>
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<td>Banner</td>
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<tr>
<td>I-766 (Employment Authorization Card) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.</td>
<td>(This banner text and the related fields appear, when the user selects the option 'I-766 (Employment Authorization Card)' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')</td>
</tr>
<tr>
<td>Alien Number</td>
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<tr>
<td>Document Expiration Date</td>
<td>Calendar option</td>
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<td>Banner</td>
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<tr>
<td>Immigrant Visa (Temporary Resident Card) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.</td>
<td>(This banner text and the related fields appear, when the user selects the option 'Immigrant Visa (Temporary Resident Card)' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')</td>
</tr>
<tr>
<td>Alien Number</td>
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<tr>
<td>Passport Number</td>
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<tr>
<td>Visa Number</td>
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</table>

S94 Maryland - HBE CMS Alternate Application For Health Coverage

TN No: MD-13-0021-MM2

Maryland

Approval Date: 02/12/2014
Effective Date: 10/01/2013
<table>
<thead>
<tr>
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<th>Comments</th>
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<td>Date of Birth</td>
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</table>

**Banner**

Naturalization Certificate has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.

- Alien Number: Mandatory
- Naturalization Number
- First Name
- Middle Name
- Last Name
- Date of Birth: Calendar Option
- Text box

**Banner**

Temporary I-551 Stamp has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.

- Alien Number: Mandatory
- Document Expiration Date: Calendar Option
- First Name
- Middle Name
- Last Name
- Date of Birth: Calendar Option
- Text box

**Banner**

Unexpired Foreign Passport has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.

- I-94 Number: Mandatory
- SEVIS ID
Supporting Document Details | Comments
---|---
Passport Number | Mandatory
Visa Number | Mandatory
Document Expiration Date | Mandatory + Calendar Option
First Name | 
Middle Name | 
Last Name | 
Date of Birth | Calendar option
Text box | 

**Banner**

VT/WB Admission Stamp in Unexpired Foreign Passport has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.

I-94 Number | Mandatory
Passport Number | Mandatory
Visa Number | Mandatory
Document Expiration Date | Mandatory + Calendar Option
First Name | 
Middle Name | 
Last Name | 
Date of Birth | Calendar option
Text box | 

**Banner**

Other has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.

Identification Number | Mandatory
Other Document Description | Mandatory
First Name | 
Middle Name | 
Last Name | 
Date of Birth | Calendar option
Text box | 

(This banner text and the related fields appear, when the user selects the option 'VT/WB Admission Stamp' 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')

(This banner text and the related fields appear, when the user selects the option 'Other' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')
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<td>X*</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Last Name</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X*</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X*</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Supplement 1 to Attachment 3.1G

8 Household Member Extra Details

More Information about Judy

Based on the information you already provided about this person, we need to ask some more questions so we can be sure that we're giving everyone in your household the help they need.

Race and Ethnicity (Optional)
Please select options from below that best describe Judy. This information is captured for statistical purposes only. The response will not impact the individual's eligibility for assistance.

If Hispanic/Latino ethnicity check all that apply

- Mexican
- Mexican American
- Chicano/a
- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Puerto Rican
- Cuban
- Vietnamese
- Other Asian
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander

Is Judy an American Indian or an Alaskan native? *

Additional Information
We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If someone doesn't have an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1 800 325 0778.

Does Judy have an SSN? *

Is Judy a US Citizen? *

Is Judy currently pregnant or gave birth in the last 3 months? *

7.6 Married Couple Filing Jointly

Married Couple Filing Status

Banner
Please indicate the filing status of the below couple(s).
Married Couple Filing Status

You have indicated that the following people in your household are married and expected to file taxes - to ensure you get the right help in paying for your health insurance, we need to know whether they intend to file jointly or separately.

Does <primary> plan to file a joint federal tax return with <name> next year?

(If the dropdown value for the field file a joint federal tax return is 'NO' the following field(s) appear)

Will <tax filer> be claimed as a dependent on someone else’s federal income tax return?

Please indicate the filing status of the below couple(s)

Jerry Marty

* indicates a required field

You have indicated that the following people in your household are married and expected to file taxes - to ensure you get the right help in paying for your health insurance, we need to know whether they intend to file jointly or separately.

Does Jerry plan to file a joint federal tax return with Marty next year? *

Yes  No *

Will Jerry be claimed as a dependent on someone else’s federal income tax return?

Yes  No *

7.7 Dependents

<table>
<thead>
<tr>
<th>Additional Information about the next person</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner</td>
<td></td>
</tr>
<tr>
<td>Please indicate who claims [name] as a dependent</td>
<td></td>
</tr>
<tr>
<td>For anyone in your household who isn’t expected to file taxes themselves, we need to know whether they are expected to be included as either a spouse or dependent on the tax return of anyone else in the household.</td>
<td></td>
</tr>
<tr>
<td>Is anyone outside this household expected to enter [name] as a spouse or dependent on their tax return?</td>
<td>No Yes</td>
</tr>
</tbody>
</table>
8 Section VIII – More about this household

8.1 Additional information for all Applicants

<table>
<thead>
<tr>
<th>Additional information for all Applicants</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please answer these additional questions about the household</td>
<td></td>
</tr>
<tr>
<td>Additional information on the household, such as whether someone is disabled or blind, will help us work out whether you may be entitled to help on grounds other than your income.</td>
<td></td>
</tr>
<tr>
<td>Is anyone in the household blind?</td>
<td>No Yes</td>
</tr>
<tr>
<td>Is anyone in the household disabled?</td>
<td>No Yes</td>
</tr>
<tr>
<td>Additional Information for all Applicants</td>
<td>Values (If applicable)</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Does anyone in the household have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?</td>
<td>No Yes</td>
</tr>
</tbody>
</table>

Additional Information for all Applicants

Please answer these additional questions about the household.

Is anyone in the household blind?  

Is anyone in the household disabled?  

Does anyone in the household have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?  

Save & Exit  

Bck  

Next  

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Approval Date: 02/12/2014  

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9 Section IX – Expedited Income

10 Section X - Current/monthly income

10.1 Flow Chart

10.2 Income Information

Income Information

Please select the individuals below who have income

Martin  Judy  Barry  Jennifer

The page allows you to indicate the members in the household who receive income. If you or anyone in the household has any sort of income please tell us about it.

Does Martin have any income? Default to NO

Yes

Save & Exit

Back  Next
10.3 Enter Income Details

<table>
<thead>
<tr>
<th>Enter Income Details</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>From the information you have given us &lt;name&gt; has income, please enter &lt;name’s&gt;</td>
<td></td>
</tr>
<tr>
<td>income details below</td>
<td></td>
</tr>
<tr>
<td>This page is designed to capture income for an individual in the household. If</td>
<td></td>
</tr>
<tr>
<td>an individual receives income from more than one source, be sure to select ‘Yes’</td>
<td></td>
</tr>
<tr>
<td>for the last question and you will be able to enter additional income records.</td>
<td></td>
</tr>
<tr>
<td>Please be sure to enter your income before taxes are taken out.</td>
<td></td>
</tr>
<tr>
<td>Income Type</td>
<td></td>
</tr>
<tr>
<td>Amount</td>
<td>Numeric</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annually, Bi-Weekly,</td>
</tr>
<tr>
<td></td>
<td>Monthly, Quarterly,</td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
</tr>
<tr>
<td>Start Date</td>
<td></td>
</tr>
<tr>
<td>End Date</td>
<td></td>
</tr>
<tr>
<td>Does [name] have any more income?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>If income type = 'Wages and Salaries' then the following is displayed</td>
<td></td>
</tr>
<tr>
<td>What is the name of your employer?</td>
<td></td>
</tr>
<tr>
<td>If income type = 'Foreign income', 'Interest' or 'Social Security income' then</td>
<td></td>
</tr>
<tr>
<td>the following is displayed</td>
<td></td>
</tr>
<tr>
<td>What portion of this amount is tax exempt?</td>
<td></td>
</tr>
</tbody>
</table>
Enter Income Details

From the information you have given us, Martin has income. Please enter Martin’s income details below:

- Martin
- Judy
- Barry
- Jennifer

This page is designed to capture income for an individual in the household. If an individual receives income from more than one source, be sure to select ‘Yes’ for the last question and you will be able to enter additional income records. Please be sure to enter your income before taxes are taken out.

Income Type:
- Wages and Salaries
- Alimony and Maintenance
- American Indian Alaskan Native Income
- Dividends
- Foreign Income
- Interest
- Net Self Employment Income
- Pension/Retirement Benefits
- Prizes and Awards
- Farming or fishing Income
- Rental or royalty income
- Capital gains
- Scholarship Payments
- Social Security Income
- Lump sum Amount
- Unemployment Insurance
- Other

Please Select:
- Wages and Salaries
- Alimony and Maintenance
- American Indian Alaskan Native Income
- Dividends
- Foreign Income
- Interest
- Net Self Employment Income
- Pension/Retirement Benefits
- Prizes and Awards
- Farming or fishing Income
- Rental or royalty income
- Capital gains
- Scholarship Payments
- Social Security Income
- Lump sum Amount
- Unemployment Insurance
- Other
### Income Deductions

<table>
<thead>
<tr>
<th>Income Deductions</th>
<th>Values (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certain allowable expenses such as alimony payments can be deducted from your income to make the cost of health insurance a little lower. Please indicate if you incur any of the following:</td>
<td></td>
</tr>
<tr>
<td>Does &lt;name&gt; pay for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower.</td>
<td>No, Yes</td>
</tr>
<tr>
<td>If the answer to the above field is 'YES', then the following displays</td>
<td></td>
</tr>
<tr>
<td><strong>Cluster: Deductible Income</strong></td>
<td></td>
</tr>
<tr>
<td>Deduction Type</td>
<td>Alimony paid</td>
</tr>
<tr>
<td></td>
<td>Certain business expenses of reservists, performing artists, and fee-basis government officials</td>
</tr>
<tr>
<td></td>
<td>Deductible part of self-employment tax</td>
</tr>
<tr>
<td></td>
<td>Domestic production activates deduction</td>
</tr>
<tr>
<td></td>
<td>Educator expenses</td>
</tr>
<tr>
<td></td>
<td>Health savings account deduction</td>
</tr>
<tr>
<td></td>
<td>Moving expenses</td>
</tr>
<tr>
<td></td>
<td>Penalty on early withdrawal of savings</td>
</tr>
<tr>
<td></td>
<td>Rent or Royalties</td>
</tr>
<tr>
<td></td>
<td>Self-employed SEP, SIMPL, and qualified plans</td>
</tr>
<tr>
<td></td>
<td>Self-employed health insurance deduction</td>
</tr>
<tr>
<td>Amount</td>
<td>Numeric</td>
</tr>
<tr>
<td>Start Date</td>
<td></td>
</tr>
<tr>
<td>End Date</td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
</tr>
<tr>
<td>Does &lt;name&gt; have any more Deductible Income?</td>
<td>No, Yes</td>
</tr>
</tbody>
</table>
Income Deductions

Please indicate whether Martin has any allowable deductions.

