Table of Contents

State/Territory: Maryland

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

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.

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

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*

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*

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*

c. Family planning services and supplies for individuals of childbearing age.

☒ Provided: ☒ No limitations ☐ With limitations*

*Description provided on attachment.

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

X /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).

X /Provided: / /No limitations X /With limitations*

*Description provided on attachment.

State/Territory: Maryland

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

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.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE MEDICALLY NEEDY

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 NEEDY 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.

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

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).

[X] Provided: [X] 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.

[X] Provided: + [ ] Additional coverage ++

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

[X] Provided: + [ ] Additional coverage ++ [ ] Not provided.

21. Nurse practitioners' services.

[X] Provided: [ ] No limitations [X] 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.

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: / / No limitations /X/ With limitations*

b. Services of Christian Science nurses.

/ / Provided: / / No limitations / / With limitations*

c. Care and services provided in Christian Science sanitoria.

/ / Provided: / / No limitations / / With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

/X/ Provided: / / No limitations /X/ With limitations*

e. Emergency hospital services.

/X/ Provided: / / No limitations /X/ With limitations*

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.

/X/ Provided: / / No limitations /X/ With limitations*

State/Territory: Maryland

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Nurse Anesthetist services.

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

[ ] Not provided

~~h. Nurse Practitioner Services~~

~~[x] Provided: [ ] No limitations [x] With limitations~~

~~[ ] Not Provided~~

6/18/19
Number 23 changed to 24, and NP services were partially superceded (date/ TN unknown)

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.

__X__ 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.

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 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.**

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:

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

Measure:
Hospital admissions- heart disease
Measure Specification, including a description of the numerator and denominator.
Hospital admissions with congestive heart failure and/or heart disease 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- hepatitis C
Measure Specification, including a description of the numerator and denominator.
Hospital admissions with hepatitis C-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

Measure:
Hospital admissions- HIV/AIDS
Measure Specification, including a description of the numerator and denominator.
Hospital admissions with HIV/AIDS-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

Measure:

Hospital admissions- hypertension

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with hypertension related complications as a 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- kidney disease

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with chronic kidney disease 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- mental health

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with mental health conditions 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- obesity

Measure Specification, including a description of the numerator and denominator.
Hospital admissions with obesity related complications as a 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- substance use disorder
Measure Specification, including a description of the numerator and denominator.
Hospital admissions with substance use disorder 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 costs
Measure Specification, including a description of the numerator and denominator.
Hospitalization costs per member per month, aggregated and by Health Home provider.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ( ) Monthly
- ( ) Quarterly
- (●) Annually
- ( ) Continuously
- ( ) Other

Measure:
Inpatient admissions
Measure Specification, including a description of the numerator and denominator.
Inpatient admissions per 1000 Health Home participants per month, stratified by mental health diagnoses and all other diagnoses.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ( ) Monthly
- ( ) Quarterly
- (●) Annually
- ( ) Continuously
- ( ) Other

Measure:
Mental health readmissions
Measure Specification, including a description of the numerator and denominator.
Mental health readmissions within 30 days.
Data Sources:

Claims/Encounters
Frequency of Data Collection:
- ○ Monthly
- ○ Quarterly
- ◉ Annually
- ○ Continuously
- ○ Other

Measure:
Potentially preventable readmissions
Measure Specification, including a description of the numerator and denominator.
Potentially preventable readmissions within 30 days as a percentage of potentially preventable hospital admissions, stratified by mental health diagnoses and all other diagnoses.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ○ Monthly
- ○ Quarterly
- ◉ Annually
- ○ Continuously
- ○ Other

Emergency Room Visits

Measure:
Emergency department costs
Measure Specification, including a description of the numerator and denominator.
Emergency Department costs per member per month, aggregated and by HH provider.
Data Sources:
Claims/Encounters
Frequency of Data Collection:
- ○ Monthly
- ○ Quarterly
- ◉ Annually
- ○ Continuously
- ○ Other

Measure:
Emergency department visits- asthma
Measure Specification, including a description of the numerator and denominator.
Asthma 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- 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**

○ Continuously ○ Other	
Measure: Emergency department visits- hypertension Measure Specification, including a description of the numerator and denominator. Hypertension 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- kidney disease Measure Specification, including a description of the numerator and denominator. Chronic kidney 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- obesity Measure Specification, including a description of the numerator and denominator. Obesity-related complications 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- substance use Measure Specification, including a description of the numerator and denominator. Substance use disorder 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
Measure Specification, including a description of the numerator and denominator.
Emergency Department (ED) visit rate per 1000 Health Home participants per month, stratified by mental health diagnoses and all other diagnoses.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- ○ Monthly
- ○ Quarterly
- ◉ Annually
- ○ Continuously
- ○ Other

Skilled Nursing Facility Admissions

Measure:
Nursing facility admissions
Measure Specification, including a description of the numerator and denominator.
Nursing Facility admission rate per 1000 Health Home participants per month, all facility admissions.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- ○ Monthly
- ○ Quarterly
- ◉ Annually
- ○ Continuously
- ○ Other

Measure:
Nursing facility costs
Measure Specification, including a description of the numerator and denominator.
Skilled nursing facility costs per member per month, aggregated and by HH provider.
Data Sources:
Claims/Encounters
Frequency of Data Collection:

- ○ Monthly
- ○ Quarterly
- ◉ Annually
- ○ Continuously
- ○ Other

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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

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:

	Name of Method	Description	
+	Service Access and Information Link	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.	X

☑ 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.

STATE OF MARYLAND
DHMH

To find out if you quality 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.

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

1915(i) State plan Home and Community-Based Services

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*:**

◉	**Not applicable**
○	**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)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1115 of the Act.** *Specify the program*:

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 *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. 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.

☒ *(By checking 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*):

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

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

1. The State Medicaid Agency performs individual state HCBS enrollment.

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. The ASO is responsible for prior authorization of State Plan HCBS

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 the 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.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	10/1/24	9/30/25	200
Year 2			
Year 3			
Year 4			
Year 5			

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. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.

☒ 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.

☒ 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/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency
●	By Other (*specify State agency or entity under contract with the State Medicaid agency*): The Behavioral Health The Administrative Services Organization (ASO) is the entity contracted by the State Medicaid Agency that is responsible for the independent evaluation and reevaluations.

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 1915(i) eligibility determination to the Department for final approval and enrollment.

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 1915(i) eligibility criteria, including re-evaluation criteria, are outlined in #5 below.

Once the evaluator has determined eligibility for 1915(i) 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 1915(i) 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 3to 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 (CASII) 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 a combination of 2 or more inpatient psychiatric hospitalizations, ER visits, crisis stabilization center visits, or mobile crisis team responses 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, crisis stabilization center visits, mobile crisis team responses, 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 10.63.01, 10.63.04, and 10.21.22 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):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
A child or youth must demonstrate the following minimum requirements to be considered for 1915(i) services: 1) Impaired Functioning & Service Intensity: A recent 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	Maryland allows reimbursement to nursing homes for eligible persons who require hospital care, but who, because of their mental or physical condition, 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.	The medical necessity criteria for developmental disability as set forth in Md. Code Reg. 10.22.01.01: (16) "Developmental disability" as a chronic disability of an individual that: (a) Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments; Is likely to continue indefinitely; (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.	For inpatient hospital psychiatric emergency detention or involuntary admission, Md. 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

the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6- 21 a. Youth must receive a score of 3, 4 or 5 on the ECSII, or 3, 4, 5 or 6 on the CASII. b. Youth with a score of 4 or less 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 1. Be 6-21 years old and have a combination of 2 or more inpatient psychiatric hospitalizations, emergency room visits, crisis stabilization			(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 continuous assent to retention by the facility; and (5) The individual is able to ask for release

center visits, or mobile crisis team responses 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 one or more psychiatric inpatient hospitalizations, ER visits, crisis stabilization center visits,			

or mobile crisis team responses in the past 12 months. 2) Other Community Alternatives: The accessibility and/or intensity of currently available community services are inadequate 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 10.63.01, 10.63.04, and 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. Behavioral Health Disorder:
   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.

☐ **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).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* A participant requires at least one 1915(i) State Plan service to be determined to need the 1915(i) State Plan HCBS benefit.
ii.	**Frequency of services.** The state requires (select one):
◉	**The provision of 1915(i) services at least monthly**
○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

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 are not group homes with staff providing services. 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.

Settings are reviewed by Care Coordination Organizations (CCOs) as part of the referral process.

The State monitors compliance of the home and community-based settings requirement annually as part of the Quality Improvement Strategy (QIS).

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:

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.

iii. 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 at a minimum every 6 months by the Care Coordinator 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: conduct a strengths based initial assessment of the participant, their family members, and potential team members to identify needs 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. 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 with each party accountable for ensuring high quality services for the individual and family. The team determines the supports and services that need to be in place for the family, with the family and youth driving the process. 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 authorized services are consistent with the POC.

All services made available in the 1915(i) and Public Behavioral Health System will address individualized needs and are assessed for meeting medical necessity criteria.Choice of providers is a primary responsibility for families. If a family is dissatisfied with a provider, the CCO will handle the situation using an internal process to address the family's needs, mediate as applicable, or support a transition to another provider. This includes dissatisfaction with CCOs and any other providers. Each CCO has its own internal grievance process as part of their policies and procedures. Any unresolved grievances against the CCOs are resolved at the CSA/LBHA level.

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 their needs. 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.

The CCO is responsible for monitoring service providers' implementation of plans of care. BHA or its designee will review a sample of plans of care, review participant records, and track and trend the results as part of quality management activities in line with the quality assurance plan outlined below. Results of ongoing monitoring activities for reportable events reports, and annual reports, according to the quality improvement strategies, will be provided to the Medicaid Agency. The Medicaid Agency will review the quarterly and annual reports that are prepared by the ASO. 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):*

	Medicaid agency		Operating agency		Case manager
✔	Other (*specify):*	Care Coordination Organization			

Services

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 twice each week, including at least one in-person contact. 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 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 Behavioral 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)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Intensive In-Home	Health Occupations Article, Annotated Code of Maryland and COMAR 10.63.03	Certificate from national or intermediate purveyor	All providers must have a certificate or letter from the national or intermediate purveyor or developer of the particular evidence-based practice or promising practice or from MDH to demonstrate that the provider meets all requirements for the specific type of Intensive In-Home Service, including but not limited to the requirements for quality assurance, auditing, monitoring, data collection and reporting, fidelity monitoring, participation in outcomes evaluation, training, and staffing, as outlined in regulation. MDH will maintain a publicly available list of practices that meet the criteria for intensive in-home services, including but not limited to Family Centered Therapy (FCT) and Intervention Program For Children (IHIP-C). Providers of Intensive In-Home Services must ensure that 1) There are Clinical Leads, Supervisors, and Therapists on staff who are responsible for creating, implementing and managing the treatment plan with the child and family; and2) For IIHS models including an on- call and crisis intervention element, these services, are: 2) For IIHS models including an on-call and crisis intervention element, these services, are: i) Provided by a licensed mental health professional (psychiatrist, psychologist, nurse psychotherapist (APRN-PMH), psychiatric nurse practitioner (CRNP- PMH) LCSW-C, LCSW, or 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)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Intensive In- Home Services	BHA verifies provider approvals such as PRP, OMHC if applicable. BHA certifies programs not approved by BHA through its Administrative Service Organization	At the time of application, and through a representative sample on an annual basis

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

	Participant-directed	✔	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
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.

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):*

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 Behavioral 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 Behavioral 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)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Community- Based Respite Care	Health Occupations Article, Annotated Code of Maryland and COMAR 10.63.03.15		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: 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 10.63.03.15 for screening, assessment, staff training and expertise, provision of care, and conclusion of respite episode. a. Providers are approved by the Maryland Department

			of Health

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

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

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

	Participant-directed	✔	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: **Out-of-Home Respite**

Service Definition (Scope)*:*

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 Behavioral 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)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Out-of-Home Respite	Health Occupations Article, Annotated Code of Maryland and COMAR 10.63.03.15		Out-of-Home Respite Care Providers must: A. Meet the out-of-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 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 10.63.03.15 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)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Out-of-Home Respite Care	BHA initial verification of license or approval Administrative Service Organization on behalf of the Department	BHA: At the time of enrollment and at least every three years ASO: At the time of enrollment and through a representative sample annually

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

	Participant-directed	✔	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 Behavioral 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 hours monthly, unless specially approved by BHA for higher levels.

☑ Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Family Peer Support	N/A	The National Certification for Family Peer Specialists (CFPS). The provider may have the certificate, be in the process of obtaining it or under the supervision of an individual who has the certification.	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) 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; 3) 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 4) 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; and (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.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Family Peer Support	Administrative Service Organization on behalf of the Department	BHA: At the time of enrollment and at least every five years ASO

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

☐	Participant-directed	✔	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: **Expressive and Experiential Behavioral Services**

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)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
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: • Art Therapist certified by the Art Therapy Credentials Board in the American Art Therapy Association or licensed as a Licensed Clinical Professional Art Therapist (LCPAT) • Registered Dance Therapist or Dance Therapists Registered by the American Dance Therapy Association • Equine Therapist certified by the Equine Assisted Growth and Learning Association (EAGALA) or the Professional Association of Therapeutic Horsemanship International (PATH Int.) (formally the North American Riding for the Handicapped Association (MARHA)) • Horticultural Therapist registered by the American Horticultural Therapy Association • Music Therapist 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 • A comparable association with equivalent requirements The Maryland Department of Health 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)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Expressive and Experiential Behavioral Service	Administrative Service Organization on behalf of the Department	At the time of application and annually

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).

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):*

a. 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):*

b. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness 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)*:

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

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

d. 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.

e. ☐ **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.)

Requirement	1a) Service plans address the assessed needs of 1915(i) participants
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of service plans that adequately address the assessed needs of 1915(i) participants
Discovery Activity *(Source of Data & sample size)*	Defensible sample of case files (electronic or paper) of participants who were enrolled during the time period under review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA with CSAs/ LBHAs

Requirement	1a) Service plans address the assessed needs of 1915(i) participants
Frequency	Every 12 months
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA with CSAs/ LBHAs
Frequency *(of Analysis and Aggregation)*	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.