- Martin
- Judy
- Barry
- Jennifer

Certain allowable expenses such as any alimony payments can be deducted from your income to make the cost of health insurance a little lower. Please indicate if you have any of the following:

Does Martin pay for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower.

Deductible Income

- Deduction type: 
- Amount: 
- Start Date: 
- End Date: 
- Frequency: 

Does Martin have any more Deductible income?

Save & Exit

10.5 American Indian/Alaskan Native Excludable Income

Excludable Income

Getting Started
- Please select all items that can be excluded from John's income tax return

Applicant Details

Household Income
- John has indicated to have income from American Indian/Alaskan Native sources. Is any of this from distributions, payments, ownership interest and real property usage rights?

Household Income
- Additional Householder Information

Summary

10.6 American Indian/Alaskan Native Income Details

American Indian or Alaskan Native Details | Values (If applicable)
--- | ---
Please provide some information about the American Indian or Alaskan Native income

<name> has indicated to have income from American Indian/Alaskan Native sources, is any of this from distributions, payments, ownership interest and real property usage rights?

No
Yes

Cluster: American Indian or Alaskan Native Income
<table>
<thead>
<tr>
<th>American Indian or Alaskan Native Details</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the income type?</td>
<td>Distributions from Alaska Native Corporations and Settlement Trusts</td>
</tr>
<tr>
<td></td>
<td>Distributions from any property held in trust</td>
</tr>
<tr>
<td></td>
<td>Distributions results from real property ownership interests</td>
</tr>
<tr>
<td></td>
<td>Payments from rents, leases, rights of way, royalties, usage rights, or natural resources</td>
</tr>
<tr>
<td></td>
<td>Payments resulting from items that have religious or culture significance</td>
</tr>
<tr>
<td></td>
<td>Student financial assistance from the Bureau of Indian Affairs</td>
</tr>
<tr>
<td>What is the amount expected to be received?</td>
<td></td>
</tr>
<tr>
<td>How often does &lt;name&gt; receive this income?</td>
<td>Frequency</td>
</tr>
<tr>
<td>What is the start date?</td>
<td></td>
</tr>
<tr>
<td>Is there an end date?</td>
<td></td>
</tr>
<tr>
<td>Does &lt;name&gt; have any more American Indian or Alaskan Native income?</td>
<td>No</td>
</tr>
</tbody>
</table>

**Getting Started**
- Please provide some information about the American Indian or Alaskan Native income.

**Applicant Details**

**Household Information**
- American Indian or Alaskan Native Income
  - What is the income type?
  - What is the amount expected to be received?
  - How often does <name> receive this income?
  - What is the start date?
  - Is there an end date?
  - Does John have any more American Indian or Alaskan Native income?
10.7 Summary
### Supplement 1 to Attachment 3.1G

**Form Name:**

[Handwritten text]

**About Primary Applicant**

- **Name:** [Handwritten text]
- **Address:** [Handwritten text]
- **Phone:** [Handwritten text]
- **SSN:** [Handwritten text]
- **Relationship:** [Handwritten text]

**Medical History**

- **Date of Birth:** [Handwritten text]
- **Sex:** [Handwritten text]
- **Smoke:** [Handwritten text]
- **Alcohol:** [Handwritten text]
- **User of Tobacco:** [Handwritten text]
- **Medical Conditions:** [Handwritten text]

**Annual Household Income**

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Income Type</th>
<th>Income Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Handwritten text]</td>
<td>[Handwritten text]</td>
<td>[Handwritten text]</td>
</tr>
</tbody>
</table>

**Medical Drugs**

- **Prescription:** [Handwritten text]
- **Rx Use:** [Handwritten text]

**Family Members**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Handwritten text]</td>
<td>[Handwritten text]</td>
<td>[Handwritten text]</td>
</tr>
</tbody>
</table>

**Healthcare Providers**

- **Doctor:** [Handwritten text]
- **Hospital:** [Handwritten text]

**Insurance Information**

- **Provider Name:** [Handwritten text]
- **Policy Number:** [Handwritten text]

**Emergency Contact**

- **Name:** [Handwritten text]
- **Relationship:** [Handwritten text]

**Address**

- **City:** [Handwritten text]
- **State:** [Handwritten text]
- **Zip Code:** [Handwritten text]

**Employment**

- **Employer:** [Handwritten text]
- **Occupation:** [Handwritten text]

**Financial Information**

- **Monthly Income:** [Handwritten text]
- **Monthly Expenses:** [Handwritten text]

**Social Security**

- **Number:** [Handwritten text]

**Bank Information**

- **Account Number:** [Handwritten text]
- **Routing Number:** [Handwritten text]

**Medical History**

- **Diabetes:** [Handwritten text]
- **Hypertension:** [Handwritten text]

**Signatures**

- **Applicant:** [Handwritten text]
- **Witness:** [Handwritten text]

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**Maryland**

**Approval Date:** 02/12/2014
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10.8 Annual Income

<table>
<thead>
<tr>
<th>Annual Income</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please review the annual income calculation for &lt;name&gt;</td>
<td></td>
</tr>
<tr>
<td>We have calculated what we expect the annual income for this person to be based on the information you have provided us. This may not match your expectation of what the annual income will be (for example, if this person's income fluctuates during the year) - if that is the case, please indicate so below. If you told us you had income deductions this is reflected in the amount shown.</td>
<td></td>
</tr>
<tr>
<td>Based on the information you have provided the expected annual income for &lt;name&gt; is $&lt;amount&gt;</td>
<td></td>
</tr>
</tbody>
</table>
| Is this what you expect <name's> annual income to be? | No
| Yes |
| If the answer to the above field is "NO", and the applicant is NOT eligible for Medicaid then the following displays | |
| What do you expect the annual income to be? | Numeric |

Annual Income

Please review the annual income calculation for Martin

<table>
<thead>
<tr>
<th>Martin</th>
<th>Judy</th>
<th>Barry</th>
<th>Jennifer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

We have calculated what we expect the annual income for this person to be based on the information you have provided. This may not match your expectation of what the annual income will be (for example, if this person's income fluctuates during the year) - if that is the case, please indicate so below. If you told us you had income deductions this is reflected in the amount shown.

Based on the information you have provided, the expected annual income for Martin is $25,000.00

| Is this what you expect Martin's annual income to be? | No
| What do you expect the annual income to be? | $25,000.00 |

11 Section XI – Discrepancies

MHC displays this page only for any applicant who has failed the reasonable compatibility test and is not eligible for Medicaid or CHIP.
11.1 Income Discrepancies

<table>
<thead>
<tr>
<th>Income Discrepancies</th>
<th>Date this change occurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost a job</td>
<td></td>
</tr>
<tr>
<td>Switched to a new job that pays less</td>
<td></td>
</tr>
<tr>
<td>Working fewer hours</td>
<td></td>
</tr>
<tr>
<td>Faced a pay cut</td>
<td></td>
</tr>
<tr>
<td>On unpaid leave (for example, to care for a new baby)</td>
<td></td>
</tr>
<tr>
<td>Other (please explain below)</td>
<td></td>
</tr>
</tbody>
</table>

Please add any additional comments here.
### 12 Section XII - APTC program questions

#### 12.1 Additional Insurance Assistance Information

<table>
<thead>
<tr>
<th>Additional Insurance Assistance Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Banner</strong></td>
</tr>
<tr>
<td>Please answer these questions about the household</td>
</tr>
<tr>
<td>Please choose any of the people below who use tobacco</td>
</tr>
<tr>
<td>Please choose any of the people below who are incarcerated</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
</tr>
<tr>
<td>Please choose any of the people below who are enrolled in a health program or plan.</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
</tr>
<tr>
<td>Please choose any of the people below who are either enrolled on or eligible for employer-sponsored coverage. The access to coverage could be either through their own employment or as an individual related to the employee.</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
</tr>
<tr>
<td>Are any of these people eligible to receive, or have they ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these health programs?</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
</tr>
</tbody>
</table>
**Additional Insurance Assistance Information**

Please answer these additional questions about the household.

Indicates a required field

Some of the people you are applying for appear to be eligible for insurance assistance. We require some extra information about these people in order to process their application.

Please choose any of the people below who use tobacco.

- Marge
- Homer

Please choose any of the people below who are incarcerated.

- Marge
- Homer

Please choose any of the people below who are currently enrolled on a health program or plan.

- Marge
- Homer

Please choose any of the people below who are either enrolled on or eligible for employer-sponsored coverage. The access to coverage could be either through their own employment or as an individual related to the employee.

- Marge
- Homer

Are any of these people eligible to receive, or have they ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these health programs?

- Homer

---

**12.2 Health Program/Plan Coverage Information**

<table>
<thead>
<tr>
<th>Health Program/Plan Coverage Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Information for Employer</td>
<td></td>
</tr>
<tr>
<td>(If the user selects the option 'YES' for the question 'Is anyone in your household currently enrolled on a Health Program or Plan?', then the following screen appears)</td>
<td></td>
</tr>
<tr>
<td>Cluster Name: Health Program/Plan coverage Information</td>
<td></td>
</tr>
<tr>
<td>Please indicate if [name] is currently enrolled on any of these programs/plans</td>
<td></td>
</tr>
</tbody>
</table>

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TN No: MD-13-0021-MM2

Maryland

Approval Date: 02/12/2014
Effective Date: 10/01/2013
12.3 Employer Sponsored Coverage

Employer Sponsored Coverage Information

<name> is indicated to have income <xxx> in the form of <income type>. Please enter information on the employer-sponsored coverage corresponding to this employment.

Employer-sponsored health coverage is coverage that pays a portion of the total cost for medically related expenses such as doctor visits, hospital stays, prescription drugs and durable medical equipment. If you are enrolled in employer sponsored coverage please answer 'Yes'.

Is <name> enrolled on employer-sponsored coverage through this employment?

Is <name> eligible for the employer-sponsored coverage, but is not enrolled?
Employer-Sponsored Coverage Information

Martin is indicated to have income $25,000.00 in the form of Wages and Salaries. Please enter information on the employer-sponsored coverage corresponding to this employment.

Employer-sponsored health coverage is coverage that pays a portion of the total cost for medically related expenses such as doctor visits, hospital stays, prescription drugs and durable medical equipment. If you are enrolled in employer-sponsored coverage, please answer 'Yes'.

Is Martin enrolled on employer-sponsored coverage through this employment? [ ]

Is Martin eligible for the employer-sponsored coverage, but is not enrolled? [ ]

12.4 Additional Information of Employer

Additional Information of Employer

(If the user selects the option 'YES' for the question 'Is eligible for employer sponsored coverage information?', then the following screen appears)

Additional Information for Employer

Please provide additional information on the employer-sponsored coverage. The information provided on this page will be used to determine if the coverage qualifies as minimum essential coverage, which may influence the eligibility determination.

Members of Household display

Please provide additional information on the employer-sponsored coverage. The information provided on this page will be used to determine if the coverage qualifies as minimum essential coverage, which may influence the eligibility determination.

Cluster: Employer Details

Employer Name
Employer Identification Number
Is Employer employed full time?

Cluster: Address

Apt/Suite
Address
City
State
Zip Code

Cluster: Coverage Details

Lowest Cost Plan
Employee Contribution for self only coverage
Additional Information of Employer

Frequency of Contribution

Please select the household member that are eligible for coverage by the plan entered above and not currently covered under any other employment sponsored plan.

Is [name] eligible for any other employer sponsored coverage through his employment?

12.5 Employer Plan Coverage

Employer Plan Coverage
**Employer Plan Coverage**

(If the user selects the option 'YES' for the question 'Is enrolled for employer sponsored coverage information?', then the following screen appears)

Please provide additional information on the employer-sponsored coverage. The information provided on this page will be used in the determination eligibility for the health insurance programs.

**Members of household display**

Please provide additional information on the employer-sponsored coverage. The information provided on this page will be used in the determination eligibility for the health insurance programs.

**Cluster: Employer Details**

**Employer Name**

**Employer Identification Number**

**Is [name] employed full-time?**

**Cluster Name: Address**

**Apt/Suite**

**Address**

**City**

**State**

**Zip Code**

**County**

**Cluster: Coverage Details**

**Plan Enrolled on**

**Date when the current coverage ends**

---

**Supplement 1 to Attachment 3.1G**
### 13 Section VIII – Medicaid & CHIP specific questions

#### 13.1 Additional Information for Medicaid/CHIP Applicants

<table>
<thead>
<tr>
<th>Additional Information for Medicaid/CHIP Applicants</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner</td>
<td></td>
</tr>
<tr>
<td>Please answer these additional questions about the household</td>
<td></td>
</tr>
<tr>
<td>Some of these people you are applying for appear to be eligible for Medicaid or CHIP. To ensure that these people get the right services, please answer the questions below</td>
<td></td>
</tr>
<tr>
<td>Does anyone in the household have unpaid medical bills from the last 3 months?</td>
<td></td>
</tr>
<tr>
<td>Please choose the members who have unpaid medical bills</td>
<td>No, Yes</td>
</tr>
<tr>
<td>If anyone selected 'Yes' to the above question then the following questions display</td>
<td></td>
</tr>
<tr>
<td>At the time the medical bills were incurred were your household's income the same or lower than your household's current income?</td>
<td>Same, Lower</td>
</tr>
<tr>
<td>If anyone selected 'Yes' to 'Are you an American Indian or Alaska Native' then this question displays</td>
<td></td>
</tr>
<tr>
<td>Are any of these people eligible to receive, or have they ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these health programs?</td>
<td></td>
</tr>
<tr>
<td>If found ineligible for coverage today would you like to be evaluated for a Retro-Active Medicaid determination?</td>
<td>No, Yes</td>
</tr>
<tr>
<td>Cluster: Employer Sponsored Coverage</td>
<td></td>
</tr>
<tr>
<td>&lt;name&gt; is indicated to have income &lt;xxx&gt; in the form of &lt;income type&gt;. Please enter information on the employer-sponsored coverage corresponding to this employment</td>
<td></td>
</tr>
<tr>
<td>Is &lt;name&gt; enrolled on employer-sponsored coverage through this employment?</td>
<td>No, Yes</td>
</tr>
</tbody>
</table>

---

S94 Maryland - HBE CMS Alternate Application For Health Coverage

Page 62 of 66
Additional Information for Medicaid/CHIP Applicants

Please answer these additional questions about the household.

Does anyone in the household have unpaid medical bills from the last 3 months?

Please choose the members who have unpaid medical bills:

- Barry
- Jennifer
- Johnny

At the time the medical bills were incurred were your household's income the same or lower than your household's current income?

If found ineligible for coverage today would you like to be evaluated for a Retro-Active Medicaid determination?

Are any of these people eligible to receive, or have they ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these health programs?

Employer Sponsored Coverage

Marlin is indicated to have income 25,000.00 in the form of Wages and Salaries. Please enter information on the employer-sponsored coverage corresponding to this employment.

Is Marlin enrolled on employer-sponsored coverage through this employment?

13.2 Unpaid Medical Bills Details

<table>
<thead>
<tr>
<th>Enter Unpaid Medical Bills Details</th>
<th>Values (If applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner</td>
<td></td>
</tr>
<tr>
<td>From the information you have given us &lt;name&gt; has unpaid medical bills. Please enter &lt;name's&gt; unpaid medical bills details below.</td>
<td></td>
</tr>
<tr>
<td>This page is designed to capture details about unpaid medical bills for an individual in the household in the last 3 months. If there is more than one unpaid medical bill be sure to select 'Yes' for the last question and you will be able to enter additional unpaid medical bills details.</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>Date of Service</td>
<td></td>
</tr>
<tr>
<td>Does &lt;name&gt; have any more unpaid medical bills?</td>
<td>No</td>
</tr>
</tbody>
</table>

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14 Section XV Review & Sign

14.1 Submit Application

Submit Application

Please read the following terms and conditions indicate consent and sign. If you disagree with a statement additional questions may appear or your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.

I know that if Medicaid pays for a medical expense, any money I get from other health insurance or legal settlements will go to Medicaid in an amount equal to what Medicaid pays for the expense.

I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and won't have to cooperate.
Submit Application

I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage. During the renewal process, the Maryland Health Connection will use income data including information the tax returns of household members. This will determine yearly eligibility for help paying for health insurance of the next 4 years. The Maryland Health Connection will send me a notice and let me make changes. If I don't respond, the Maryland Health Connection will continue my eligibility at the level indicated by the data. I understand this renewal process will occur each year for the next 5 years unless I tell the Maryland Health Connection that I don't want to renew or if I leave the Maryland Health Connection. I also understand that I can change my answer later. If I don't check the box, I can select less than 5 years.

Cluster: More Information and Appeals

If I think the Health Insurance Maryland Health Connection or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Maryland Health Connection or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Maryland Health Connection at <x-xxx-xxx-xxxx>. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file

I'm signing this application under penalty of perjury. This means I've provided true answers to all the questions on this form to the best of my knowledge. I know if I'm not truthful, there may be a penalty.

First Name
Middle Initial
Last Name
14.2 Submit Application Renewal

Submit Application

I give permission for my eligibility for help paying for health insurance to be renewed for a period of:

- 1 year
- 2 years
- 3 years
- 4 years
- Don't renew my eligibility for help paying for health insurance

[Submit] [Cancel]

14.3 Submit Application Confirmation

Submit Application

Your application has been successfully submitted. Please write down your Reference Number for future use.

Reference Number: 256

Follow-up
If any of the information you submitted on this application requires follow-up (for example if we can't automatically verify some information) an agency representative will contact you using your preferred contact method. If you would like to talk with an agency representative please call your local office at <xxx-xxxx>

[Close]
Hospital Presumptive (Temporary) Eligibility Process

Maryland Department of Health and Mental Hygiene
Agenda for today

• Why does Maryland now have a Hospital Presumptive Eligibility (HPE) process?
• What is HPE?
  – Maryland’s experience with Presumptive Medical Eligibility
  – Definitions and distinctions
• The hospitals’ role in HPE
• DHMH’s role in HPE
• The applicant’s role in HPE
• Accountability and sanctions
• Feedback and Q & A
Why does Maryland now have a Hospital Presumptive Eligibility (HPE) Process?

• Section 2202 of the Patient Protection and Affordable Care Act (ACA) allows Hospitals that are participating providers under a state’s Medicaid program to determine eligibility for medical assistance.

• Hospitals are not required to participate as an HPE eligibility determination site.
  – Hospitals have the option to participate in HPE.
  – The State must allow any qualified and interested hospital to participate.
WHAT IS HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE)?
Why Hospital Presumptive Eligibility (HPE)?

- HPE enables:
  - Timely access to necessary health care services
  - Immediate temporary medical coverage while full eligibility is being determined
  - A pathway to longer-term Medicaid coverage
  - A coverage determination based on minimal eligibility information requirements
Why Hospital Presumptive Eligibility (HPE)?

- HPE allows hospitals to be reimbursed for services provided during the temporary coverage period even if individual is ultimately determined ineligible for Medicaid/CHIP.

- NOTE: To be reimbursed, services must be covered under the Maryland Medicaid Fee-for-Service Program.
When Does HPE Coverage Begin?

- HPE period begins with, and includes, the day on which the hospital makes the HPE determination.
When does HPE Coverage End?

• Hospital Presumptive Eligibility period ends with:
  – The day on which the state makes the eligibility determination for full Medicaid; or
  – The last day of the month following the month in which the hospital makes the HPE determination, if the individual does not file a full application by that time.
How often may someone have HPE coverage?

• Only one period of HPE coverage is allowed in any 12-month period.

• Pregnant women are allowed one period of HPE coverage per pregnancy.

• This is calculated from the last day of the most recent prior period of HPE.
What does HPE cover?

• HPE offers full access to all benefits under Maryland Medicaid Fee-for-Service.
What eligibility groups are included?

Refer to Maryland’s “Quick Guide to Income Eligibility”

• Hospital Presumptive Eligibility uses the following income guidelines.
  – Parents and Caretaker Relatives
    • Over 65 or with Medicare (through 123% FPL)
    • Others (through 133% FPL)
  – Pregnant Woman (through 259% FPL)
  – Medicaid Children (through 317% FPL)
What eligibility groups are included (cont.)?

– CHIP Children
  • Included in Medicaid (Expansion CHIP)

– Newly Eligible Adults (through 133% FPL)

– Individuals (to age 26) formerly in Foster Care in Maryland (no FPL limit)
Does the applicant have to be admitted to the hospital?

- No, there is no requirement that the applicant be admitted or be seeking hospital services at the time of an HPE determination.
Hospital Presumptive (Temporary) Eligibility Process

THE HOSPITAL’S ROLE IN HPE
The hospital’s role in HPE

- Identify individuals who may be eligible for Medicaid/CHIP health coverage;
- Screen individuals through the Eligibility Verification System to ensure that they are not already covered through Medicaid or other programs.
- Make immediate temporary eligibility determinations for these individuals;
- Educate individuals about their responsibility to complete the full Maryland MA application for health coverage with timeframes required by the Hospital Presumptive Medical process;
- Provide the full Maryland MA application; and
- Assist the individual with completing the full application.
Qualified hospitals: Agreement/Certification

• To become an approved eligibility determination site, hospitals must:
  – Be enrolled with Maryland Medicaid as a participating provider;
  – Notify DHMH of their decision to become a Hospital Presumptive Eligibility determination site;
  – Agree to make determinations consistent with DHMH policies and procedures and meet established quality standards; and
  – Maintain with DHMH an up-to-date list of all the name of individuals in the hospitals certified to make HPE determinations.
Qualified hospitals: Agreement/Certification

• Only hospital employees are able to conduct HPE determinations.