Requirement	1b) Service plans are updated annually
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans that are updated at least once in the last 12 months
Discovery Activity *(Source of Data & sample size)*	Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA with CSAs/ LBHAs

Requirement	1b) Service plans are updated annually
Frequency	Every 12 months
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA with CSAs/ LBHAs
Frequency *(of Analysis and Aggregation)*	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.

Requirement	1c) Service plans document choice of services and providers
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of participants whose POC indicates they were afforded choice in the selection of services and providers
Discovery Activity *(Source of Data & sample size)*	Review of all POC during identified time period for a defensible sample of participants who were enrolled during the time period under review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA with CSAs/ LBHAs

Requirement	1c) Service plans document choice of services and providers
Frequency	Every 12 months
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA with CSAs/ LBHAs
Frequency *(of Analysis and Aggregation)*	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.

Requirement	2a) Eligibility Requirements: 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
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of applicants who receive an evaluation for 1915(i) State Plan HCBS eligibility for whom there is a reasonable indication that the 1915(i) services may be needed in the future
Discovery Activity *(Source of Data & sample size)*	Review of all POC during identified time period for defensible sample of participants who were enrolled during the time period under review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ASO

Requirement	2a) Eligibility Requirements: 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
Frequency	Semi-Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA with ASO & CSAs
Frequency *(of Analysis and Aggregation)*	Based on findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

Requirement	2b) Eligibility Requirements: the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reviewed 1915(i) evaluations that were completed using the processes and instruments approved in the 1915(i) HCBS State Plan
Discovery Activity *(Source of Data & sample size)*	Review of all POC and referral forms uploaded into the ASO's system during the identified time period for a defensible sample of participants who were enrolled
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ASO

Requirement	2b) Eligibility Requirements: the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Frequency	Semi-Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA with ASO & CSAs
Frequency *(of Analysis and Aggregation)*	Based on findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies

Requirement	2c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually, as specified in the state plan for 1915(i) HCBS
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of participants who were re-evaluated for eligibility after one year.
Discovery Activity *(Source of Data & sample size)*	Review of authorization data for participants who were continually enrolled for one year from the sample
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ASO

Requirement	2c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually, as specified in the state plan for 1915(i) HCBS
Frequency	Semi-Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH
Frequency *(of Analysis and Aggregation)*	Based on findings, the MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

Requirement	3a) Providers meet required qualifications
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of providers who have submitted 1915(i) HCBS claims who are approved as providers by Maryland Medicaid
Discovery Activity *(Source of Data & sample size)*	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.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ASO

Requirement	3a) Providers meet required qualifications
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA
Frequency *(of Analysis and Aggregation)*	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.

Requirement	3b) Providers meet required qualifications
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of providers who meet the initial and ongoing requirements established by MDH/BHA
Discovery Activity *(Source of Data & sample size)*	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.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	ASO

Requirement	3b) Providers meet required qualifications
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA
Frequency *(of Analysis and Aggregation)*	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.

Requirement	4) Settings meet the home and community- based setting requirements as specified in this SPA
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of youth who are dis-enrolled as a result of moving to a setting that is not authorized in this SPA
Discovery Activity *(Source of Data & sample size)*	Semi-annual sampling of entire enrolled roster
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA with the CSAs/ LBHAs

Requirement	4) Settings meet the home and community- based setting requirements as specified in this SPA
Frequency	Semi-Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA
Frequency *(of Analysis and Aggregation)*	Based on the findings, The State Medicaid Agency and BHA will create a performance improvement plan within 30 working days of identification of deficiencies

Requirement	5a) The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of quarterly progress reports submitted to MDH/the State Medicaid Agency
Discovery Activity *(Source of Data & sample size)*	Quarterly reports are provided to The State Medicaid Agency by the ASO
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA

Requirement	5a) The SMA retains authority and responsibility for program operations and oversight.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA & MDH/State Medicaid Agency
Frequency *(of Analysis and Aggregation)*	Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

Requirement	5b) The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of enrollment census updates distributed to the State Medicaid Agency
Discovery Activity *(Source of Data & sample size)*	Review of distribution list for census updates issued by the ASO
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA

Requirement	5b) The SMA retains authority and responsibility for program operations and oversight.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA & MDH/State Medicaid Agency
Frequency *(of Analysis and Aggregation)*	Based on the findings, MDH and BHA will create a performance improvement plan within 30 working days of identification of deficiencies.

Requirement	6a) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of HCBS benefit service claims processed appropriately against fund source, authorization history, service limitations, and coding.
Discovery Activity *(Source of Data & sample size)*	Defensible sampling strategy; point in time review of services received.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/ASO

Requirement	6a) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA
Frequency *(of Analysis and Aggregation)*	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.

Requirement	7) The state identifies, addresses and seeks to prevent incidents of abuse, neglect, exploitation, including the use of restraints, and unexplained deaths.
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of reportable events involving abuse, neglect, exploitation, and/or unexplained deaths reported that are resolved according to policy
Discovery Activity *(Source of Data & sample size)*	All reportable event forms are reviewed for compliance.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDH/BHA

Requirement	7) The state identifies, addresses and seeks to prevent incidents of abuse, neglect, exploitation, including the use of restraints, and unexplained deaths.
Frequency	Annually, and continuously, as needed when a complaint/incident is received.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDH/BHA
Frequency *(of Analysis and Aggregation)*	MDH will investigate if a performance improvement plan is needed. If necessary, the program director must submit a proposal within 10 working days.

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

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.

2. Roles and Responsibilities

MDH, BHA, in conjunction with the ASO and the CSAs, will gather and analyze the data and identify areas for quality improvement.

3. Frequency

Annually

4. Method for Evaluating Effectiveness of System Changes

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

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 full benefit 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. lf 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 long term care 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 aged 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 l 902(a)(l 0)(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.
    6. Effective October 1, 2023, CFC individuals will be able to choose from the agency or self-directed model. All CFC individuals are considered eligible to participate in the self-directed model.
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). Maryland Access Point (MAP) is a gateway to long term services and supports in Maryland (also known as no wrong door entry

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

point). MAP Specialists connect individuals with public and private resources for long term services and supports. Individuals are primarily referred to the CFC program by MAP Specialists through the State's data management system or by emailing or calling the Department. Individuals may also be referred to the CFC program by local Areas on Aging, Local Health Departments, Supports Planning Agencies, friends and family, Department of Human Services, Department of Social Services, or any other entity that interacts with an individual expressing interest in the program. Like MAP, these entities would refer individuals by emailing or calling the Department. Lastly, an individual may also contact the Department directly by emailing or calling to be referred to the CFC program.

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.

X 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

X Financial Management Services in Accordance with 441.545(b)(l)

___Other Service Delivery Model as Described Below:

Financial Management Services

The State will make financial management services available to all individuals in the self-directed model through its contracts with one or more Financial Management and Counseling Services (FMCS) contractor(s). The State assures that financial management service activities will be provided in accordance with 42 CFR 441.545(B)(1).

In addition to the activities the FMCS contractor(s) is/are required to provide in accordance with 42 CFR 441.545(B)(1), the FMCS contractor(s) will be responsible for reviewing and confirming the person-centered service plans for individuals in the self-directed model. An individual's chosen supports planner (e.g., independent case manager) is responsible for creating the person-centered service plan in collaboration with the individual and/or the individual's authorized representative. The Department is responsible for rendering a decision on the person-centered service plan (e.g.; approve, deny, or seek clarification before rendering a decision).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

The FMCS activities will include:

- Providing education on the philosophy of self-direction to assist an individual with making an informed decision on a service delivery model;
- Assisting an individual with recruiting, hiring, and dismissing staff;
- Assisting an individual with establishing a pay rate for staff;
- Counseling an individual on budget development and utilization;
- Assisting an individual with employment taxes and insurance and payroll processing; and
- Training the individual, the individual's authorized representative, and/or direct service staff.

The FMCS will be claimed as an administrative service.

iii. Service Package

A. The following are included Community First Choice 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 personal assistance (formerly named personal care) services.

a. Personal assistance services mean hands-on assistance, supervision, and/or cueing specific to the functional needs of an individual 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 recommended budgets. The interRAI is a globally recognized standardized assessment that allows for person-centered comprehensive planning of services and supports for elderly and disabled individuals living in community-based settings. Upon completion of the interRAI assessment, the state's data management system will automatically populate certain results including level of care, clinical recommendations, and a RUG score based on the individual's medical and activities of daily living (ADL) needs. The Department partnered with the Hilltop Institute to develop RUG budgets informed by service utilization and spending. This methodology is applied consistently among all individuals applying for or enrolled in the CFC program. The highest RUG correlates to a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

recommended initial flexible budget of $43,680 annually, but it is not the maximum amount of services or hours an individual can receive.

ii. There will be an initial recommended budget for personal assistance services based on RUGs, or other case mix strategy, that will help inform supports planners and individuals in developing the plan of service. This is a soft limit, which can be exceeded based on medical necessity.

iii. Prior authorization with a medical necessity review is needed if an individual requests services with associated costs above and beyond the recommended budget.

The State will claim an enhanced match on this service.

b. Nurse Monitoring - Nurse monitors will evaluate the outcome of the provision of personal assistance services. This service will be provided by the Local Health Departments.

The State will claim an enhanced match on this service.

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.

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 individual receiving the training and sensitive to the educational background, culture, and general environment of the individual receiving the training.

ii. To participate in the Community First Choice program as a provider of consumer training, a provider must: 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 individual'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 individual may work on activities that aid in the acquisition, maintenance, and enhancement of skills.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

The State will claim an enhanced match on this service.

c. Items that increase independence and substitute for human assistance as described in B.1. Individuals 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 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 an individual 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 Community First Choice individuals 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.
      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 individual's plan of service (POS) and the units submitted for payment may not exceed what is approved in the individual's POS. There is no lifetime limit on the number of installation fees, but each additional installation will need to be approved in the individual's POS.

   The State will claim an enhanced match on this service.

3. Voluntary training on how to select, manage, and dismiss personal assistance providers.
   a. The State will develop training materials and provide technical assistance to supports planners who are responsible for providing training to individuals in the agency model. For individuals in the self-directed model, supports planners will provide information about self-direction and make a referral to the Financial Management and Counseling Services (FMCS) contractor of the individual's choice. The FMCS contractors are responsible for training self-directing individuals.
      i. Supports planners must meet minimum qualifications established through a solicitation process. Current standards are:
         - At least two (2) years of experience providing community-based case management and/or supports planning for individuals with complex medical and/or behavioral health needs, older adults,

children and youth with disabilities beyond those ancillary to the provision of other services;

- Knowledge of resources available for individuals with complex medical and/or behavioral health needs, older adults and/or adults, children and youth with disabilities. These resources may include private, public, non-profit, local, regional, and national entities;
- At least two (2) year of experience working with Medical Assistance programs, including Managed Care Organizations (MCOs);
- At least two (2) years of experience working with Medicare and/or private insurance programs in conjunction with Medical Assistance programs;
- Freedom from any conflicts of interest;
- Linguistic competency, including, at a minimum, standard operating procedures that demonstrate compliance with the Department's Limited English Proficiency (LEP) Policy and a scope of work from an interpretation and translation services vendor.

ii. FMCS contractors must meet minimum qualifications established through a procurement process. Current standards are:

- The FMCS agency must not be on the Health and Human Service (HHS) Office of the Inspector General's List of Excluded Participants and Entities (LEIE) or the federal General Services Administration System for Award Management (SAM).

b. Supports planners will provide training to individuals upon enrollment and at the individual's or Department's request thereafter. The FMCS contractors will provide training to individuals upon enrollment in the self-directed model and at the individual's or Department's request thereafter. Even when an individual chooses to waive supports planning, the individual will still be assigned a supports planner in the Department's data management system in the event the individual needs assistance or would like to request training.

The State will claim an enhanced match on this service.

4. Support System Activities
   a. Under Community First Choice, the Area Agencies on Aging and supports planning providers identified through a competitive solicitation will engage individuals in a person-centered planning process that identifies the goals,

strengths, risks, and preferences of the individual. Supports planners will coordinate community services and supports from various programs and payment sources to aid individuals in developing a comprehensive plan for community living. Supports planners will support individuals in accessing housing services, identifying housing barriers such as past credit issues, evictions, or convictions, and in resolving the identified barriers. Supports planners will assist the individual in developing a comprehensive plan of service that includes both state and local community resources, coordinating the transition from an institution to the community, and maintaining 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 appropriate information, training, and assistance to ensure that individuals are able to manage their services.

    Individuals in the self-directed model will also be supported by the Financial Management and Counseling Services (FMCS) contractors through counseling and training on managing their services and budgets. Information regarding these supports will be communicated to an individual in a manner and language understandable by the individual, including communications in plain language and the provision of needed auxiliary aids and services, when applicable.
c. Also in accordance with §441.555 of the CFR, the individual's chosen Supports Planning Agency and FMCS contractor (if individual is interested in self-direction) will discuss:
    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 risks and responsibilities in self-direction,
    vi. The ability to freely choose from available home and community-based providers, available service models, and for self-directing individuals, available FMCS contractors,
    vii. Individual rights, including appeal rights,
    viii. Reassessment and review schedules,
    ix. Goals, needs, and preferences of Community First Choice (CFC) services and supports,
    x. Identifying and accessing services, supports, and resources,
    xi. Risk management agreements, including,
        A.) Tools and instruments used to mitigate identified risks,

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

B.) Criminal or background checks as part of the risk management agreement.

xii. A personalized back-up plan,

xiii. Information on how to recognize and report critical events; and

xiv. Information about how an individual can access a Maryland-based advocate or advocacy system.

d. In accordance with §441.550 of the CFR, the POS for individuals in the self-directed model will authorize the individual to perform, at minimum, the following tasks:

i. Recruit and hire or select providers to provide self-directed CFC services and supports, including specifying personal assistance provider qualifications,

ii. Dismiss providers of self-directed CFC services and supports,

iii. Supervise providers in the provision of self-directed Community First Choice (CFC) services and supports,

iv. Manage providers in the provision of self-directed CFC services and supports, which includes determining provider duties, scheduling providers, training providers in assigned tasks, and evaluating providers' performance,

v. Determining the amount paid for a self-directed CFC service, support, or item, in accordance with state and federal compensation requirements; and

vi. Reviewing and approving provider payment requests for self-directed CFC services and supports.

The State will claim an enhanced match on this service.

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

1. Expenditures relating to a need identified in an individual's person-centered plan of service 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 or an appropriate license from the state in which the site is located.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

2. This service will be provided as it substitutes for human assistance and, along with personal assistance, is limited by the Resource Utilization Group allocated budget. As noted previously, there is an exceptions process for individuals requesting services in an amount greater than the recommended budget.
3. Home-delivered meals may not be approved for individuals who require assistance warming up a meal, feeding oneself and/or cleaning up after the meal.
4. The number of approved meals may not exceed 14 per week and a maximum of two meals per day.

ii. Environmental Assessments

1. The service must be provided by 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, chronic illness, or condition in a individual, environmental factors in the facility or home, the individual's ability to perform activities of daily living (ADLs), the individual's strength, range of motion, and endurance, and the individual's need for assistive devices and equipment.

iii. Technology that Substitutes for Human Assistance

1. To participate as a provider of assistive devices, equipment, or technology services, the provider must be either a provider of disposable medical supplies and durable medical equipment or the store, vendor, organization, or company, which sells or rents the equipment or system, subject to approval by the Department or its designee 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 an individual to live in the community and/or participate in community activities.
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 ADLs 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, except in the case of a request for a repair to a stair glide with associated costs at or below $1,500. 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.
7. This expense will be combined with adaptations and together be capped at $15,780, per individual, for every three-year period.
8. The Department may approve services that exceed this cost cap in circumstances where there is documentation that the additional services will reduce the on-going cost of care or avert institutionalization. The units of service may not exceed what is approved in the individual's plan of service (POS).

iv. Accessibility Adaptations

1. Accessibility adaptations empower an individual to live in the community and/or participate in community activities.
2. Adaptations may include wheelchair ramps or lifts, stair glides, widening doorways, roll-in showers, roll-under sinks, pull-down cabinetry, and other barrier removal.
3. Each adaptation must:
    a. Be pre-authorized by the Department or its designee through the POS as necessary to prevent the individual’s institutionalization,
    b. Ensure the individual’s health, safety, and independence,
    c. Specifically relate to activities of daily living or instrumental activities of daily living,
    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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

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 individual,
    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 $15,780, per individual, for every three-year period.
6. The Community First Choice (CFC) program only covers items not covered under the State plan home health benefit.

The State will claim an 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 the CFC program. The State will administer transition funds until such time as a contractor can be secured via a procurement. Transition services will be covered when based on assessment of need and listed as a service in the individual's recommended plan of care.
        i. Televisions, television access, or gaming units are not covered by transition services.
        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 individual, per transition.

The State will claim an enhanced match on these services.

iv. Use of Direct Cash Payments

___The State elects to disburse cash prospectively to CFC individuals. The State assures that all Internal Revenue Service requirements regarding payroll/tax filing functions will be followed, including when individuals perform the payroll/tax filing functions themselves.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

X The State elects not to disburse cash prospectively to CFC individuals.

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 personal assistance 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 personal assistance services and supports that the individual requires in order to lead an independent life.

D. With respect to expenditures during the first 12-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 personal assistance services and supports provided under section 1905(a), section 1915, section 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 personal assistance services and supports.

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

1. The number of individuals who are estimated to receive home and community-based personal assistance services and supports under this option during the fiscal year.
2. The number of individuals that received such services and supports during the preceding fiscal year.
3. The specific number of individuals served by type of disability, age, gender, education level, and employment status.
4. Data regarding how the State provides Community First Choice (CFC) and other home and community-based services.
5. The cost of providing CFC and other home and community-based services and supports.
6. The specific number of individuals previously served under any other home and community-based services program under the State plan or under a waiver.
7. Data regarding the impact of CFC services and supports on the physical and emotional health of individuals.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

8. 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 personal assistance 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:
   1. Withholding and payment of federal and state income and payroll taxes.
   2. The provision of unemployment and workers compensation insurance.
   3. Maintenance of general liability insurance.
   4. Occupational health and safety.
   5. 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, older adults, and their representatives. The Department discussed the self-direction service delivery model with the council and included their feedback in the implementation plan.

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. Prior to enrollment in the Community First Choice (CFC) program, the Local Health Departments or a State contractor conduct a comprehensive evaluation, which includes a standardized assessment of need. After enrollment, CFC individuals are assessed annually and upon a significant change in health or functional status.
   1. The assessment is performed in-person by a licensed registered nurse or licensed social worker and entered in the Department's data management system.
   2. The individual's plan of service is completed by a supports planner chosen by the individual.
   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 claim an enhanced match on these services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

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

B. The Local Health Departments or a State contractor conduct the initial, annual, and significant change evaluations, which include a standardized assessment of need. Assessments are completed upon application to the CFC program to determine initial eligibility and annually to maintain eligibility.

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 health or functional status will be conducted in the same manner and by the same entity as the initial and annual assessments. Per 42 CFR 441.535(c) and 441.540(c), a Community First Choice (CFC) individual may also request a reassessment at any time.

Describe the process that is used to develop the person-centered service plan, including 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 the individual receives and from whom:

D. Several entities are involved in the development of the plan of service (POS) with the individual, including the supports planner. After receiving a referral, the Local Health Departments or a State contractor schedule a visit with the individual to conduct a comprehensive evaluation, including the completion of a standardized assessment of need. The Local Health Departments or State contractor make recommendations for services and supports in the recommended plan of care based on the standardized assessment of need.

E. All CFC applicants are mailed a package with brochures of available supports planning agencies for their jurisdiction. Per 42 CFR 441.540(a)(l), an individual may select from any available supports planning agency in the jurisdiction. The applicant may call the Department or the supports planning agency to indicate agency selection, which is entered in the Department's data management system. The assigned supports planner schedules and completes an in-person meeting with the applicant and the applicant's identified representative, if applicable, to explore the applicant's needs, preferences, strengths, risks, and goals through a person--centered planning process. Supports planning agencies have demonstrated the ability to be culturally sensitive and effectively relate to the cultural/ethnic diversity of program individuals. Individuals can choose a new supports planning agency if they are unsatisfied with their current selection.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

F. Supports planners use the Department's data management system and have access to the recommended plans of care completed by the assessors. Using that information and input from the individual, a supports planner creates a proposed POS. Supports planners assist individuals in identifying enrolled providers and make referrals for counseling and training on self-direction, when requested.

G. Supports planners coordinate community services and supports from various programs and payment sources to aid individuals in developing a comprehensive plan for community living. Person-centered planning is essential to assure that the individual's personal strengths, goals, risks, and preferences are incorporated into service planning and reflected on the plan of service (POS). Supports planners engage individuals in a person-centered planning process designed to offer individuals choice and control over the process and resulting plan. Per 42 CFR 441.540(a)(1), the person-centered planning process may include representatives chosen by the individual.

H. Risk mitigation strategies, including back-up plans that are based on the unique needs of the individual, aim to 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 contains 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, and back-up staffing. The proposed POS is effective upon approval by the Department or its designee.

I. Per 42 CFR 441.530(a)(l)(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).

Describe the timing of the person-centered service plan to assure the individual has access to services as quickly as possible, the frequency of review, how and when the plan is updated, and mechanisms to address an individual's changing circumstances and needs:

J. The process begins when an applicant expresses interest in the Community First Choice program. The Department or the Maryland Access Point sites initiate a referral to the Local Health Department for the comprehensive evaluation. The assessment and recommended plan of care are completed within 15 calendar days of referral.

K. Supports planner selection begins when the medical and financial eligibility processes have been completed. The Department or the Maryland Access Point sites mail a supports planning

selection packet to the applicant at the same time that they make the referral for an assessment. An applicant has 21 calendar days to select a supports planner or one will be automatically assigned via the Department's data management system. Individuals may choose to switch to a different supports planning agency, that has availability, at any time. Individuals can do this by calling the Department, the existing supports planning agency, or the new supports planning agency of their choice. The supports planner has 20 days to submit the plan of service (POS) after the completion of the comprehensive evaluation and recommended plan of care.

L. Supports planners assist applicants in the creation of an initial plan, which must be approved by the Department or its designee prior to enrollment. Supports planners must submit a POS annually and upon a change in the individual's needs or at the individual's request. As with the initial plan, the Department or its designee must review and approve an annual or revised POS before changes are effective.

Describe 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 comprehensive evaluation, which includes a standardized assessment of need, is completed by a licensed registered nurse or licensed social worker. The POS is developed 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 standardized assessment of need and completing the POS with the individual. Supports planning entities that have responsibility for service plan development may not provide other direct services to individuals unless there are administrative separations in place to prevent and monitor potential conflicts of interest.

N. The Department or its designee reviews and approves all POS prior to implementation to assure that there are no conflicts of interest.

vii. Home and Community-Based Settings

Specify the settings Community First Choice (CFC) services will be provided:

A. 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.

B. CFC services are 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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

unrelated individuals. CFC individuals may receive services in the workplace or other community settings, but services may not be provided in provider-owned or provider-controlled settings. Settings criteria will meet the requirements of 42 CFR 441.530.

viii. Qualifications of Providers of Community First Choice (CFC) Services

A. In accordance with CFR 441.565 (a)(l)-(3):
    1. An individual retains the right to train personal assistance providers in the specific areas of assistance needed by the individual, and to have the personal assistance 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 personal assistance provider(s) can meet any additional qualifications required or desired by individuals.
B. In accordance with 42 CFR 441.565(c):
    1. For the self-directed model with a service budget, an individual has the option to permit family members, or any other individuals, to provide CFC services and supports identified in the person-centered service plan, provided they meet the qualifications to provide the services and supports established by the individual, including additional training.
C. Provider qualifications are designed to ensure necessary safeguards to protect the health and welfare of individuals. Personal assistance providers are Residential Service Agencies licensed by the Office of Health Care Quality or, for individuals in the self-directed model, one or more individuals employed by the individual.
    1. Agency providers of personal assistance and individuals employed by self-directing individuals to provide personal assistance are required to be certified in the performance of first aid and Cardiopulmonary Resuscitation.
    2. Agency providers of personal assistance must receive instruction, training, and assessment from the agency's delegating nurse regarding all services identified in the individual's care plan.
    3. An agency provider of personal assistance must be a Certified Nursing Assistant if engaging in delegated tasks, which would normally be performed by a nurse or either a Certified Medicine Aide or a Medication Technician if administering medications.
    4. Agency providers of personal assistance are required to verify that all workers providing personal assistance have complied with background check requirements. Individuals in the self-directed model are also required to complete a background check on any individual they intend to employ, prior to hire, but have the right to waive any further

action based on the results of the background check unless the results indicate a history of behavior that could be harmful to individuals.

5. All providers of CFC services must meet the Department's general Medicaid provider requirements and general requirements for CFC participation. Agency providers of personal assistance are required to ensure that their workers meet the applicable standards prior to working with CFC individuals.
6. To participate as a provider of accessibility adaptations, a provider must have a current license with the Maryland Home Improvement Commission.

ix. Quality Assurance and Improvement Plan

Describe the State's Community First Choice (CFC) quality improvement strategy, including:

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. The CFC program will adopt the waiver Quality Improvement Strategy, where appropriate. CFC will have a Quality Improvement Strategy designed to continuously review operations and when issues are discovered, remediate those issues and implement quality improvement activities to prevent the repeat of operational problems. The State Medicaid Agency oversees a cross-agency quality committee called the Home and Community-Based Services (HCBS) Council. The HCBS Council meets regularly to address operational issues through data analyses, share program experiences and information, and further refine the Quality Improvement Strategy.
B. The Office of Long Term Services and Supports (OLTSS) is the lead entity responsible for trending, prioritizing, and implementing system improvements; as such, the OLTSS collects, aggregates, and analyzes data in support of this. While most of these data are maintained in the Department's data management system and the Medicaid Management Information System, the OLTSS also collects and aggregates data outside of these systems; for example, through ongoing provider audits. The OLTSS utilizes a combination of reports built into the Department's data management system and custom reports to extract and aggregate data. Most data analysis conducted by the OLTSS is quantitative, rather than qualitative, and most often seeks to evaluate the delivery and quality of CFC services and supports.
C. Partners in the Quality Improvement Strategy include, but are not limited to the Office of Health Care Quality, providers, individuals, individuals' families, the Community Options Advisory Council, and the HCBS Council. The State may convene a specific task group to address significant problem areas, which will include stakeholders from the partners identified above.
D. In accordance with the Department's Reportable Events Policy, all entities associated with the CFC program are required to report alleged or actual adverse incidents that occurred with

individuals. All reportable events for CFC individuals are analyzed by the OLTSS to identify trends related to areas in need of improvement. Any person who believes that an individual has experienced abuse, neglect, or exploitation is required to immediately report the alleged abuse, neglect, or exploitation to law enforcement and Adult or Child Protective Services, as appropriate. The event report must be submitted to the Office of Long Term Services and Supports (OLTSS) within one (1) business day of knowledge or discovery of the incident.

E. The OLTSS, or its designee, monitors provider settings and service delivery through a variety of activities, including reviews of provider data, plans of service (POS), reportable events noting alleged or actual adverse incidents that occurred with individuals, and conducting on-site visits to sites. The Department continues to utilize the Community Settings Questionnaire (CSQ), which was implemented at the inception of the Community First Choice (CFC) program, to determine whether an individual's setting is compliant. An individual's supports planner completes a CSQ with the individual and/or the individual's identified representative, if applicable, during the initial and annual plan processes, and upon any change in the individual's residence. The OLTSS reviews all CSQ to determine if the individual resides in a compliant setting, and will review aggregated CSQ data, as needed, to ensure continual compliance.

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

F. Performance Measures
    1. As noted, the Department has adopted the waiver Quality Improvement Strategy, where appropriate, including collecting and analyzing data on CFC individuals, services, and supports for all performance measures that are included in the approved waiver application. Current performance measures seek to evaluate the timeliness of level of care determinations and the person-centered planning process, the effectiveness of the person-centered planning process in meeting individuals' needs, maintenance of provider qualifications, effectiveness of the incident management system in assuring individuals' health and welfare, and fiscal integrity. The Department reviews these data quarterly to identify opportunities for continuous quality improvement.
    2. In addition to the performance measures outlined in the waiver application, the Department evaluates performance through reports built into the Department's data management system and custom reports on interRAI assessments, supports planning, POS, nurse monitoring, and reportable events.