• Hospitals may not contract HPE functions to other entities or use contracted hospital personnel to make HPE determinations.
What do the hospitals do?

I. Check eMedicaid for current MA eligibility and prior PE period.
II. Complete Application for HPE Eligibility.
III. Make eligibility determination based on required information in Application for HPE Eligibility.
IV. Notify the applicant.
V. Notify the Department of determination on date of application completion.
VI. Assist the HPE Application with completion of the full MA application before the end of the HPE period.
I. Check eligibility using EVS

- Before making HPE determinations, check EVS to see if the applicant is currently receiving Medicaid/CHIP.
- If an applicant has current Medicaid or CHIP coverage, the individual will not be eligible for HPE.
II. Complete Part 1 of the HPE Application

• Use the DHMH Hospital Presumptive Medical application.
  – Use only information provided by the applicant or his/her representative in Part 1 of the HPE application.
  – No additional documentation or verification may be required at the time of the HPE determination.
  – Document the decision and the date of the decision on the application form. The decision should be made the first day the patient received services.
II. Complete Part I of the HPE Application, continued

- Information Required for Determination
  - Applicant’s full legal name
  - Family size
  - Household’s gross monthly income
  - Maryland resident? (Yes/No)
  - U.S. citizen, U.S. national or qualified non-citizen? (Yes/No)

  - For more information on these groups: [https://www.healthcare.gov/immigration-status-and-the-marketplace/](https://www.healthcare.gov/immigration-status-and-the-marketplace/).
II. Complete Part I of the HPE Application, continued

• If information is readily available, also complete the following:
  – Other medical coverage? (precludes HPE for CHIP)
  – Pregnant? (Yes/No) If yes, pregnancy due date
  – In Foster Care at age 18?
  – Receiving Medicare benefits? (precludes HPE coverage for “new adult” applicants)
III. Make eligibility determination

• Refer to the *Quick Guide to Income Eligibility* to help make the determination.
  
  – **Income guidelines may change yearly.** Please be sure you are using the most recent version.

• The *Quick Guide* includes the following guidance for each eligibility group:
  
  – What income to count in the applicant’s family
  
  – Who to include in applicant’s family size
III. Make eligibility determination, continued

• When is the HPE determination made?
  – At the time of the HPE application.

• The hospital gives the individual **written notice** of whether s/he is eligible, or ineligible, for HPE coverage.

• The Hospital Presumptive Eligibility period begins on the date the qualified hospital determines the individual is eligible.
IV. Notify the applicant

• Hospital provides the **eligible** individual with:
  
  – An approval notice;
  
  – A copy of the completed HPE Application;
  
  – The full MA application packet, marked with “Hospital Presumptive” at the top of the front page;
  
  – An explanation that the individual must complete and submit the full MA application before their temporary coverage end date in order to prevent a coverage gap should the individual be MA eligible; and
  
  – Assistance with completing the full MA application.
IV. Notify the applicant, continued

• Hospital provides the ineligible individual with:
  – A denial notice;
  – A copy of the completed HPE Application;
  – The full MA packet; and
  – Assistance with completing the MA application, or information on resources to help the individual complete and submit the MA application.
HPE Application

For all applicants, make sure all parts of the form are completed.
IV. Notify the applicant, continued

• What is in a Notice of Approval?
  – Client name, date of birth, SSN when provided
  – Hospital name, provider number, date of notice
  – Date of Notice -- Eligibility approval date
  – Next steps:
    • Assistance with completing the full MA application
    • Ensure individual understands the importance of supplying any supplemental information for the full MA application before the end of the HPE period to avoid any gap in coverage.
  – No appeal rights - HPE determinations are final.
  – Hospital representative signature, title and contact information
IV. Notify the applicant, continued

• The Approval Notice is proof of coverage.
  – If the applicant is eligible, the Notice of Approval will be the individual’s proof of coverage until they receive their Maryland Medical Assistance Number and Coverage Letter.
Hospital gives an Approval Notice to all eligible applicants.
IV. Notify the applicant, continued

- **What is in a Notice of Denial?**
  - Applicant name, date of birth, SSN when provided
  - Hospital name, provider number and date of notice
  - Denial of eligibility for Hospital Presumptive Eligibility
  - Next steps:
    - Give applicant full MA application, as well as information on completing full application.
    - Notify applicant that HPE determinations are final. There are no HPE appeal rights.
  - Hospital representative signature, title and contact information
Denial Notice

Hospital gives a Denial Notice to all ineligible applicants.

DENIAL NOTICE FOR HOSPITAL PRESUMPTIVE (TEMPORARY) ELIGIBILITY FOR MEDICAL COVERAGE

WHY YOU ARE RECEIVING THIS NOTICE
You do not qualify for temporary health coverage through the Maryland Medical Assistance (MA) Program.

You can apply for health coverage at any time. You may qualify for other MA health coverage.

PRESUMPTIVE ELIGIBILITY DETERMINATIONS ARE FINAL
There is no right to appeal a presumptive eligibility decision.

Authorized Signature

Date

Hospital Representative Name and Title:

Hospital Representative Contact Information:

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Martin O’Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary
IV. Notify the applicant, continued

- Hospitals are responsible to:
  - Provide the eligible individual with the full Maryland MA application;
  - Provide individual assistance in completing the MA application; and
  - Ensure individual understands the importance of supplying any supplemental information for the full MA application before the end of the HPE period to avoid any gap in coverage.

- For HPE applicants who need to submit supplemental information to complete the full MA application, hospitals should follow up with individual to check on their progress with application completion.
V. Notify the Division of Recipient Eligibility Program (DREP)

• What to fax to DREP:
  
  – A copy of the completed Approval or Denial Notice issued to the individual, and
  
  – A copy of the individual’s completed Hospital Presumptive Eligibility application.
V. Notify the Division of Recipient Eligibility Program (DREP)

- Hospitals should check EVS within a week of submitting the required forms to OHA to confirm if approved individuals are in the system.
  - If the EVS enrollment is not complete, contact the DREP.

- If an individual has already submitted a medical application but has not received an update on the status of the application:
  - Contact DREP to identify the application and ensure its processing is expedited.
Hospital Presumptive (Temporary) Eligibility Process

DHMH’S ROLE IN HPE
What are DHMH’s responsibilities?

• Confirm initial screening criteria:
  – Hospital is a qualified hospital.
  – Individual reflects no MA eligibility on MMIS and EVS.
  – Individual does not currently receive coverage under a period of Hospital Presumptive Eligibility.
  – Individual has not received coverage based on Hospital Presumptive Eligibility within the past 12 months.
What are DHMH’s responsibilities?

• Accept the hospital’s determination and not question the decision unless:
  – The determination comes in from a non-qualified hospital;
  – The individual is found to have current MA coverage; or
  – The individual has HPE benefits or has had HPE benefits in the prior 12 months.

• Under no circumstances, will an HPE decision be reversed, or HPE eligibility terminated retroactively, even though someone determined eligible through HPE could potentially be found ineligible based on the full determination.
What are DHMH’s responsibilities?

• Systems entry and documentation
  – Verify current Medical Assistance status when hospital submits HPE electronic application;
  – Return message to hospital when HPE applicant is already enrolled in another MA program; and
  – Enter approved HPE applicants into MMIS.
What are DHMH’s responsibilities?

• Ensure eligible individual is not auto-enrolled in a managed care organization (MCO) for the presumptive period.

• This means the individual will receive all health care services (physical, dental, mental health) on a fee-for-service basis.
What are DHMH’s responsibilities?

• Prior to end of HPE period, report to hospital which HPE applicants have yet to complete their full MA application.

• Upon receipt of a full MA application from a HPE beneficiary, DHMH will:
  – Complete the determination of ongoing eligibility under the appropriate program, and
  – If found eligible for Medicaid/CHIP, ensure that the individual is enrolled in a managed care entity (MCO).
What are DHMH’s responsibilities?

• Ensure that the presumptive coverage ends. The HPE period ends with:
  – The day on which the state makes the eligibility determination for full Medicaid, or
  – The last day of the month following the month in which the hospital makes the HPE determination, if the individual does not file a full application by that time.

• When HPE ends, individuals do not receive a notice of their coverage ending. The approval notice they receive in the hospital serves as their notice that this benefit is temporary and will end the last day of the month following the month in which the hospital made the HPE determination.
Hospital Presumptive (Temporary) Eligibility Process

THE APPLICANT’S RESPONSIBILITIES
What are the applicant’s responsibilities?

• Provide true and accurate information for DHMH.

• If approved:
  – Submit completed MA application prior to the end of the month following the month of hospital’s HPE determination.
  – If no application is received, coverage closes effective the end of the month following the month of hospital’s determination.

• If denied:
  – No obligation, but may complete MA application for full eligibility determination.
Hospital Presumptive (Temporary) Eligibility Process

ACCOUNTABILITY

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O’Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary
Partners in accountability

• Hospital Recordkeeping Requirements (maintain records for seven years):
  – Signed HPE applications;
  – Approval Notices issued;
  – Denial Notices issued; and
  – Record of full MA application completion for each approved HPE applicant.
Partners in accountability

• DHMH Recordkeeping Requirements:
  – Number of applicants, statewide and by Hospital, who:
    • Submitted a full DHMH MA application before the end of the HPE period.
    • Were ultimately determined eligible for Medicaid/CHIP.
    • Were ultimately determined ineligible for Medicaid/CHIP.
  – All claims and payments related to Hospital Presumptive Eligibility approvals for:
    • Individuals ultimately eligible for Medicaid/CHIP, and
    • Individuals ultimately ineligible for Medicaid/CHIP
Standards for accountability

• The HPE program is launching with the following “test” standards.

• After the first year of HPE implementation, the Department will evaluate these metrics and refine the standards as necessary following discussions with CMS.
## Standards and Criteria

<table>
<thead>
<tr>
<th>Proposed Quality Standard</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 90 percent of the time</td>
<td>The Hospital’s determination that the applicants do not have current Medicaid/CHIP is correct</td>
</tr>
<tr>
<td>2. 90 percent of the time</td>
<td>The Hospital’s determination that applicants did not receive temporary coverage within the past 12 months is correct.</td>
</tr>
<tr>
<td>3. 90 percent of all approved HPE applicants</td>
<td>Submit a full MA application no later than the last day of the month following the month during which the HPE determination is made.</td>
</tr>
</tbody>
</table>
Sanctions and disqualification

• As the program progresses and Standards and Criteria are refined, DHMH proposes to enforce the Standards as follows:

• Plan of Correction
  – If the prescribed standards are not met for a period of one calendar quarter, DHMH will establish with the Hospital a written Plan of Correction (POC) that describes:
    • Targets and timelines for improvement;
    • Steps to be taken in order to comply with the performance standards;
    • How additional staff training would be conducted, if needed;
    • The estimated time it would take to achieve the expected performance standards, which would be no greater than three months; and
    • How outcomes would be measured.
Sanctions and disqualification

• DHMH may impose additional correction periods, as appropriate.

• If targets are not met after a sufficient period for improvement, as determined in discussions between DHMH and the hospital, the Department may disqualify a hospital from making eligibility determinations under the HPE program.
Hospital Presumptive (Temporary) Eligibility Process

CONTACTS AND INFORMATION

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O’Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary
Contacts and information

- The director of the Division of Recipient Eligibility Programs
  - Janet S. Smith
    - (410) 767-5377
    - janet.smith@maryland.gov
FEEDBACK AND Q & A

Hospital Presumptive (Temporary) Eligibility Process
Division of Medicaid and Children's Health Operations

Mr. Dennis Schrader
Medicaid Director
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201

Re: Approval of State Plan Amendment MD-19-0009 Migrated_HH.MD HHS

Dear Mr. Dennis Schrader:

On September 27, 2019, the Centers for Medicare and Medicaid Services (CMS) received Maryland State Plan Amendment (SPA) MD-19-0009 for Migrated_HH.MD HHS to This amendment increases the rates for the Behavioral Health, Health Home program, by 3.5 percent, for dates of service beginning July 1, 2019.

We approve Maryland State Plan Amendment (SPA) MD-19-0009 on October 29, 2019 with an effective date(s) of July 01, 2019.

If you have any questions regarding this amendment, please contact Talbatha Myatt at talbatha.myatt@cms.hhs.gov.

Sincerely,
Francis T. McCullough
Director
Division of Medicaid Field Operations
East Regional Operations Group
Division of Medicaid and Children's Health Operations

Health Homes Payment Methodologies

fee for service
Individual Rates Per Service
Fee for Service Rates based on
severity of each individual's chronic conditions
Capabilities of the team of health care professionals, designated provider, or health team
Other
Health Homes may receive a one-time reimbursement for the completion of each participant's initial intake and assessment necessary for enrollment into the Health Home. The payment will be the same as the rate paid for monthly services on a per-member basis. The monthly rate is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland, including the provision of a minimum of two services in the month. The Health Homes are not paying any monies to other providers. There is only one exchange of payment and that is from the State to the Health Home providers. Health Home providers must document services and outcomes within the participant's file and in eMedicaid. These documents are accessible to the Department and the Department's designees through eMedicaid and are auditable. Rates are reviewed annually. Health Home participants may only be enrolled in one Health Home at a time. If participant is enrolled in a Health Home, Maryland's system automatically blocks the participant from being enrolled in another Health Home.

Health Homes will be paid a monthly rate based on the employment costs of required Health Home staff, using salary and additional employment cost estimates for each of the required positions and their respective ratios. Payment is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland. Failure to meet such requirements is ground for payment sanctions or revocation of Health Home status. The Department does not pay for separate billing for services which are included as part of another service. At the end of each month, Health Homes will ensure that all Health Home services and outcomes have been reported into eMedicaid. The provider will then submit a bill within 30 days for all participants that received the minimum Health Home service requirement in the preceding month. The provider may begin billing for a Health Home participant when the intake portion of that individual's eMedicaid file has been completed with the necessary demographics, qualifying diagnoses baseline data, and consent form. The initial intake process itself qualifies as a Health Home service. The ongoing criteria for receiving a monthly payment is:

1. The individual is identified in the State's Medicaid Management Information System (MMIS) as Medicaid-eligible and authorized to receive PRP, MT, or OTP services;
2. The individual was enrolled as a Health Home member with the Health Home provider in the month for which the provider is submitting a
3. The individual has received a minimum of two Health Home services in the previous month, which are documented in the eMedicaid system. The agency's fee schedule (rate) was last updated on July 1, 2019 and is effective for services provided on or after that date. Effective July 1, 2019, the Health Home rate will be $110.19.

<table>
<thead>
<tr>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Member, Per Month Rates</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Methodology Included in the Plan</td>
<td></td>
</tr>
<tr>
<td>Incentive Payment Reimbursement</td>
<td></td>
</tr>
</tbody>
</table>

There are no variations in payment.

- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- Alternative models of payment, other than Fee for Service or PMPM payments (describe below)
Health Homes Payment Methodologies

Package Header

<table>
<thead>
<tr>
<th>Package ID</th>
<th>MD2019MS0002O</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submission Type</td>
<td>Official</td>
</tr>
<tr>
<td>Approval Date</td>
<td>10/29/2019</td>
</tr>
<tr>
<td>Superseded SPA ID</td>
<td>MD-18-0008</td>
</tr>
</tbody>
</table>

Initial Submission Date 9/27/2019
Effective Date 7/1/2019

Agency Rates

Describe the rates used

- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date
7/1/2019

Website where rates are displayed
health.maryland.gov/providerinfo
Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
   • the frequency with which the state will review the rates, and
   • the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Behavioral Health rates are typically reviewed and updated for inflation annually. This program was added to that annual review process in FY 2017. Effective July 1, 2016 the Health Home rate will be increased 2% bringing the rate to $100.85. This change is being submitted to CMS through a separate process, with public notice being published June 10th. MD then increased the rate by 2%, effective July 1, 2017 and by 3.5% in 2018 and 2019. There is no tiered payment for this service. All Health Homes receive the same monthly rate if they perform the minimum number of services for that individual.
Health Homes Payment Methodologies

Assurances

1. The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

   Describe below how non-duplication of payment will be achieved

   Recipients of specified waiver services and mental health case management that may be duplicative of Health Home services will not be eligible to enroll in a Health Home. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

2. The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

3. The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

4. The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

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PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 10/30/2019 7:13 AM EDT
Package Information

Package ID: MD2018S00110
Program Name: Migrated_HH, MD HHS
SPA ID: MD-18-0008
Version Number: 2
Submitted By: Katia Fortune
Package Disposition: 

Submission Type: Official
State: MD
Region: Philadelphia, PA
Package Status: Approved
Submission Date: 8/20/2018
Approval Date: 10/16/2018 2:59 PM EDT

Priority Code: P2
Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Date: 10/16/2018
Head of Agency: Robert Neall
Title/Dept: Secretary of Health
Address 1: 201 West Preston Street
Address 2:
City: Baltimore
State: MD
Zip: 21201

MACPro Package ID: MD2018MS500110
SPA ID: MD-18-0008

Subject
MD 18-0008 Behavioral Health Home Rate Increase

Dear Robert Neall

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.
The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for Behavioral Health Home Rate Increase SPA

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Health Homes Intro</td>
<td>7/1/2018</td>
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<tr>
<td>Health Homes Geographic Limitations</td>
<td>7/1/2018</td>
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<tr>
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<tr>
<td>Health Homes Monitoring, Quality Measurement and Evaluation</td>
<td>7/1/2018</td>
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</table>

Increased Geographic Coverage  
☑ Yes  
☐ No

Increase in Conditions Covered
☐ Yes
☐ No

This SPA increases Behavioral Health, Health Home rates following Governor Hogan’s approval for a 3.5 percent rate increase for the Maryland Medical Assistance, for dates of service beginning July 1, 2018. This represents an estimated $196,472 increase in total funds (50 percent general funds, $98,236, and 50 percent $98,236 federal funds).

Sincerely,

Alissa DeBoy
Mrs.

Approval Documentation

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Submission - Summary

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State Information

State/Territory Name: Maryland

Medicaid Agency Name: Maryland Department of Health, Office of Health Care Financing

Submission Component

- [State Plan Amendment]
- Medicaid
- CHIP
Submission - Summary

Package Header

- **Package ID**: MD2018M500110
- **Submission Type**: Official
- **Approval Date**: 10/16/2018
- **Superseded SPA ID**: N/A

SPA ID and Effective Date

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Executive Summary

Summary Description Including Goals and Objectives
This SPA updates the reimbursement for Maryland Medical Assistance Behavioral Health, Health Home program. In accordance with Governor Hogan’s rate increase for Maryland Medical Assistance, this proposal would increase the rates for Behavioral Health, Health Home program by 3.5 percent for dates of service beginning July 1, 2018. This represents an estimated $196,472 increase in total funds (50 percent general funds, $98,236, and 50 percent $98,236 federal funds).

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

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Federal Statute/ Regulation Citation
n/a
Submission - Summary

Package Header

Package ID MD2018Ms00110
Submission Type Official
Approval Date 10/16/2018

SPA ID MD-18-0008
Initial Submission Date 8/20/2018
Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

☐ No comment
☐ Comments received
☐ No response within 45 days
☐ Other

Describe
Rebecca Frechard, LCPC
Director, Medicaid Behavioral Health Division
Office of Health Services
Submission - Public Comment

Package Header

Package ID: MD2018MS00110
Submission Type: Official
Approval Date: 10/16/2018
Superseded SPA ID: N/A

SPA ID: MD-18-0008
Initial Submission Date: 8/20/2018
Effective Date: N/A

Name of Health Homes Program
Migrated_HH.MD HHS

Indicate whether public comment was solicited with respect to this submission.