G. Outcome Measures
    1. The Department is able to track individuals' health and functional status over time using the standardized assessment of need (currently the Department uses the interRAI assessment) and analyze data by service type and key demographics. The Department

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

intends to use these data to evaluate the degree to which the receipt of CFC services and supports is positively correlated with improvements in health outcomes over time.

H. Satisfaction Measures

1. The Department currently utilizes the Money Follows the Person Quality of Life Survey, amended with several questions from the Participant Experience Survey to evaluate individuals' satisfaction with the Community First Choice (CFC) program. The Department or its designee analyze the results of the surveys and use the results to inform programmatic changes. The Department will perform these surveys internally with a random sample of individuals until such time as the Department is able to secure a contractor through a procurement process.

How the State's quality assurance system will measure individual outcomes associated with the receipt of community-based personal assistance services and supports;

I. As noted in relation to outcome measures, the Department is able to track individuals' health and functional status over time using the interRAI assessment and analyze data by service type and key demographics. The Department intends to use these data to evaluate the degree to which the receipt of CFC services and supports is positively correlated with improvements in health outcomes over time.

J. The Department also utilizes reports available in its data management system to monitor progress on an individual's individual goals, which are included in the individual's plan of service and monitored by the individual's supports planner during quarterly and annual visits.

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;

K. The Office of Long Term Services and Supports is responsible for the operation and oversight of the incident reporting and management system for CFC individuals. The Reportable Events (RE) Policy helps to ensure individuals' health and welfare in the community, and uphold the rights and choices of individuals, by formalizing a process to identify, report, and resolve RE in a timely manner. RE are defined as the allegation or actual occurrence of an incident that adversely affects, or has the potential to adversely affect, the health and/or welfare of an individual. RE must be entered into the Department's data management system. Currently, only supports planners and Local Health Department assessors and nurse monitors are authorized to enter RE into the Department's data management system; however, per the RE Policy, all CFC providers are required to report RE upon knowledge or discovery. All CFC providers must comply with the legal responsibility to report suspected abuse, neglect, and/or exploitation to Adult Protective Services or Child Protective Services, as applicable, and/or law enforcement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

L. The supports planner must also develop and submit an intervention and action plan, which seeks to address, to the extent possible, the root cause of the incident detailed in the RE. During its detailed review and follow-up, the Office of Long Term Services and Supports will ensure that the intervention and action plan and any subsequent actions taken, assure the individual's immediate safety and reasonably address the root cause of the incident. This includes ensuring that appropriate referrals have been made to external parties responsible for the investigation of alleged abuse, neglect, and exploitation, and tracking progress until resolution.

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;

M. Supports planners provide training to individuals in the agency model, using materials and guidance developed by the Department, on managing their services in a way that maximizes independence and control. Supports planners also provide information on the self-directed model to all individuals and refer individuals to the Financial Management and Counseling Services (FMCS) contractors if individuals are interested in self-direction. FMCS contractors are responsible for training self-directing individuals.

N. Supports planners meet with individuals at least once every 90 days to monitor implementation of individuals' plans of service and identify any unmet needs. Individuals who choose to waive these minimum contact standards may identify unmet needs via a consumer portal in the Department's data management system. An individual may submit a revised plan to the Department or its designee at any time.

O. Individuals whose service requests are denied by the Department or its designee receive a denial letter, which includes the 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 and/or the individual's identified representative, if applicable, to follow to request an appeal, as well as the time frames to do so. The letter also includes information regarding required procedures to ensure continuation of benefits, if applicable, while the appeal process is underway. The Department or its designee mails the letter to the individual and the individual's identified representative, if applicable. The independent Office of Administrative Hearings (OAH) sends the appellant/representative information regarding the date and time of the hearing. The OAH includes information, which explains the nature of administrative hearings 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 attorney. The information from the OAH also includes contact information for Legal Aid and Disability Rights Maryland, the State's Protection and Advocacy Agency,

instructions on how to obtain special accommodations, such as an interpreter, and conditions under which an appellant may request a postponement. Individuals and/or their identified representatives, if applicable, may request assistance applying for a Fair Hearing from a provider, supports planner, or other individual of their choosing.

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;

P. Supports planners educate individuals 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 refer individuals who are interested in self-direction to Financial Management and Counseling Services (FMCS) contractors and assist individuals in selecting providers of consumer training services and learning how to navigate the consumer portal of the Department's data management system. Individuals may monitor provider time keeping, view reports, and request updates to their plans of service through the Department's data management system.

Q. Individuals employed by individuals in the self-directed model to provide personal assistance will not use the Department's Electronic Visit Verification (EVV) system and the individual is responsible, with support from the FMCS, for utilizing the contractor's system to track the employees' hours worked.

R. Effective July 1, 2023, personal assistance providers residing with individuals to whom they are providing services may be exempted from the EVV requirement.

How the State will elicit feedback from key stakeholders to improve the quality of the community-based personal assistance services and supports benefit;

S. The Community First Choice (CFC) Development and Implementation Council, currently referred to as the Community Options Advisory Council, remains a consumer majority committee that advises the Department on specific program policies, overall program direction, and opportunities for continuous quality improvement. The Council meets at least quarterly, either in-person or virtually, with attendance from stakeholders and advocates.

The methods used to continuously monitor the health and welfare of CFC individuals; and

T. The Department monitors the health and welfare of Community First Choice individuals through all of the previously noted performance, outcome, and satisfaction measures, as well as through

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Maryland

Community First Choice State Plan Option

its continuous evaluation of performance through reports built into the Department's data management system and custom reports on interRAI assessments, supports planning, plans of service, nurse monitoring, and reportable events.

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

U. The person-centered planning process begins before the individual's choice of a supports planner. The Department mails materials to individuals on all available supports planning agencies, by jurisdiction, and includes information on all resources and services available. Supports planners are required to counsel individuals on their choice between receiving institutional and community-based services during the initial and annual person-centered planning processes.

Alternative Benefit Plan

State Name: Maryland | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: MD - 18 -0012

Alternative Benefit Plan Populations — ABP1

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

Alternative Benefit Plan Population Name: SSA 1902 (a)(10)(A)(i)(VIII) - Adult Group

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:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

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.

V.20160722

Alternative Benefit Plan

State Name: Maryland | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: MD - 18 - 0012

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

V.20160722

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

Approval Date: November 15, 2018
Effective Date: July 1, 2018

Alternative Benefit Plan

State Name: Maryland | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: MD - 18 -0012

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

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).

Selection of Base Benchmark Plan

TN No: MD 18-0012
Supercedes: MD 15-0007
Approval Date: November 15, 2018
Effective Date: July 1, 2018

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

V.20160722

Alternative Benefit Plan

State Name: Maryland | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: MD - 18 - 0012

Alternative Benefit Plan Cost-Sharing — ABP4

☑ 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. **No**

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

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

Approval Date: November 15, 2018
Effective Date: July 1, 2018

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services — Collapse All ☐

Benefit Provided: Physician Services
Source: State Plan 1905(a)
Remove

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 serices 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
Source: State Plan 1905(a)
Remove

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
Source: State Plan 1905(a)
Remove

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.

Remove

Benefit Provided: Clinic Services

Source: State Plan 1905(a)

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:

Remove

Benefit Provided: Home Health Care Services: Nursing & Aide Services

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:

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.

Remove

Benefit Provided: Personal Care Services

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Alternative Benefit 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:

Benefit Provided:
Community First Choice

Source:
State Plan 1915(k)

Remove

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:

Benefit Provided:
Federally-Qualified Health Services

Source:
State Plan 1905(a)

Remove

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:

Benefit Provided:
Hospice Care- in home/ambulatory setting

Source:
State Plan 1905(a)

Remove

Alternative Benefit Plan

Authorization:
Other

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:
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.

Benefit Provided:
Abortions-Hyde Compliant

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None - These are abortions that comply with the Hyde Amendment

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

☑ 2. Essential Health Benefit: Emergency services — Collapse All ☐

Benefit Provided: Outpatient Hospital: Emergency Hospital Services
Source: State Plan 1905(a)
Remove
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:

Benefit Provided: Any Other Medical Care: Em. Transportation
Source: State Plan 1905(a)
Remove
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

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization — Collapse All ☐

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

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 — Collapse All ☐

Benefit Provided: Inpatient Hospital Care- Maternity and Newborn
Source: State Plan 1905(a)
Remove

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

Benefit Provided: Physician Services-Maternity and Newborn
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Note- Program requires authorization for physician services for certain inpatient services, such as Transplant Services. There is not authorization for normal maternity care.

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

Benefit Provided: Clinic Services- Maternity and Newborn
Source: State Plan 1905(a)
Remove

Authorization: None
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:

Benefit Provided:
Services furnished by Nurse Midwife

Source:
State Plan 1905(a)

Remove

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

Alternative Benefit Plan

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided: Outpatient Hospital Services-Mental Health/Subs

Source: State Plan 1905(a)

Remove

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 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: Physician Services-Mental Health/Sub

Source: State Plan 1905(a)

Remove

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 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: Clinic Services-Mental Health

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Alternative Benefit 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 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:
Medical Care Furnished by Licensed Practitioners

Source:
State Plan 1905(a)

Remove

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:

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.

Benefit Provided:
Inpatient Hospital Services - MH/SUD

Source:
State Plan 1905(a)

Remove

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:

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.

Add

☒ 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.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☒ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

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.

Alternative Benefit Plan

☑ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

Benefit Provided: Physical Therapy and Related Services-Rehab.
Source: State Plan 1905(a)
Remove

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)
Remove

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 Supples 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)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
100 days or less per 12 month eligibility period

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.

Benefit Provided:
Habilitation Services- Physical Therapy and Other

Source:
State Plan Other

Remove

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:
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.

Benefit Provided:
Prosthetic devices

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

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 osseoint. 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.

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services — Collapse All ☐

Benefit Provided: Other Laboratory and X-Ray Services

Source: State Plan 1905(a)

Remove

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

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

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).

Benefit Provided: Physician Services

Source: State Plan 1905(a)

Remove

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:

Benefit Provided: Medical Care by Other Licensed Practitioners

Source: State Plan 1905(a)

Remove

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:

These providers include nurse practitioners and nutritionists/dietitians.

Benefit Provided: Home Health Care Services - DME/DMS - Diabetes

Source: State Plan 1905(a)

Remove

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.

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: State Plan 1905(a)

Remove

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

Alternative Benefit Plan

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Primary Care Visit-Duplication
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Specialist Visit-Duplication
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Mastectomy Related Services-Duplication
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Outpatient Facility Fee-Duplication
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Urgent Care Facilities
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Admin. of Injectable Prescrip. Drugs-Duplication
Source: Base Benchmark
Remove

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:

Administration of Injectable Prescription Drugs by a Health Care provider was mapped to the 'ambulatory patient' EHB category. The services are a duplication of Physician Services in the existing State Plan.

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

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:

Routine Gynecological Care was mapped to 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:	Source:	
Renal Dialysis-Duplication	Base Benchmark	Remove

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:

Renal Dialysis was mapped to the 'ambulatory patient' EHB category. The services are a duplications of Outpatient Hospital Services in the existing State Plan.

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

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:

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:	Source:	
Clinical Trial Patient Cost Services-Duplication	Base Benchmark	Remove

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:

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:	Source:	
Other Practitioner Office Visits-Duplication	Base Benchmark	Remove

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:

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

Base Benchmark Benefit that was Substituted:	Source:	
Home Health Services-Duplication	Base Benchmark	Remove

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:

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.

Base Benchmark Benefit that was Substituted:	Source:	
Emergency Room Services-Duplication	Base Benchmark	Remove

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:

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.

Base Benchmark Benefit that was Substituted:	Source:	
Emergency Room Transportation-Duplication	Base Benchmark	Remove

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:

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.

Base Benchmark Benefit that was Substituted:	Source:	
Inpatient Hospital Services-Duplication	Base Benchmark	Remove

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:

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.

Base Benchmark Benefit that was Substituted:	Source:	
Inpatient Physician/Surgical Services-Duplication	Base Benchmark	Remove

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:

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.

Base Benchmark Benefit that was Substituted:	Source:	
Bariatric Surgery-Duplication	Base Benchmark	Remove

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

Base Benchmark Benefit that was Substituted: Hospice Services-Duplication

Source: Base Benchmark

Remove

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:

Hospice Services were mapped with the 'Hospitalization and Ambulatory' EHB category. The services are a duplication of the Hospice Services in the existing State Plan. Services are provided in inpatient and home settings.

Base Benchmark Benefit that was Substituted: Organ and Tissue Transplant-Duplication

Source: Base Benchmark

Remove

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 were mapped with the 'Hospitalization' EHB category. The services are a duplication of Inpatient Hospital--Organ Transplants in Essential Health Benefit category #3 and Physician Services in the existing State Plan.

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care-Duplication

Source: Base Benchmark

Remove

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 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.

Base Benchmark Benefit that was Substituted: Elective Abortions-Hyde Compliant

Source: Base Benchmark

Remove

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

Base Benchmark Benefit that was Substituted: Mental Health Outpatient Services-Duplication

Source: Base Benchmark

Remove

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 were mapped with the 'Mental Health and Substance Abuse Disorder

Alternative Benefit Plan

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

Base Benchmark Benefit that was Substituted: Mental Health Inpatient Services-Duplication
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Substance Use Disorder Inpatient Services-Dupli
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Substance Use Disorder Outpatient Services-Dupli
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Profess. Services by Licensed Men. Sub Pract-Dup
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Diagnostic for Mental/Substance Disorders-Duplic
Source: Base Benchmark
Remove

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

Base Benchmark Benefit that was Substituted:	Source:	
Generic Drugs- Duplication	Base Benchmark	Remove

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.

Base Benchmark Benefit that was Substituted:	Source:	
Preferred Drugs-Duplication	Base Benchmark	Remove

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:

Preferred Drugs were mapped with the 'Prescription Drugs' EHB category. The services are a duplication of Prescribed Drugs in the existing State Plan.