- [ ] Public notice was not federally required and comment was not solicited
- [ ] Public notice was not federally required, but comment was solicited
- [x] Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- [ ] Newspaper Announcement
- [ ] Publication in state’s administrative record, in accordance with the administrative procedures requirements
- [ ] Email to Electronic Mailing List or Similar Mechanism
- [ ] Website Notice
- [ ] Public Hearing or Meeting
- [ ] Other method

Upload copies of public notices and other documents used

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Upload with this application a written summary of public comments received (optional)

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No items available

Indicate the key issues raised during the public comment period (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue
# Submission - Tribal Input

**Package Header**

<table>
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**SPA ID** MD-18-0008

**Initial Submission Date** 8/20/2018

**Effective Date** N/A

**Name of Health Homes Program** Migrated_HH_MD HHS

**One or more Indian health programs or Urban Indian Organizations furnish health care services in this state**

- [x] Yes
- [ ] No

**This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations**

- [ ] Yes
- [x] No

**Explain why this SPA is not likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations**

- Even though not required, the state has solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA
- The state has not solicited advice from Indian Health Programs and/or Urban Indian Organizations prior to submission of this SPA
- UIO expressed no concern, and had no comments (see attached document)

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

**Solicitation of advice and/or Tribal consultation was conducted in the following manner:**

- [ ] All Indian Health Programs
- [ ] All Urban Indian Organizations

**Date of solicitation/consultation:** 8/7/2018

**Method of solicitation/consultation:** email

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

- [ ] All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state’s responses to any issues raised. Alternatively, indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

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**Indicate the key issues raised (optional)**

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
Submission - Other Comment

Package Header

Package ID   MD2018M50011O
Submission Type   Official
Approval Date   10/16/2018
Superseded SPA ID   N/A

SPA ID   MD-18-0008
Initial Submission Date   8/20/2018
Effective Date   N/A

SAMHSA Consultation

Name of Health Homes Program
Migrated_HH,MD HHS

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation

1/3/2013
2/15/2013
Health Homes Intro

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Migrated_HH.MD_HHS

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Health Homes for individuals with chronic conditions augments the State’s broader efforts to integrate somatic and behavioral health services, as well as aim to improve health outcomes and reduce avoidable hospital encounters. The program targets populations with behavioral health needs who are at high risk for additional chronic conditions, offering them enhanced care coordination and support services from providers with whom they regularly receive care. Health Homes are designed to enhance person-centered care, empowering participants to manage and prevent chronic conditions in order to improve health outcomes, while reducing avoidable hospital encounters. Several provider types are eligible to enroll as Health Homes, including psychiatric rehabilitation programs, mobile treatment service providers, and opioid treatment programs. Health Homes serve individuals who experience serious persistent mental illness (SPMI), serious emotional disturbance (SED) and those with opioid substance use disorders determined to be at risk for additional chronic conditions. Health Homes will receive a flat per member, per month payment to provide these services, as well as a one-time payment for each individual’s initial intake assessment.

General Assurances

☐ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.

☐ The state provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.

☐ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.

☐ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.

☐ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.

☐ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.
Health Homes Geographic Limitations

Package Header

Package ID  MD2018M500110
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Approval Date  10/16/2018
Superseded SPA ID  16-0001

SPA ID  MD-18-0008
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Effective Date  7/1/2018

☐ Health Homes services will be available statewide
☐ Health Homes services will be limited to the following geographic areas
☐ Health Homes services will be provided in a geographic phased-in approach
Health Homes Population and Enrollment Criteria

Package Header

- **Package ID**: MD2018M500110
- **SPA ID**: MD-18-0008
- **Submission Type**: Official
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- **Effective Date**: 7/1/2018
- **Superseded SPA ID**: 16-0001

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants:

- Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
  - Medically Needy
    - Medicaid Needy
    - Medically Needy Pregnant Women
    - Medically Needy Children under Age 18
  - Optional Medicaid Needy (select the groups included in the population)
- Families and Adults
  - Medically Needy Children Age 18 through 20
  - Medically Needy Parents and Other Caretaker Relatives
- Aged, Blind and Disabled
  - Medically Needy Aged, Blind or Disabled
  - Medically Needy Blind or Disabled Individuals Eligible in 1973
Health Homes Population and Enrollment Criteria

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Population Criteria

The state elects to offer Health Homes services to individuals with

☐ Two or more chronic conditions
☐ One chronic condition and the risk of developing another

Specify the conditions included

☐ Mental Health Condition
☐ Substance Use Disorder
☐ Asthma
☐ Diabetes
☐ Heart Disease
☐ BMI over 25
☐ Other (specify)

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<tr>
<td>Opioid Substance Use Disorder</td>
<td>Opioid Substance Use Disorder</td>
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Specify the criteria for at risk of developing another chronic condition

Eligibility criteria based on opioid substance use disorder:
1. The consumer has been diagnosed with an opioid substance use disorder.
2. The consumer must be engaged in opioid maintenance therapy.
3. The consumer is determined to be at risk for additional chronic conditions due to current tobacco, alcohol, or other non-opioid substance use, or a history of tobacco, alcohol, or other non-opioid substance dependence.

Specify the criteria for a serious and persistent mental health condition

Eligibility criteria based on SPMI or SED:
1. The consumer has been diagnosed with SPMI or SED, meeting all relevant medical necessity criteria to receive psychiatric rehabilitation program (PRP) services or mobile treatment services (MTS).
2. The individual must be engaged in services with a PRP or MTS provider.
3. The consumer is not currently receiving either of the following services, considered duplicative of Health Home services:
   a. 1915(b) waiver services
   b. Targeted Mental Health Case Management
Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

☑ Opt-In to Health Homes provider
☑ Referral and assignment to Health Homes provider with opt-out
☑ Other (describe)

Describe the process used

Health Homes may enroll an eligible individual to whom they provide PRP, MT, or OTP services, contingent upon participant consent, and in the case of OTP participants, the presence of an identified qualifying risk factor. Health Homes may enroll participants only after they have been enrolled for the provider's applicable PRP, MT, or OTP services, ensuring that all relevant medical necessity criteria has been met to confirm the qualifying diagnosis. Enrollment is complete upon submission of the participant's online eMedicaid intake. Consent will authorize sharing of information between identified service providers, the State, applicable Managed Care Organizations (MCOs) and Administrative Service Organizations (ASOs) for the purpose of improved care coordination and program evaluation. The Health Home will notify other treatment providers (e.g., primary care providers) of the participant's goals and the types of Health Home services the participant is receiving and encourage participation in care coordination efforts.

The State uses claims data to identify potentially-eligible consumers who could benefit from Health Home services. This includes individuals with a qualifying diagnosis who experience frequent emergency department usage, hospitalization, or increases in level of care. MCOs and the ASO may assist the State in the identification, outreach, and referral of potential participants among their own consumers. Upon obtaining consumer consent, the State, MCO, or ASO will refer individuals to a Health Home near their residence, at which point the Health Home may outreach to the consumer directly. The State engages additional referral sources to familiarize them with the Health Home's purpose and referral protocols, as well as alert them to opportunities for continued collaboration with Health Home providers. This may include hospitals and emergency departments, public agencies, and school-based health centers.
Health Homes Providers

Package Header

Package ID: MD2018M500110
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Superseded SPA ID: 16-0001

SPA ID: MD-18-0008
Initial Submission Date: 8/20/2018
Effective Date: 7/1/2018
User-Entered:

Types of Health Homes Providers

- [ ] Designated Providers
- [ ] Physicians
- [ ] Clinical Practices or Clinical Group Practices
- [ ] Rural Health Clinics
- [ ] Community Health Centers
- [ ] Community Mental Health Centers
- [ ] Home Health Agencies
- [ ] Case Management Agencies
- [ ] Community/Behavioral Health Agencies

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

Describe the Provider Qualifications and Standards

Health Homes must be licensed by the Department of Health and Mental Hygiene as a Psychiatric Rehabilitation Program (PRP), a Mobile Treatment Services (MTS) provider or an Opioid Treatment Program (OTP). In addition, providers must:

1) Be enrolled as a Maryland Medicaid Provider;
2) Be accredited by, or in the process of gaining accreditation from, an approved accrediting body offering a Health Home accreditation product.
3) For those agencies working with minors, demonstrate a minimum of 3 years of experience serving children and youth.

- [ ] Federally Qualified Health Centers (FQHC)
- [ ] Other ( Specify)
Health Homes Providers

Package Header

Package ID MD2018MS0011O
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SPA ID MD-18-0008
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Effective Date 7/1/2018

User-Entered

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

All Health Homes must maintain staff in the ratios specified below whose time is exclusively dedicated to the planning and delivery of Health Home services.

1) Health Home Director: .5 FTE per 125 Health Home enrollees. Health Homes with less than 125 enrollees may employ 1 FTE individual to serve as both the Nurse Care Manager and Health Home Director, provided that individual is licensed and legally authorized to practice as a registered nurse. Health Homes requiring a Director at a level more than .5 FTE may choose to designate a lead Health Home Director and subsequent additional key management staff to fulfill the Director or staffing requirement.

2) Health Home Care Manager: .5 full-time equivalent (FTE) per 125 Health Home enrollees. Among providers with more than 1 FTE Care Manager, the initial 1FTE care manager role must be filled by a nurse, while subsequent staff in this role may be physicians’ assistants.

3) Physician or Nurse Practitioner Consultant: 1.5 hours per Health Home enrollee per 12 month period

4) Administrative Support Staff: The State estimates that Administrative Support Staff of approximately .25 FTE per 125 Health Home enrollees will be necessary to effectively implement the Health Home. However, because providers utilize a wide range of care management tools that may lessen the burden of administrative tasks, Health Homes may use their discretion in determining the staffing levels necessary to fulfill the administrative activities of the Health Home.

The staffing ratios specified as “per 125 Health Home enrollees” act as a minimum, requiring providers with less than 125 enrollees to maintain this level regardless of their enrollment. Smaller Health Homes may form a consortium to share Health Home staff and thus costs, although participants will be served at their own provider’s location. Creation of such consortiums is contingent upon geographic proximity and State approval of an application addendum detailing the planned collaboration.

Although the aforementioned staffing must be dedicated exclusively to Health Home activities, qualified staff members within the PRP, MT or OTP—such as licensed counselors or nurses—may provide Health Home services as well. It is expected that all staff members, not only those dedicated exclusively to the Health Home, will be fully informed of the goals of the Health Home and collaborate to serve participants.
Health Homes Providers

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Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

To encourage ongoing information-sharing and problem-solving between Health Homes, the Department offers educational opportunities such as webinars and regional meetings. Additionally, regular communication and feedback between the State and individual Health Homes facilitates a collaborative and responsive working relationship. The Maryland Department of Health closely monitors Health Home providers to ensure their services meet Maryland’s Health Home standards as well as CMS’ Health Home core functional requirements stated above. Oversight activities may include medical chart and care management record review, site audits, and team composition analysis. The State performs outreach to providers and agencies that may collaborate with Health Homes for the benefit of patients, informing them of the Health Home objectives and role in order to foster these linkages.
Health Homes Providers

Package Header

Package ID   MD2018MS0011O
Submission Type   Official
Approval Date   10/16/2018
Superseded SPA ID   16-0001

Other Health Homes Provider Standards

The state’s requirements and expectations for Health Homes providers are as follows

A Health Home serves as the central point for directing person-centered care with the goal of improving patient outcomes while reducing avoidable health care costs. While providers are afforded a degree of flexibility in the design and implementation of their Health Homes, they must meet certain requirements in addition to those delineated above. These standards are detailed below.

Initial Provider Qualifications

1. Health Home providers must be enrolled in the MD Medicaid program as a PRP, OTP, or Mobile Treatment provider and agree to comply with all Medicaid program requirements.

2. Health Home providers must have, or demonstrate their intention to pursue, accreditation from an approved body offering a Health Home accreditation product.

3. Health Home providers must directly provide, or subcontract for the provision of, Health Home services. The Health Home provider remains responsible for all Health Home program requirements, including services performed by the subcontractor.

4. Health Homes providing PRP or MT services to minors must demonstrate a minimum of 3 years of experience providing services to children and youth.