Base Benchmark Benefit that was Substituted:	Source:	
Non-Preferred Drugs Brand-Duplication	Base Benchmark	Remove

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:

Non-Preferred Drugs were mapped with the 'Prescription Drugs' EHB category. The services are a duplication of Prescribed Drugs in the existing State Plan.

Base Benchmark Benefit that was Substituted:	Source:	
Specialty Drugs-Duplication	Base Benchmark	Remove

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:

Specialty Drugs were mapped with the 'Prescription Drugs' EHB category. The services are a duplication of Prescribed Drugs in the existing State Plan.

Base Benchmark Benefit that was Substituted:	Source:	
Diagnostic Test (X-Ray and Lab Work) -Duplication	Base Benchmark	Remove

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 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.

Base Benchmark Benefit that was Substituted:	Source:	
Imaging (CT/PET Scans, MRIs)- Duplication	Base Benchmark	Remove

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.

Base Benchmark Benefit that was Substituted:	Source:	
Osteoporosis Prevention-Duplication	Base Benchmark	Remove

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.

Base Benchmark Benefit that was Substituted:	Source:	
Diabetes Equipment, Sup. and Self Mana. -Duplica	Base Benchmark	Remove

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.

Base Benchmark Benefit that was Substituted:	Source:	
Medical Foods-Duplication	Base Benchmark	Remove

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:

Medicals 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.

Base Benchmark Benefit that was Substituted:	Source:	
Allergy Related Services-Duplication	Base Benchmark	Remove

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:

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.

Base Benchmark Benefit that was Substituted:	Source:	
Child Preventive and Routine Care-Duplication	Base Benchmark	Remove

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'

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

Base Benchmark Benefit that was Substituted: Eye Glasses for Children-Duplication
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Dental Check-Up for Children-Duplication
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services-Duplication
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment- Duplication
Source: Base Benchmark
Remove

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.

Base Benchmark Benefit that was Substituted: Skilled Nursing-Duplication
Source: Base Benchmark
Remove

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

existing State Plan.

Base Benchmark Benefit that was Substituted: Outpatient Cardiac Rehabilitation-Duplication

Source: Base Benchmark

Remove

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.

Base Benchmark Benefit that was Substituted: Infertility Treatment Services-Substitution

Source: Base Benchmark

Remove

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:

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.

Base Benchmark Benefit that was Substituted: Acupuncture and Chiropractic Care- Substitution

Source: Base Benchmark

Remove

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:

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.

Base Benchmark Benefit that was Substituted: Preventive Care/Screening-Duplication

Source: Base Benchmark

Remove

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:

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

Base Benchmark Benefit that was Substituted: Immunizations-Duplication

Source: Base Benchmark

Remove

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:

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

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:	Source:	
General Anesthesia and Ass. Dental Care-Duplicat	Base Benchmark	Remove

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.

Base Benchmark Benefit that was Substituted:	Source:	
Outpatient Surgery Physician/Surgical Services	Base Benchmark	Remove

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.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered — Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source:	Explain why the state/territory chose not to include this benefit:	
Newborn hearing screen	Base Benchmark	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.	Remove
Abortions -outside of the Hyde Amendment.	Base Benchmark	Maryland provides these services, but does not collect federal dollars for them.	Remove
Routine Eye Exam-Adults	Base Benchmark	Vision is not considered and an essential health benefit for purposes of Alternative Benefit Plans.	Remove
Newborn Care	Base Benchmark	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.	Remove
Circumcision	Base Benchmark	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.	Remove

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided: Medical Care by Other Licensed Pract. -Podiatrist
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: Chronic care is limited to 1 visit every 6 weeks
Duration Limit: None
Scope Limit: None
Other: Preauthorization is required for more than five visits or care beyond 90 days.

Other 1937 Benefit Provided: Family Planning Services and Supplies
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other:

Other 1937 Benefit Provided: Counseling and Pharm. for Cessation of Tobacco
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other:

Alternative Benefit Plan

Other 1937 Benefit Provided:
Health Homes

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
As long as individuals meet the participation requirements and receives services from a qualified provider.

Other:

Other 1937 Benefit Provided:
Non-Emergency Transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Other:

Other 1937 Benefit Provided:
Optometrist Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Eye Examination Every Two Years

Duration Limit:
None

Scope Limit:
None

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

Remove

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

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

PRP services include: services to develop of 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

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Other 1937 Benefit Provided:
Nursing Home Custodial Care

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

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.

Other 1937 Benefit Provided:
Other Services Extended to Pregnant Women

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

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

Other 1937 Benefit Provided:
Community-Based Substance Abuse Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

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 Elederly

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

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

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Alternative Benefit Plan

Other 1937 Benefit Provided:
Intermediate Care Facilities-Intellectually Dis.

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Recipient has been certified that he/she requires intermediate care facility services for the intellectually-disabled or persons with related conditions.

Other 1937 Benefit Provided:
Case Management-Mental Illness

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Yes-See below

Duration Limit:
None

Scope Limit:
None

Other:
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.

Other 1937 Benefit Provided:
Case Management-HIV

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Yes-See below

Duration Limit:
None

Scope Limit:
None

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 are covered when documented as appropriate and necessary. Individuals are limited to 96 units of service per year.

Other 1937 Benefit Provided:

Case Management-Developmental Disabilities

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See below-No hard cap on the number of services

Duration Limit:

None

Scope Limit:

None

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:

Free Standing Birth Center Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) Collapse All ☐

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

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Benefits Assurances **ABP7**

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ 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).

☑ 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.

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:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT 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.

TN No: MD 15-0007
Supercedes TN No.: MD 13-0031

Approval Date: 09 14 2015
Effective Date: 01/01/2015

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

V.20130917

Alternative Benefit Plan

State Name: Maryland Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: MD - 18 - 0012

Service Delivery Systems — ABP8

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:

- [x] Managed care.
  - [x] Managed Care Organizations (MCO).
  - [ ] Prepaid Inpatient Health Plans (PIHP).
  - [ ] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [x] 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. Yes

The managed care program is operating under (select one):

- ○ 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: Aetna 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 care 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:
-Speciality mental health and substance use disorder benefits are provided by an ASO.
-Speciality 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):

V.20160722

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums	ABP9
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

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.20130917

TN No: MD 15-0007
Supercedes TN No.: MD 13-0031

Approval Date: 09 14 2015
Effective Date: 01/01/2015

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

General Assurances — ABP10

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. Yes

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

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.20130917

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- ☐

OMB Expiration date: 10/31/2014

Payment Methodology **ABP11**

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

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.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:

/X/ 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:

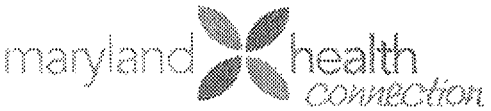
   / / Yes / / No

3. /X/ 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:

/X/ 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.



MARYLAND HBE – CMS ALTERNATE APPLICATION FOR HEALTH COVERAGE

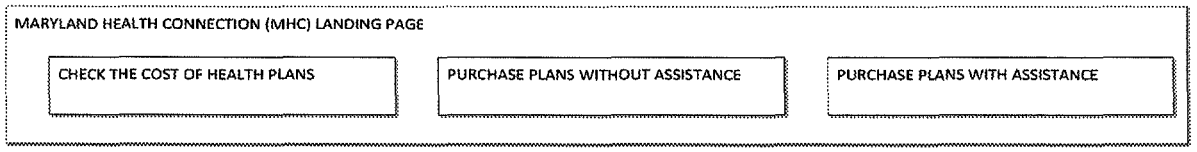
SCREEN CAPTURES and FLOW CHARTS

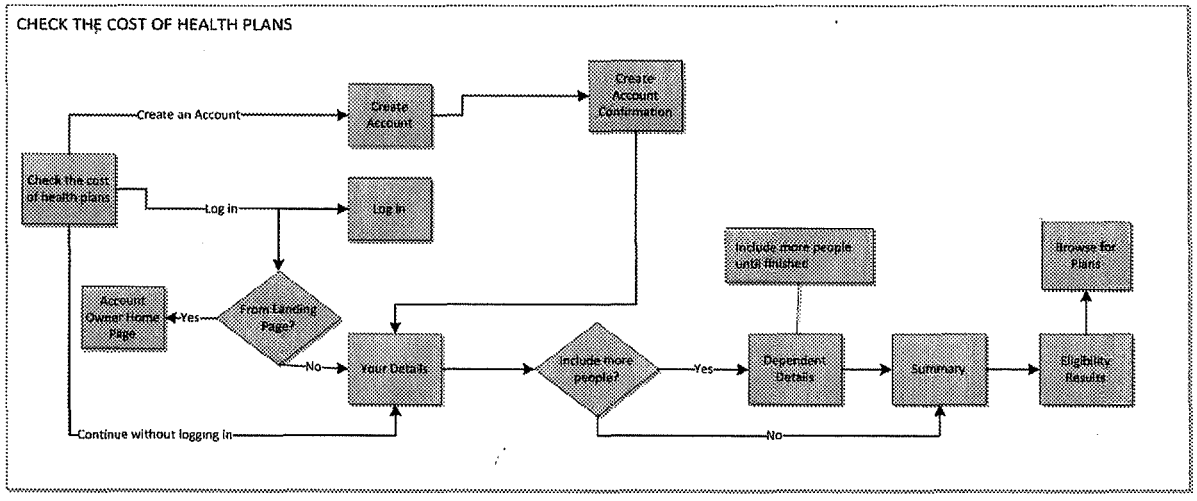
Contents

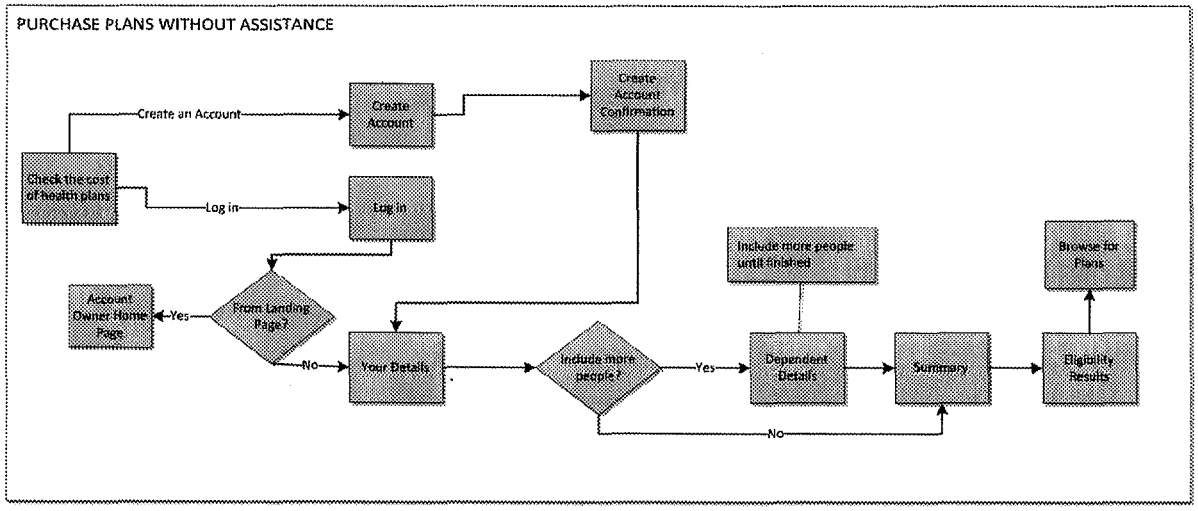
1 Section I – My Account

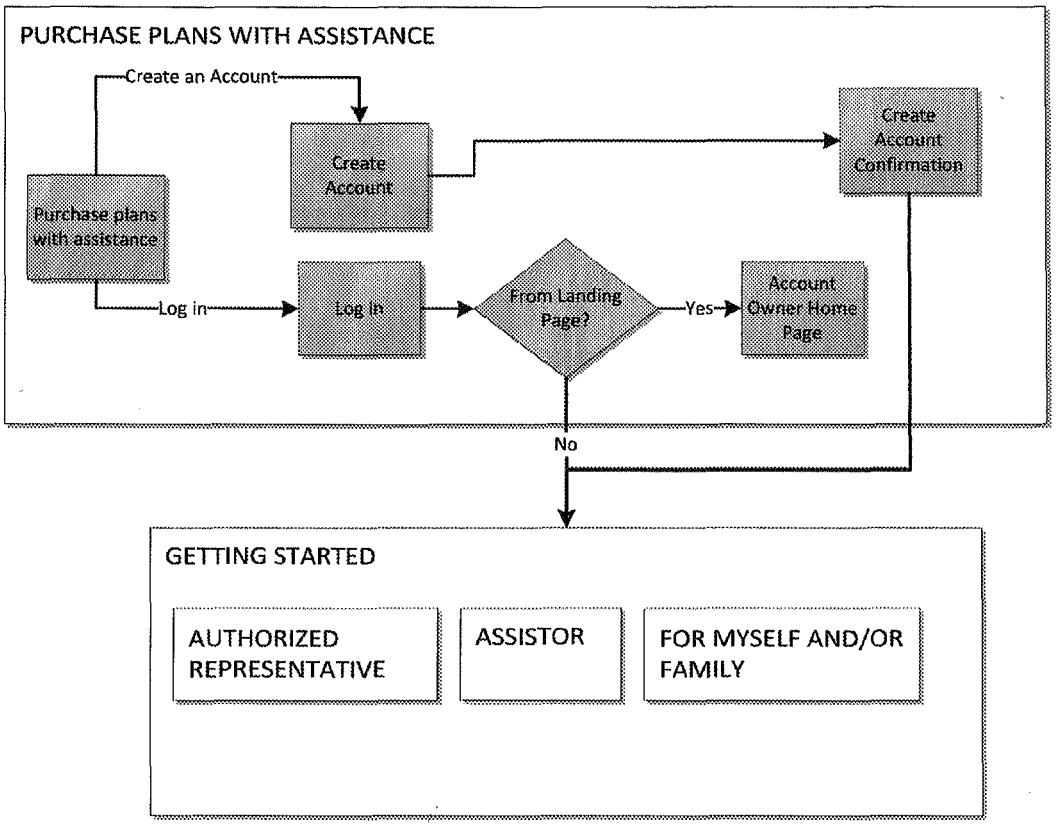
1.1 Create Account

1.1.1 Flow Charts

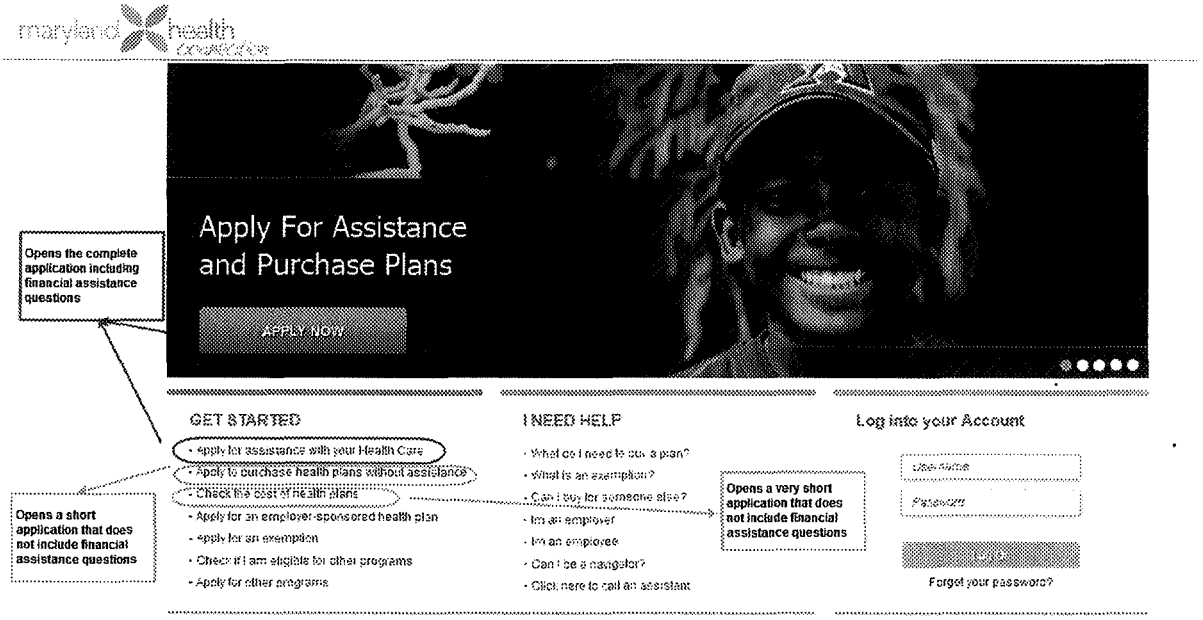




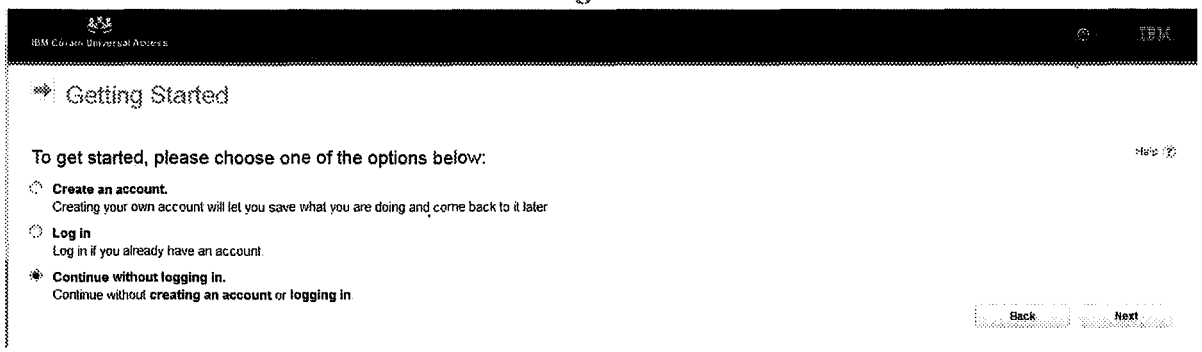




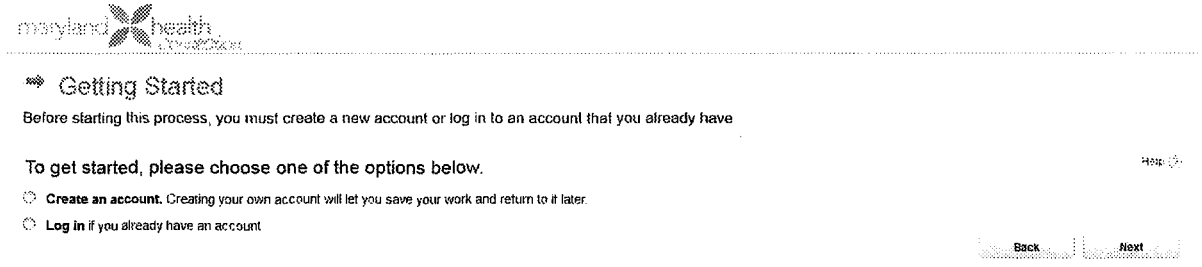
1.1.2 MHC Landing Page



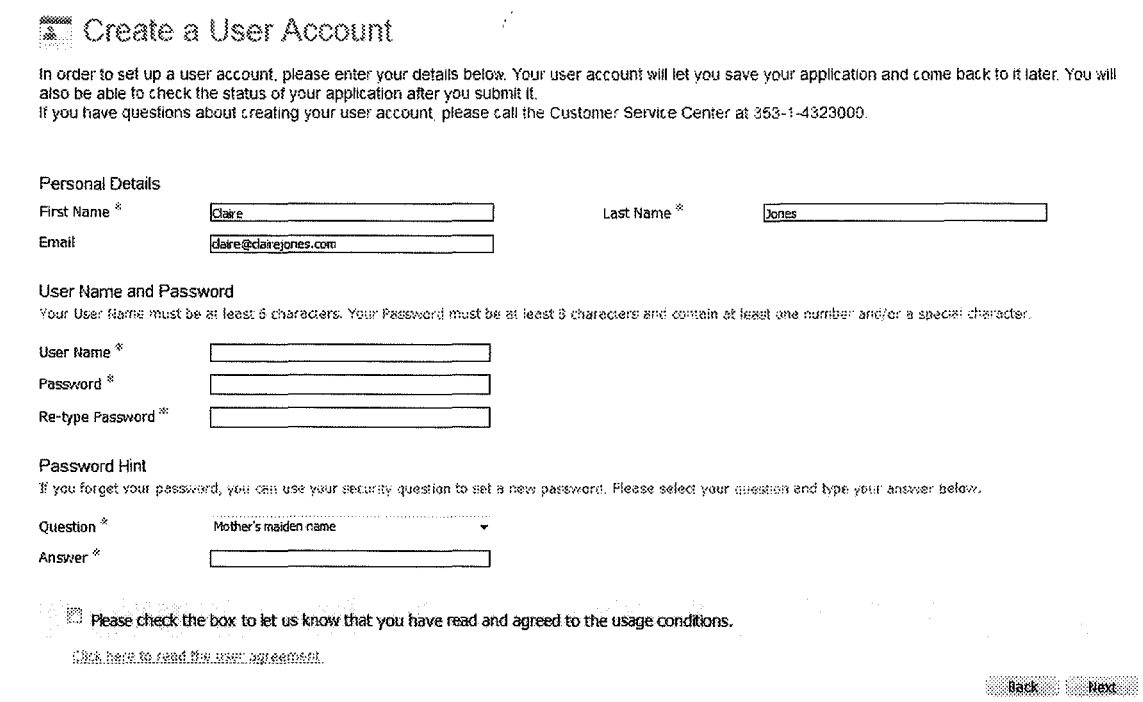
1.1.3 Check the Cost of Health Plans: Getting Started



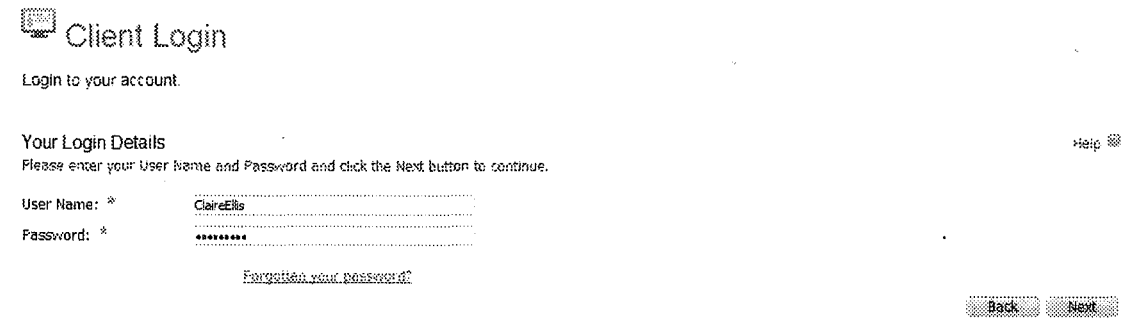
1.1.4 Purchase Plans With and Without Assistance: Getting Started