5. Health Homes must ensure a minimum of one Health Home director and one Care Manager are in place before beginning service provision, and must reach all required staffing levels within 30 days of beginning service provision.

6. Health Homes must provide services to all Health Home enrollees, with each individual’s care under the direction of a dedicated care manager accountable for ensuring access to medical and behavioral health care services and community social supports as defined in the participant’s care plan.

7. Providers must complete an application to the State demonstrating their ability to perform each of the CMS Health Home core functional components (refer to section Support for Providers). Providers must propose a set of systems and protocols, including:
   a. processes used to perform these functions;
   b. processes and timeframes used to assure service delivery takes place in the described manner; and
   c. descriptions of multifaceted Health Home service interventions that will be provided to promote patient engagement, participation in their plan of care, and that ensures patients appropriate access to the continuum of physical and behavioral health care services.

8. Health Homes must participate in federal and state-required evaluation activities including documentation of Health Home service delivery as well as clients’ health outcomes and social indicators in the eMedicaid online portal.

9. Providers must maintain compliance with all of the terms and conditions as a Health Home provider or will be discontinued as a provider of Health Home services. In the event of any recovery of funds resulting from a provider termination, the FMAP portion of funds recovered will be returned to CMS in accordance with standard protocols.

10. Providers that wish to disenroll as a Health Home must notify the State of their intent with at least 30 days notice prior to discontinuing services. They must inform Health Home participants that they will no longer provide Health Home services, and that these may be obtained elsewhere if the participants wish to transfer their care.

Ongoing Provider Qualifications

Following enrollment, Health Home providers must also:

1. Enroll with Chesapeake Regional Information System for our Patients (CRISP) to receive hospital encounter alerts and access pharmacy data;

2. Convene and document internal Health Home staff meetings every 6 months, at minimum, to plan and implement goals and objectives of practice transformation.

3. Complete a program assessment process every six months confirming that the Health Home meets all staffing and regulatory requirements, and demonstrating a quality improvement plan to address gaps and opportunities for improvement; and

4. Obtain accreditation from an approved accrediting body offering a Health Home accreditation product within 18 months of initiating the accreditation process, or demonstrate significant progress towards this goal.

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Health Homes Service Delivery Systems

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Initial Submission Date 8/20/2018
Effective Date 7/1/2018

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- Fee for Service
- PCCM
- Risk Based Managed Care
- Other Service Delivery System
Health Homes Payment Methodologies

Package Header

Package ID MD2018MS00110
Submission Type Official
Approval Date 10/16/2018
Superseded SPA ID 16-0001
User: Entered

SPA ID MD-18-0008
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Payment Methodology

The State's Health Homes payment methodology will contain the following features

- Fee for Service
- Individual Rates Per Service
- Fee for Service Rates based on
  - Severity of each individual's chronic conditions
  - Capabilities of the team of health care professionals, designated provider, or health team
  - Other

Describe below

Health Homes may receive a one-time reimbursement for the completion of each participant's initial intake and assessment necessary for enrollment into the Health Home. The payment will be the same as the rate paid for monthly services on a per-member basis. The monthly rate is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland, including the provision of a minimum of two services in the month. The Health Homes are not paying any monies to other providers. There is only one exchange of payment and that is from the State to the Health Home providers.

Health Home providers must document services and outcomes within the participant's file and in eMedicaid. These documents are accessible to the Department and the Department's designees through eMedicaid and are auditable.

Rates are reviewed annually. Health Home participants may only be enrolled in one Health Home at a time. If a participant is enrolled in a Health Home, Maryland's system automatically blocks the participant from being enrolled in another Health Home.

Health Homes will be paid a monthly rate based on the employment costs of required Health Home staff, using salary and additional employment cost estimates for each of the required positions and their respective ratios. Payment is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland. Failure to meet such requirements is ground for payment sanctions or revocation of Health Home status. The Department does not pay for...
separate billing for services which are included as part of another service. At the end of each month, Health Homes will ensure that all Health Home services and outcomes have been reported into eMedicaid. The provider will then submit a bill within 30 days for all participants that received the minimum Health Home service requirement in the preceding month. The provider may begin billing for a Health Home participant when the intake portion of that individual’s eMedicaid file has been completed with the necessary demographics, qualifying diagnoses baseline data, and consent form. The initial intake process itself qualifies as a Health Home service. The ongoing criteria for receiving a monthly payment is:

1. The individual is identified in the State’s Medicaid Management Information System (MMIS) as Medicaid-eligible and authorized to receive PRP, MT, or OTP services;
2. The individual was enrolled as a Health Home member with the Health Home provider in the month for which the provider is submitting a bill for Health Home services; and
3. The individual has received a minimum of two Health Home services in the previous month, which are documented in the eMedicaid system.

The agency’s fee schedule (rate) was last updated on July 1, 2018 and is effective for services provided on or after that date. Effective July 1, 2018 the Health Home rate will be increased 3.5% bringing the rate to $100.85.

___

- Per Member, Per Month Rates
- Comprehensive Methodology Included in the Plan
- Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- Alternative models of payment, other than Fee for Service or PMPM payments (describe below)
Health Homes Payment Methodologies

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Package ID MD2018M50011O
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Superseded SPA ID 16-0001
User Entered

SPA ID MD-18-0008
Initial Submission Date 8/20/2018
Effective Date 7/1/2018

Agency Rates

Describe the rates used
☐ FFS Rates included in plan
☐ Comprehensive methodology included in plan
☐ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date
Jul 1, 2018

Website where rates are displayed
health.maryland.gov/providerinfo
Health Homes Payment Methodologies

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state’s standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
   - the frequency with which the state will review the rates, and
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Behavioral Health rates are typically reviewed and updated for inflation annually. This program was added to that annual review process in FY 2017. Effective July 1, 2016 the Health Home rate will be increased 2% bringing the rate to $100.85. This change is being submitted to CMS through a separate process, with public notice being published June 10th. MD then increased the rate by 3.5% in 2018. There is no tiered payment for this service. All Health Homes receive the same monthly rate if they perform the minimum number of services for that individual.
Health Homes Payment Methodologies

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Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved
Recipients of specified waiver services and mental health case management that may be duplicative of Health Home services will not be eligible to enroll in a Health Home. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

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Health Homes Services

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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition
Health Home staff collaborate to provide comprehensive care management services with active patient and family participation. The Health Home coordinates primary and behavioral health care and social services to address the whole-person needs of patients at the individual and population levels. This includes the following:

a. Initial assessment: The Health Home conducts, or provides a referral to the PCP for, a comprehensive biopsychosocial assessment, if no such assessment has been performed by a licensed physician or nurse practitioner in the preceding 6-month period.

b. Development of Care Plan: Using the initial assessment and PCP records as available, the Health Home team works with the participant to develop an ITP including goals and timeframes, community networks and supports, and optimal clinical outcomes.

c. Delivery of services: The Health Home assigns each team member clear roles and responsibilities. Participant ITPs identify the various providers and specialists within and outside the Health Home involved in the consumer's care.

d. Monitoring and reassessment: The Health Home monitors individual health status and progress towards ITP goals, documenting changes and adjusting care plans as needed, twice annually minimally.

e. Outcomes and Reporting: The Health Home uses the eMedicaid portal and other available HIT tools possibly including EHR, to review and report quality metrics, assessment and survey results, and service utilization in order to evaluate client satisfaction, health status, service delivery, and costs.

f. Population-based Care Management: Providers monitor population health status and service use to determine adherence to or variance from treatment guidelines. The Health Home identifies and prioritizes and population-wide needs and trends, then implement appropriate population-wide treatment guidelines and interventions.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Health Homes have access to the State's online eMedicaid portal, allowing providers to report and review participant intake, assessment, assigned staff, ITP, clinical baselines and data relating to chronic conditions, as well as Health Home services provided, such as referrals made and health promotion activities completed. eMedicaid generates reports of the aforementioned data at a participant or provider level. Additional access to hospital encounter and pharmacy data through the Chesapeake Regional Information System for Our Patients (CRISP) Electronic Notification System will enable Health Homes to gain a more comprehensive understanding to their participants' care and health status.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
  
  Description
  Opioid Treatment Program Clinical Supervisors, Licensed Mental Health Professionals, and PRP Rehabilitation Specialists and PRP Direct Support Staff may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Clinical Supervisors may also play a role in population-based care management tasks.

- [ ] Nurse Practitioner
  
  Description
  Nurse Care Coordinators may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Nurse Care Coordinators may also play a role in population-based care management tasks.

- [ ] Nurse Care Coordinators
  
  Description
  Nurses may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Nurse Practitioners may perform the initial biopsychosocial assessment of a new Health Home participant, as well as play a role in population-based care management.

- [ ] Physicians
  
  Description
  Physicians may perform the initial biopsychosocial assessment of a new Health Home participant, as well as participate in development and ongoing monitoring and reassessment of the ITP goals. Physicians may also play a role in population-based care management tasks.

- [ ] Physician's Assistants

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Physicians' Assistants may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment.

**Social Workers**

**Description**

Social Workers may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment.

### Provider Type

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<td>Health Home Director</td>
<td>The Health Home Director may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. They may also take part in population-based care management activities.</td>
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### Care Coordination

**Definition**

Care coordination includes implementation of the consumer-centered ITP through appropriate linkages, referrals, coordination and follow-up to needed services and support. Specific activities include appointment scheduling, referrals and follow-up monitoring, tracking of appropriate screenings and EPDST needs, and communication with other providers and supports. Health Homes serving children place particular emphasis on coordination with school officials, PCPs, and involved agencies such as DSS.

The Health Home provider assigns each enrollee a Care Manager who will be responsible for coordinating the individuals' care and ensuring implementation of the treatment plan in partnership with the individual and family, as appropriate. At the population level, the Health Home provider develops policies and procedures to facilitate collaboration between primary care, specialist, and behavioral health providers, as well as agencies and community-based organizations, and for children, school-based providers. Such policies will clearly define the roles and responsibilities of each in order to ensure timely communication, use of evidence-based referrals, follow-up consultations, and regular case review meetings with all members of the Health Home team. The Health Home ensures that all regular screenings and immunizations are conducted through coordination with the primary care or other appropriate provider. In addition, members of the Health Home team meets with area providers to enhance collaboration and integration with regard to the population.

**Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum**

The eMedicaid online portal allows Health Homes to report and review referrals made to outside providers, social and community resources, and individual and family supports. Access to CRISP hospital encounter alerts will facilitate prompt discharge planning and follow-up. As the State continues to develop eMedicaid's capabilities, claims data may ultimately populate fields in the eMedicaid system, allowing Health Home providers to better track their participant needs, services received, and identify opportunities for improved care coordination.