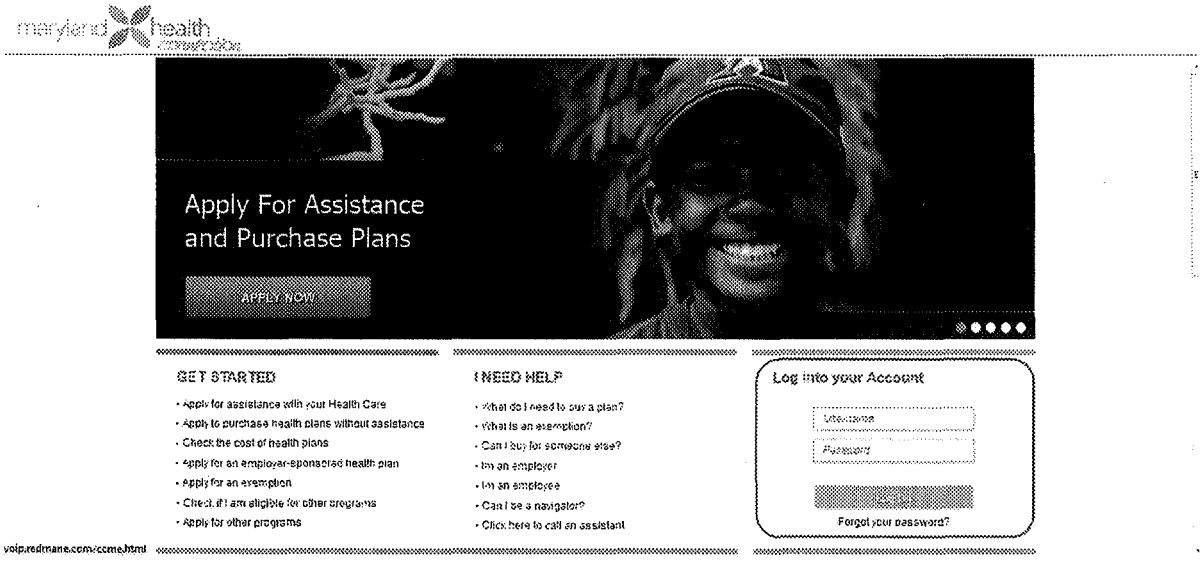
1.1.5 Create a User Account



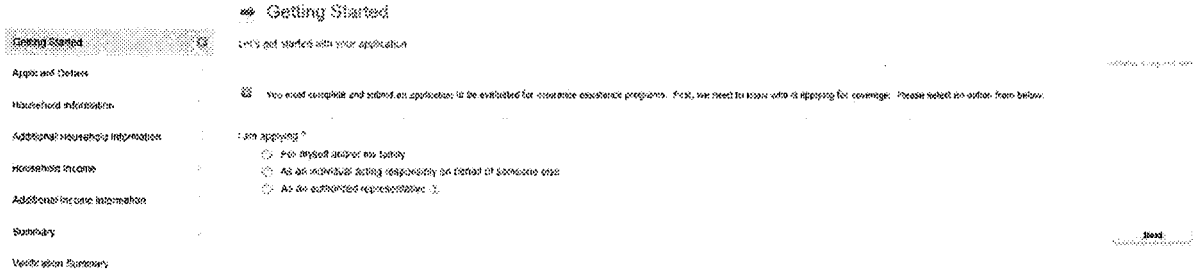
1.1.6 Client Login



1.1.7 Login from MHC Landing Page

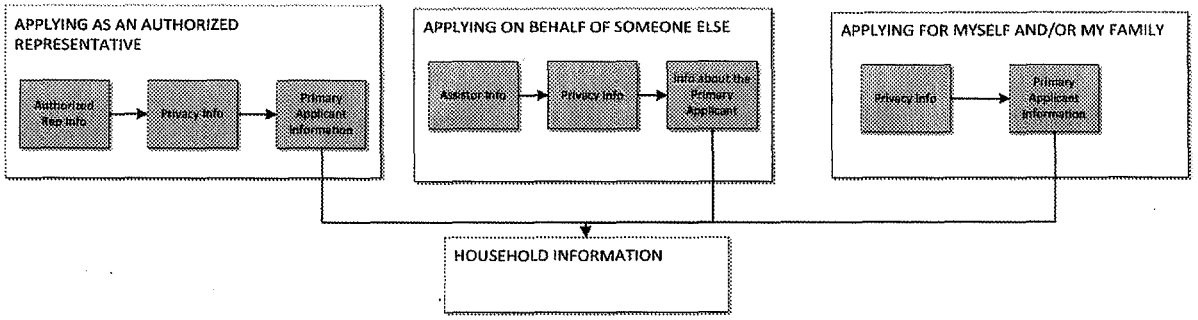


1.1.8 Purchase Plans with Assistance: Getting Started with Application

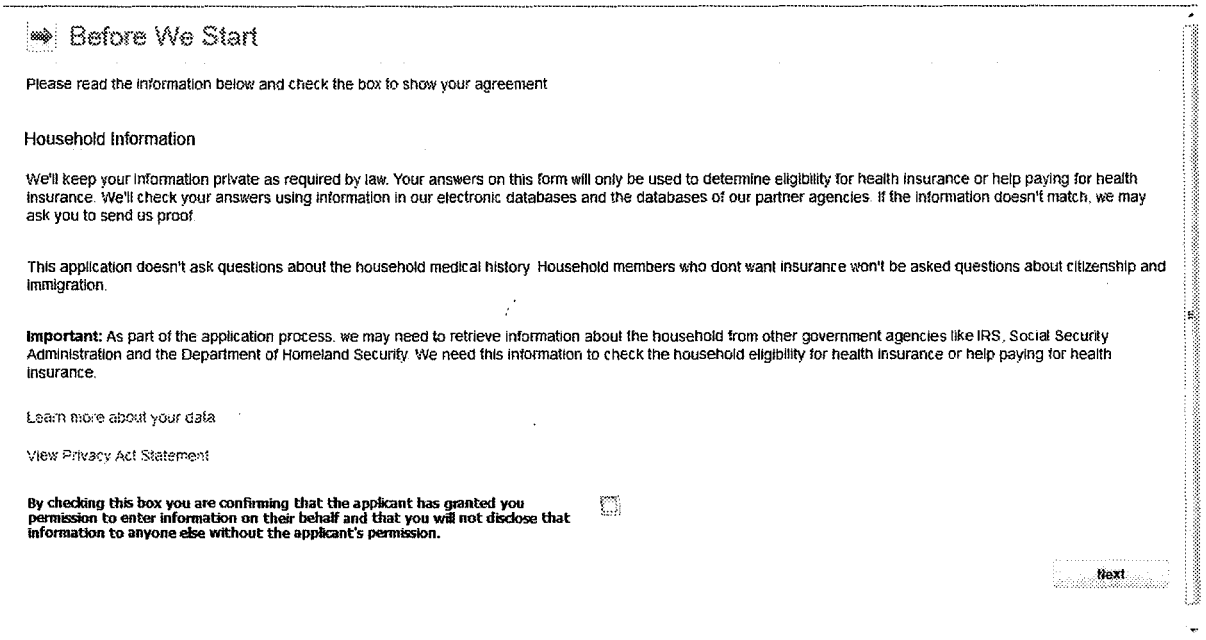


2 Section II – Privacy

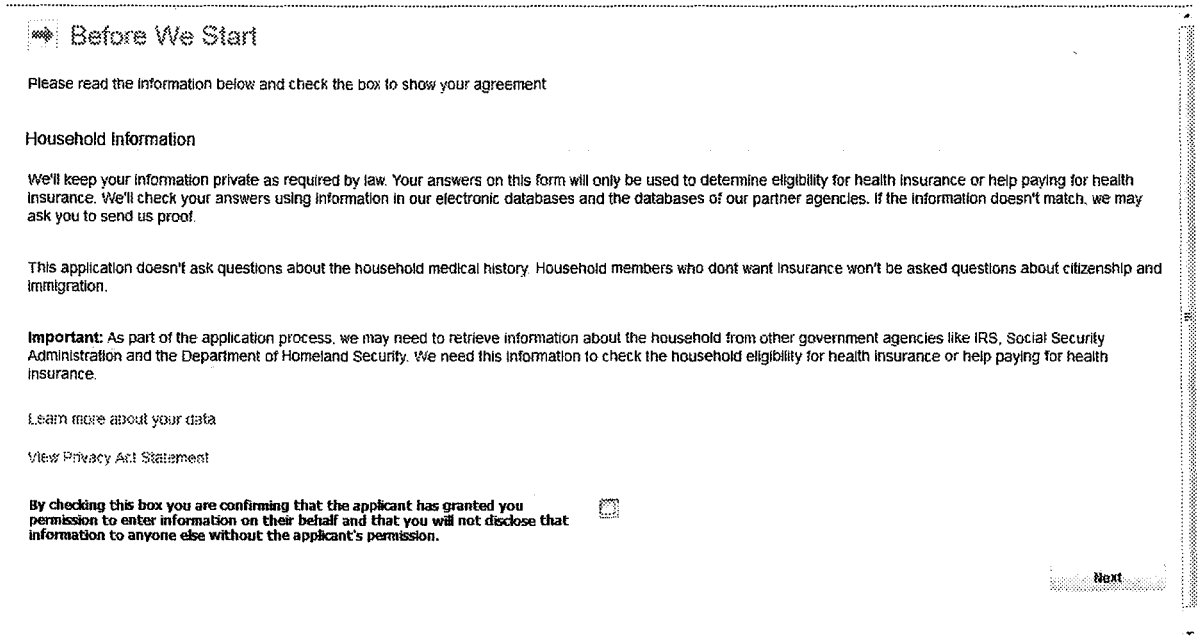
2.1 Flow Chart



2.2 For Myself and/or My Family



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 dont 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. ☐

Next

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

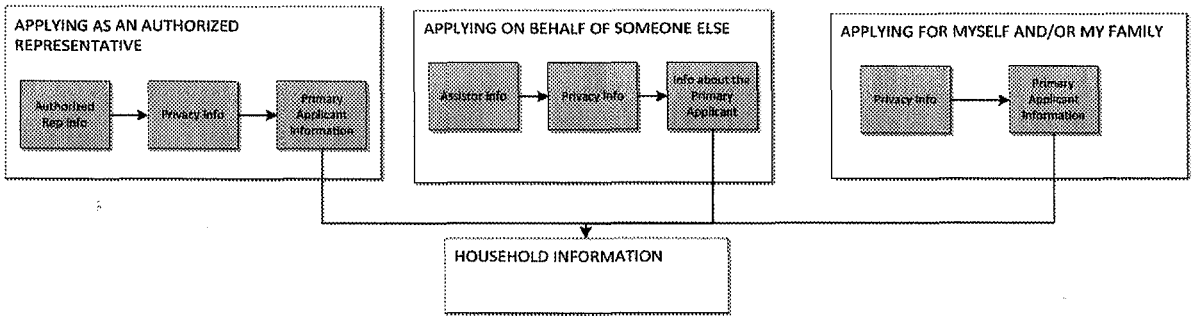
Changes to our websites may necessitate changes to our privacy statement. Notification will be posted on this website in the Privacy Notice link. The information contained in this privacy statement applies only to www.marylandhealthconnection.gov

Close

3 Section III – Getting Started

3.1 Contact Information

3.1.1 Flow Chart

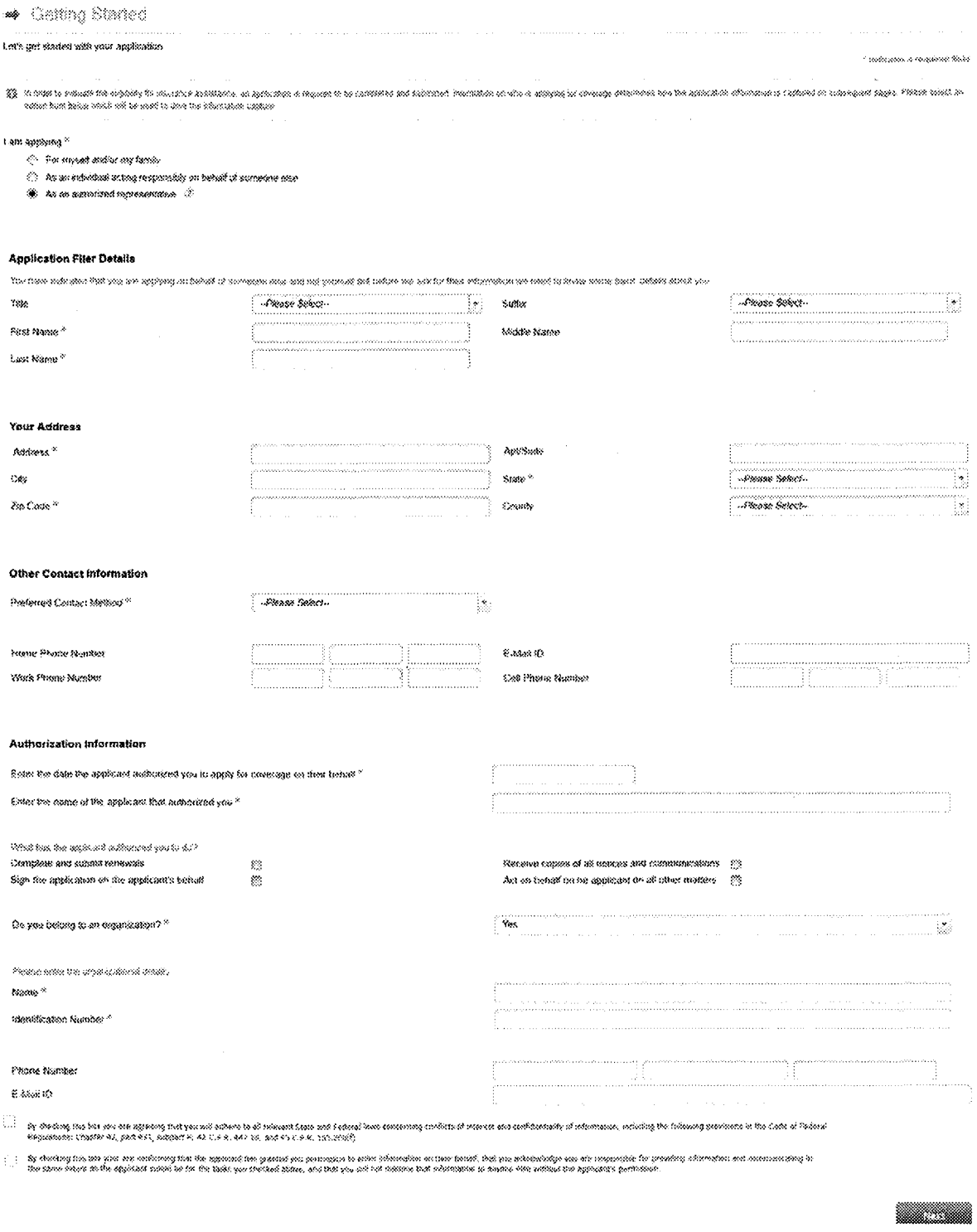


3.1.2 Authorized Representative Contact Information

Getting Started	Values (If applicable)
Banner	
Let's get started with your application	
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.	
I am applying	For myself and/or my family As an individual acting responsibly on behalf of someone else As an authorized representative
Cluster Name: Application Filer Details	
You have indicated that you are applying as an authorized representative and not yourself. Before we ask for their information we need to know about some basic details about you.	
Title	Dr. Miss Mr. Mrs. Ms. Prof.

Getting Started	Values (If applicable)
Suffix	Esquire Junior Senior First Second Third Fourth Fifth
First Name	
Middle Name	
Last Name	
Cluster Name: Your Address	
Apt/Suite	
Address	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties by state wise
Cluster Name: Other Contact Information	
Preferred Contact Method	Email Post/Mail
Home Phone Number	
Work Phone Number	
Cell Phone Number	
E-mail Address	
Cluster: Authorization Information	
Enter the date the applicant authorized you to apply for coverage on their behalf.	
Enter the name of the applicant that authorized you	
What has the applicant authorized you to do?	
Complete and submit renewals	
Sign the application on the applicant's behalf	
Receive copies of all notices and communications	
Act on behalf of the applicant on all other matters	
Do you belong to an organization?	No Yes
(If the dropdown value for the field 'Do you belong to an organization?' is 'YES' the following field(s) appear)	
Please enter the organizational details	
Name	
Identification Number	

Getting Started	Values (If applicable)
Phone Number	
E-mail Address	
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.	

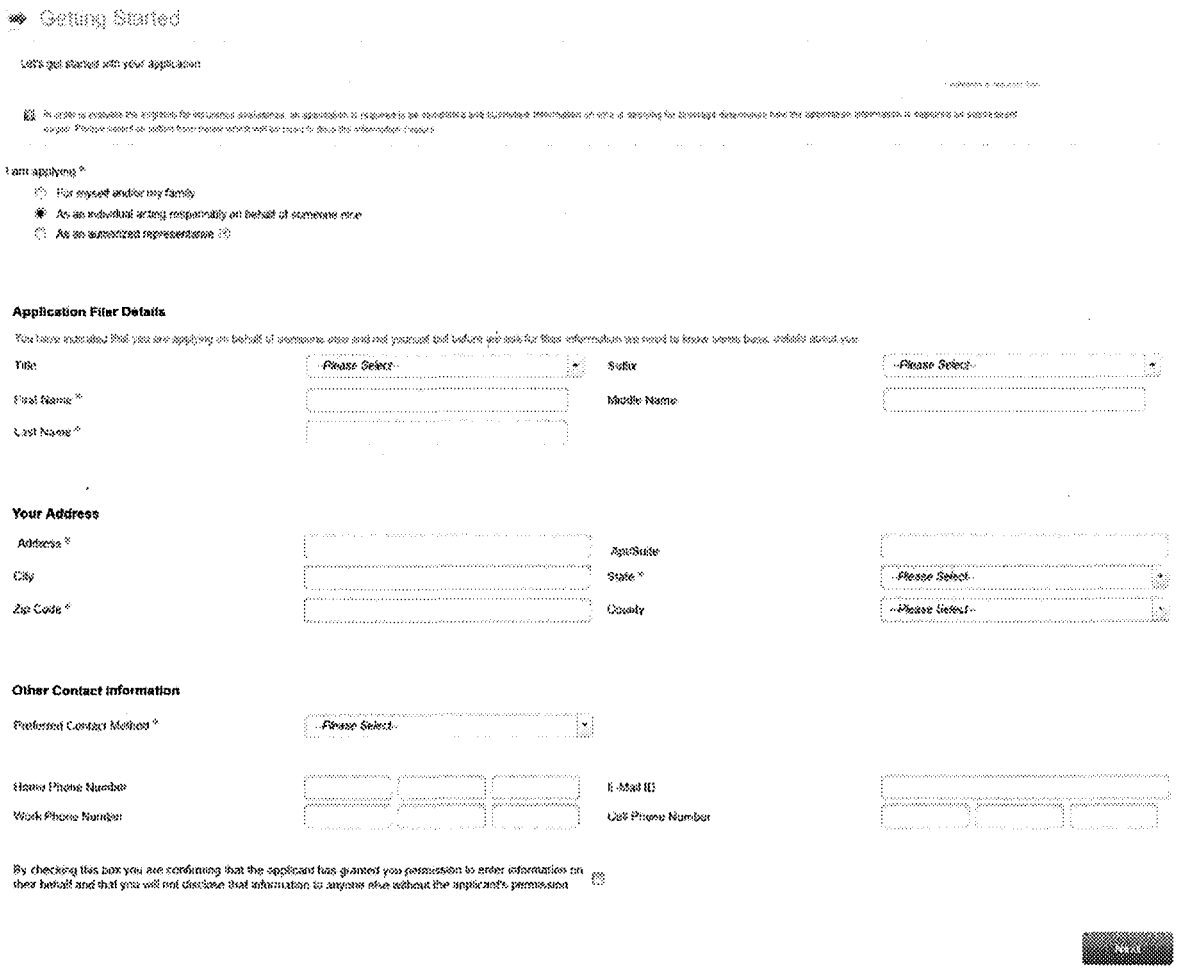


3.1.3 Assistor Contact Information

Getting Started	Values (If applicable)
Banner	

Getting Started	Values (If applicable)
Let's get started with your application	
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.	
I am applying	For myself and/or my family As an individual acting responsibly on behalf of someone else As an authorized representative
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.	
Title	Dr. Miss Mr. Mrs. Ms. Prof.
Suffix	Esquire Junior Senior First Second Third Fourth Fifth
First Name	
Middle Name	
Last Name	
Cluster Name: Your Address	
Apt/Suite	
Address	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties by state wise
Cluster Name: Preferred Method of Communication	
Communication Preference	Email Post/Mail
Home Phone Number	
Work Phone Number	

Getting Started	Values (If applicable)
Cell Phone Number	
E-mail Address	
By checking this box your 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	



3.1.4 For Myself and/or My Family Contact Information – Primary Applicant

Information About You	Values (If applicable)
Banner	
Please provide some information about yourself.	