### Scope of Service

The service can be provided by the following provider types

- **Behavioral Health Professionals or Specialists**
  - **Description**
  - Appropriate behavioral health professionals or experts - including Addictions Counselors, OTP Clinical Supervisors, PRP Rehabilitation Specialists, and PRP Direct Support Staff - may provide care coordination services.

- **Nurse Practitioner**

- **Nurse Care Coordinators**
  - **Description**
  - Nurse Care Coordinators may provide care coordination services.

- **Nurses**

- **Medical Specialists**

- **Physicians**

- **Physician's Assistants**

- **Pharmacists**

- **Social Workers**

- **Doctors of Chiropractic**

- **Other (specify)**

- **Description**
  - Social Workers may provide care coordination services.

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Health Promotion

Definition
Health Promotion services assist patients and families to participate in the implementation of their care plan and place a strong emphasis on skills development for monitoring and management of chronic and other somatic health conditions. Health promotion services will include health education and coaching specific to an individual’s condition(s), development of a self-management goals, medication review and education, and promotion of healthy lifestyle interventions. Such interventions may include, those that encourage substance use and smoking prevention or cessation, improved nutrition, obesity prevention and reduction, and increased physical activity.

Health Homes working with children will emphasize these preventive health initiatives, while actively involving parents and families in the process. This will include identifying conditions for which the child may be at risk due to family, physical, or social factors, and working with the patient and caregivers to address these areas.

At the population level, the Health Home team will use data to: identify and prioritize particular areas of need with regard to health promotion; research best-practice interventions; implement the activities in group and individual settings; evaluate the effectiveness of the interventions; and modify them accordingly.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
Health Home providers will use the eMedicaid portal to document, review, and report health promotion services delivered to each enrollee. Additionally, periodic updates to clinical outcomes may be reported in tandem with the related health promotion services delivered—for example, while reporting a discussion regarding physical activity in the eMedicaid portal, the Health Home would note the participant’s weight and BMI.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists

- Nurse Practitioner

- Nurse Care Coordinators

- Nurses

- Medical Specialists

- Physicians

- Physician’s Assistants

- Pharmacists

- Social Workers

- Doctors of Chiropractic

- Licensed Complementary and alternative Medicine Practitioners

- Dieticians

- Nutritionists

- Other (specify)

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition
Health Homes provide services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, interrupt patterns of frequent hospital emergency department use, and ensure timely and proper follow up care. The Health Home increases consumers’ and
family members’ ability to manage care and live safely in the community, shifting the use of reactive care and treatment to proactive health promotion and self-management.

Transitional care services vary by age of participants, and may include transitions to or from residential care facilities. Among transitional-age youth, services address the needs of participants and families as the individuals approach a shift into adult services and programs.

To accomplish these functions, providers establish a clear protocol for responding to CRISP alerts or notification from any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. Care Managers will follow up with consumers within two business days post-discharge discharge via home visit, phone call, or scheduling an on-site appointment.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All Health Homes are required to enroll with CRISP in order to receive alerts of hospital admissions, discharges, or transfer among their Health Home patient panel. Real-time access to this information will allow Health Home providers to provide prompt coordination and follow-up care. This ability will be augmented by real-time access to pharmacy data that may aid in medication reconciliation.

Scope of service

The service can be provided by the following provider types

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<td>As appropriate, the following providers may deliver or assist in the delivery of comprehensive transitional care services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, PRP Direct Support Staff.</td>
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<td>Nutritionists</td>
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Individual and Family Support (which includes authorized representatives)

Definition

Services include advocating for individuals and families; assisting with medication and treatment adherence; identifying resources for individuals and families to support them in attaining their highest level of health and functioning, including transportation to medically-necessary services; improving health literacy; increasing the ability to self-manage care; facilitating participation in the ongoing revision of care/treatment plan; and providing information as appropriate on advance directives and health care power of attorney. Health Homes connect participants with peer support services, many of which will be offered on-site, as well as referring participants to support groups and self-care programs as appropriate.

At the population level, services include: collecting and analyzing individual and family needs data; developing individual and family support materials and groups regarding the areas listed above; soliciting community organizations to provide group support to the population; and providing training and technical assistance as needed regarding the special needs of and effective interventions for the population.

The Health Home provider will ensure that all communication and information shared with the enrollee, the enrollee’s family and caregivers, as appropriate, is language, literacy and culturally appropriate.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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The eMedicaid tool allows Health Home providers to document, review, and report individual and family support services delivered, including referrals to outside groups or programs. Using real-time pharmacy data, Health Home providers are better able to assist individuals in obtaining and adhering to prescription medications.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dieticians
- Nutritionists
- Other (specify)

Description

As appropriate, the following providers may deliver or assist in the delivery of individual and family support services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, and PRP Direct Support Staff.

Description

Nurse Care Coordinators may provide individual and family support services.

Description

Nurses may provide individual and family support services.

Description

Physicians may provide individual and family support services.

Description

Physicians' Assistants may provide individual and family support services.

Description

Social Workers may provide individual and family support services.

Referral to Community and Social Support Services

Definition

The Health Home will identify available community-based resources and actively manage appropriate referrals, access to care, and engagement with other community, social, and school-based supports. Specific services will include: providing assistance for accessing Medical Assistance, disability benefits, subsidized or supported housing, personal needs support, peer or family support, and legal services, as appropriate. The Health Home will assist in coordinating these services and following up with consumers post service engagement.

At the population level, the Health Home team will: develop and monitor cooperative agreements with community and social support agencies that establish collaboration, follow-up, and reporting standards; recruit agencies to enter into those collaborative agreements; and provide training and technical assistance as needed regarding the special needs of and effective interventions for the population.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Using the eMedicaid online portal, Health Home providers may document, report, and review referrals to community-based resources.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses

Description

The following providers may provide referrals to community and social support services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, and PRP Direct Support Staff.

Description

Nurse Care Coordinators may provide referrals to community and social support services.

Description

Nurses may provide referrals to community and social support services.
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<td>Description: Physicians' Assistants may provide referrals to community and social support services.</td>
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<tr>
<td>Social Workers</td>
<td>Description: Social Workers may provide referrals to community and social support services.</td>
</tr>
<tr>
<td>Doctors of Chiropractic</td>
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<tr>
<td>Licensed Complementary and alternative Medicine Practitioners</td>
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Health Homes Services

Package Header

<table>
<thead>
<tr>
<th>Package ID</th>
<th>MD2018MS00110</th>
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<tbody>
<tr>
<td>SPA ID</td>
<td>MD-18-0008</td>
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<tr>
<td>Submission Type</td>
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<tr>
<td>Approval Date</td>
<td>10/16/2018</td>
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<tr>
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<td>Initial Submission Date</td>
<td>8/20/2018</td>
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<tr>
<td>Effective Date</td>
<td>7/1/2018</td>
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Health Homes Patient Flow

Describe the patient flow through the state’s Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter.

Referral & Enrollment

Potential Health Home participants may be informed of and referred to a Health Home in their region by a variety of sources. Upon engaging with a potential participant, the Health Home enrolls the individual in the appropriate PRP, MT, or OTP services for which they are eligible, and in the case of OTP patients, identify the qualifying risk factors that place them at risk for additional chronic conditions. The Health Home then explains the data-sharing elements of the program and obtain consent from the participant. Finally, the provider creates an entry and intake for the participant in the eMedicaid system, effectively enrolling them in the Health Home.

Participation

While participating in the Health Home, an individual will receive a minimum of two Health Home services per month, to be documented in the eMedicaid portal. A Case Manager will monitor their care and health status, and the Health Home team will assist with the provision of Health Home services as necessary. The Health Home will periodically reassess participants, and in doing so determine whether Health Home services are necessary.

Discharge

Discharge from the Health Home will primarily result from incidents such as relocation, incarceration, or loss of eligibility. In such cases, the Health Home provider will follow discharge protocol appropriate to the circumstances. In such cases where an individual’s PRP, MT, or OTP services cease due to stabilization or reaching age 18, they may remain in the Health Home for six months, during which the Health Home provider will emphasize support their transition to the appropriate level of care. Discharge planning may include the development of a discharge plan with referrals to the appropriate services and providers which will continue the individual’s care and support. The Health Home provider will report in eMedicaid the discharge of a participant, as well as note the completion of discharge planning.

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<tr>
<td>Health Home Participant Flow Chart (MACPRO upload)</td>
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Health Homes Monitoring, Quality Measurement and Evaluation

Package Header

Package ID MD2018M500110
Submission Type Official
Approval Date 10/16/2018
Superseded SPA ID 16-0001

SPA ID MD-18-0008
Initial Submission Date 8/20/2018
Effective Date 7/1/2018
User-Entered

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates.

Using data, the State tracks avoidable hospital readmissions by calculating ambulatory care sensitive conditions (ACSC) readmissions per 1000 enrollees. To calculate this rate: (# of readmissions with a primary diagnosis consisting of an Agency of Healthcare Research and Quality (AHRQ) ICD-9 code for ambulatory care sensitive conditions/ember months) x 12,000.

To measure cost savings generated by Chronic Health Homes, the State may compare the costs per member per month for participants by Health Home provider and by condition to costs for comparison groups of OTP, MT, and PRP participants enrolled with non-Health Home providers. The State may also compare overall costs between the groups for emergency room utilization, hospitalizations, nursing facility admissions, and pharmacy utilization. In this assessment, the State may review each Chronic Health Home independently for its overall costs and the allocation of its funds amongst services provided to inform future implementation and process modifications.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

1. eMedicaid Portal: eMedicaid is a web-based portal accessible to all networks, allowing Health Home providers to record and review of services delivered as well as clinical and social outcomes related to the individuals' chronic conditions. The portal is secure, with Health Homes' access limited to access the records of their own current enrollees. The State uses eMedicaid reports to track enrollment, compliance, and outcomes at the provider and population levels.

2. Chesapeake Regional Information System for our Patients (CRISP): All Health Home providers must enroll with CRISP's Electronic Notification System to receive hospital encounter alerts. This entails an initial upload of the Health Home's patient panel with all necessary demographic information, followed by monthly panel updates, as well as the set up of a direct message inbox and/or an interface with the provider's EHR to receive alerts.

3. Pharmacy Data: CRISP will additionally provide pharmacy data to Health Homes, including all Schedule II-V through the State's Prescription Drug Monitoring Program (PDMP), as well as any prescription drug within the Surescripts network.

4. Electronic Health Records (EHR) and Clinical Management Systems: Qualification as a Health Home provider is in part dependent upon the ability to report detailed performance metrics, measure improvement in care coordination, and gauge clinical outcomes on a provider level. Providers who do not currently use a robust EHR or clinical management system may determine that such a tool is necessary to meet the reporting and care coordination requirements of the Health Home program, as well as to improve their overall care capabilities.
Health Homes Monitoring, Quality Measurement and Evaluation

Quality Measurement and Evaluation

- The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.
- The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.