Information About You	Values (If applicable)
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	
Title	Dr. Miss Mr. Mrs. Ms. Prof.
Suffix	Esquire Junior Senior First Second Third Fourth Fifth
First Name	
Middle Name	
Last Name	
Date of Birth	
Sex	Female Male
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.	
County	List of all the counties
Local Health Department/Organization	List of all the county Health Depts.
Cluster: Your Mailing Address	

Information About You	Values (If applicable)
Do you have a mailing address?	No Yes
(If the dropdown value for the mailing address is 'YES', the following field(s) appear)	
Address Line 1	
Address Line 2	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties by state wise
(If the dropdown value for the fixed address is 'YES', the following field(s) appear)	
Address Line 1	
Address Line 2	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties by state wise
If the State does not = Maryland then this displays.	
Cluster: Temporarily Absent from State?	
Are you living outside the state temporariliy and have intentions to return to the state?	No Yes
Cluster: Your Mailing Address	
Is the mailing address the same as your home address?	No Yes
(If the dropdown value for the Mailing Address field is 'NO', the following field(s) appear)	
Address Line 1	
Address Line 2	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties by state wise
Cluster: Other Contact Information	
We need to know the best way to contact ou about this application. You may receive notifications by mail, email or phone	
Preferred Contact Method	Phone Email Text Mail

Information About You	Values (If applicable)
Preferred Language	American Sign Apache Brazilian Portugese Cambodian Cantonese English French German Irish Italian Japanese Korean Lao Navajo Russian Simplified Chinese Spanish Traditional Chinese Vietnamese
Phone Number	
Type	Business Fax Mobile Other Pager Personal
Alternate Phone Number	
Type	Business Fax Mobile Other Pager Personal
E-mail Address	
Cluster: Help paying for your health benefits	
Do you want to find out if you can get help paying for your own health insurance and health benefits?	No Yes

Information About You

Please provide some information about yourself

[illegible]

Your Details

Title		Suffix	
First Name *	Homer	Middle Name	
Last Name *	Simpson	Date of Birth *	[illegible]
Sex *	Male		

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
Are you a Maryland resident? *	No

Temporarily Absent from State?

Are you living outside the state temporarily and have intentions to return to the Maryland? *	--Please Select--

Your Mailing Address

Do you have a mailing address? *	--Please Select--

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.

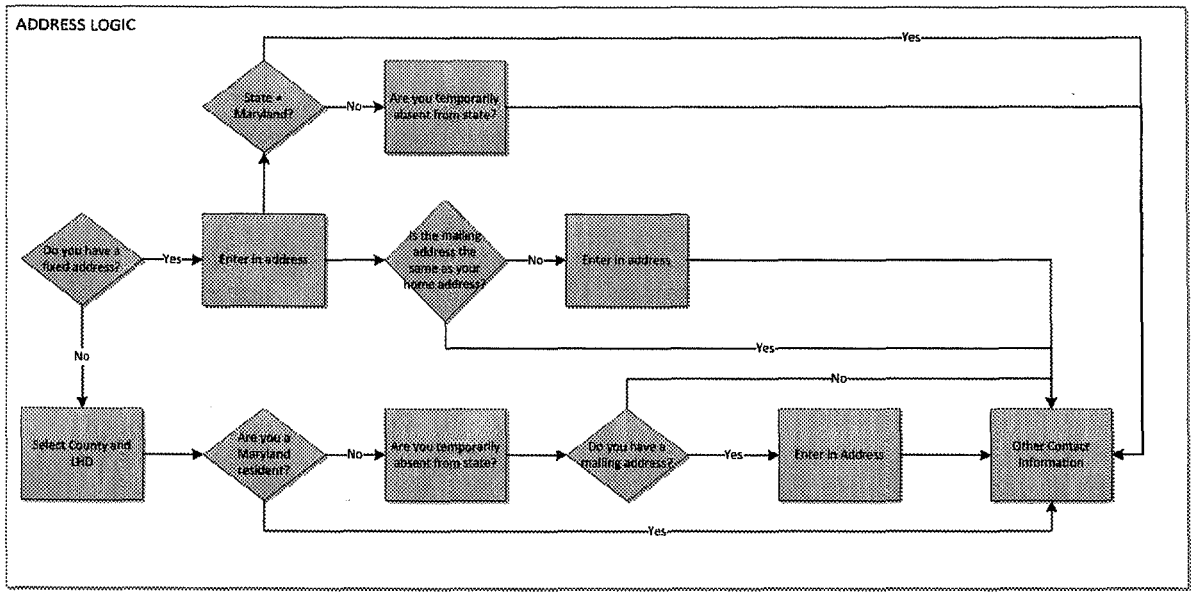
Preferred Contact Method *	--Please Select--	Preferred Language	--Please Select--
Phone Number		Type	--Please Select--
Alternate Phone Number		Type	--Please Select--
E-Mail Address			

Help paying for your health benefits

Do you want to find out if you can get help paying for your own health insurance and health benefits? *	--Please Select--

Save & Exit

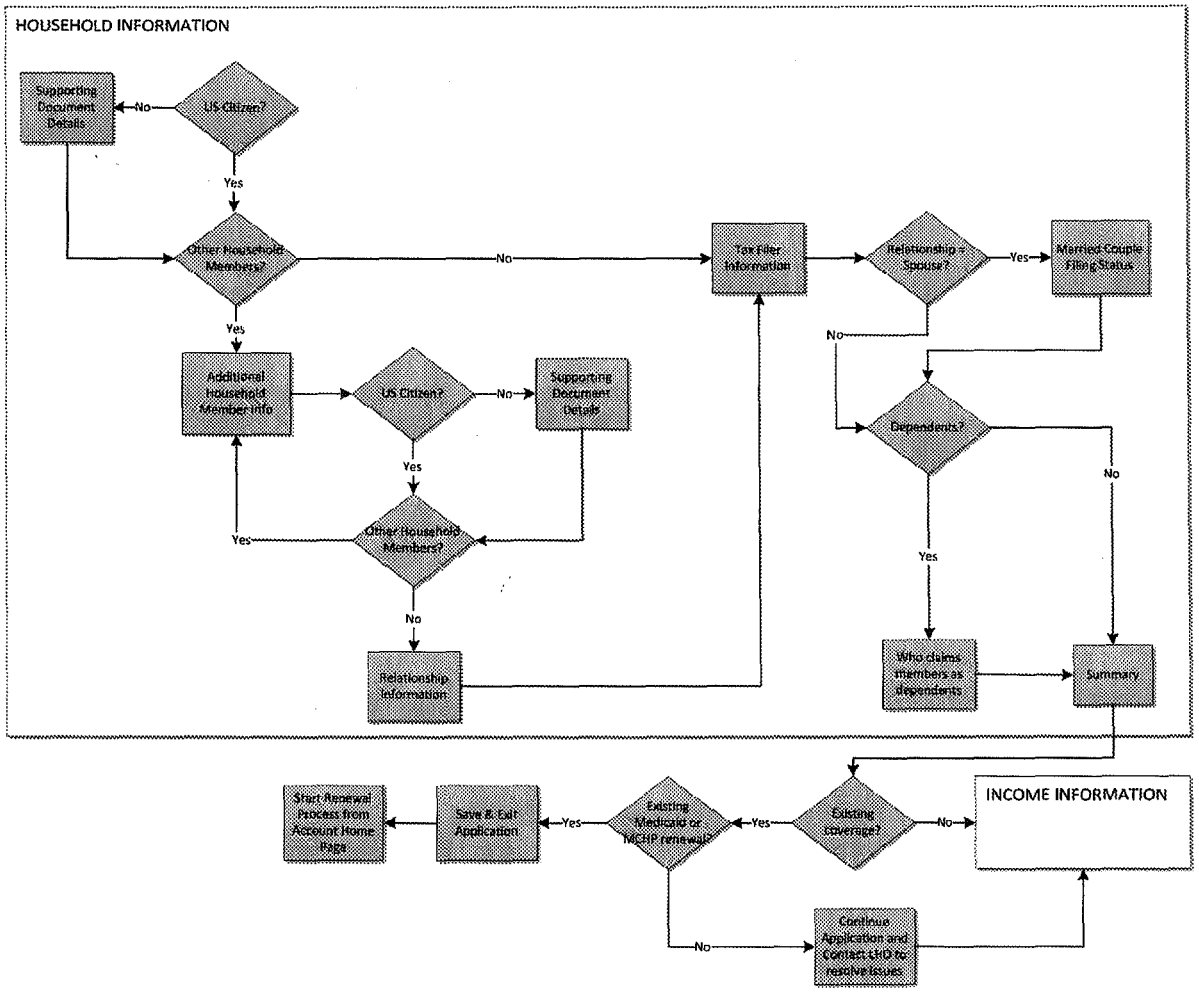
Next


ADDRESS LOGIC
Yes
State = Maryland?
No
Are you temporarily absent from state?
Do you have a fixed address?
Yes
Enter in address
Is the mailing address the same as your home address?
No
Enter in address
Yes
No
No
Select County and LHD
Are you a Maryland resident?
No
Are you temporarily absent from state?
Do you have a mailing address?
Yes
Enter in Address
Other Contact Information
Yes

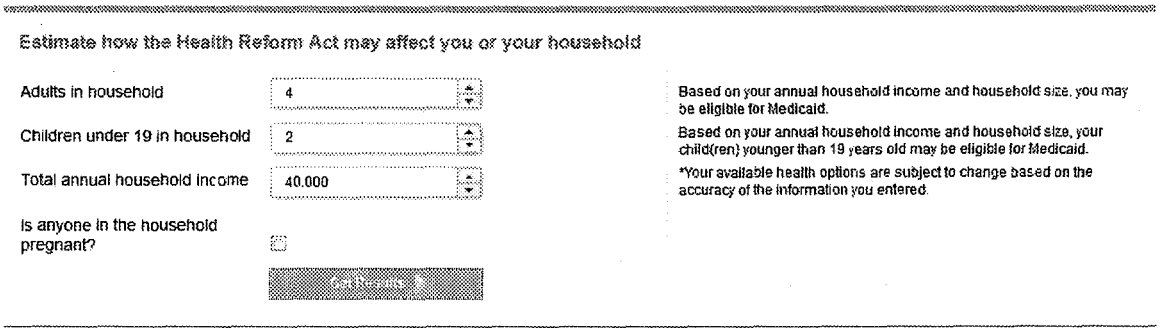
4 Section IV – Assistance with completing the application

5 Section V – Help Paying for Coverage

5.1 Flow Chart

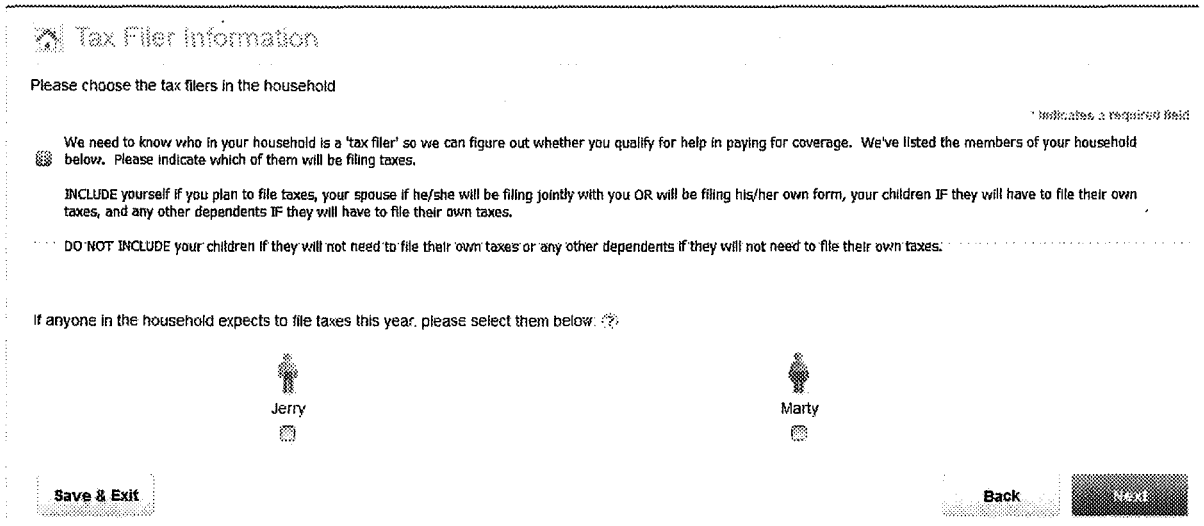


5.1.1 Pre-Screening Calculator



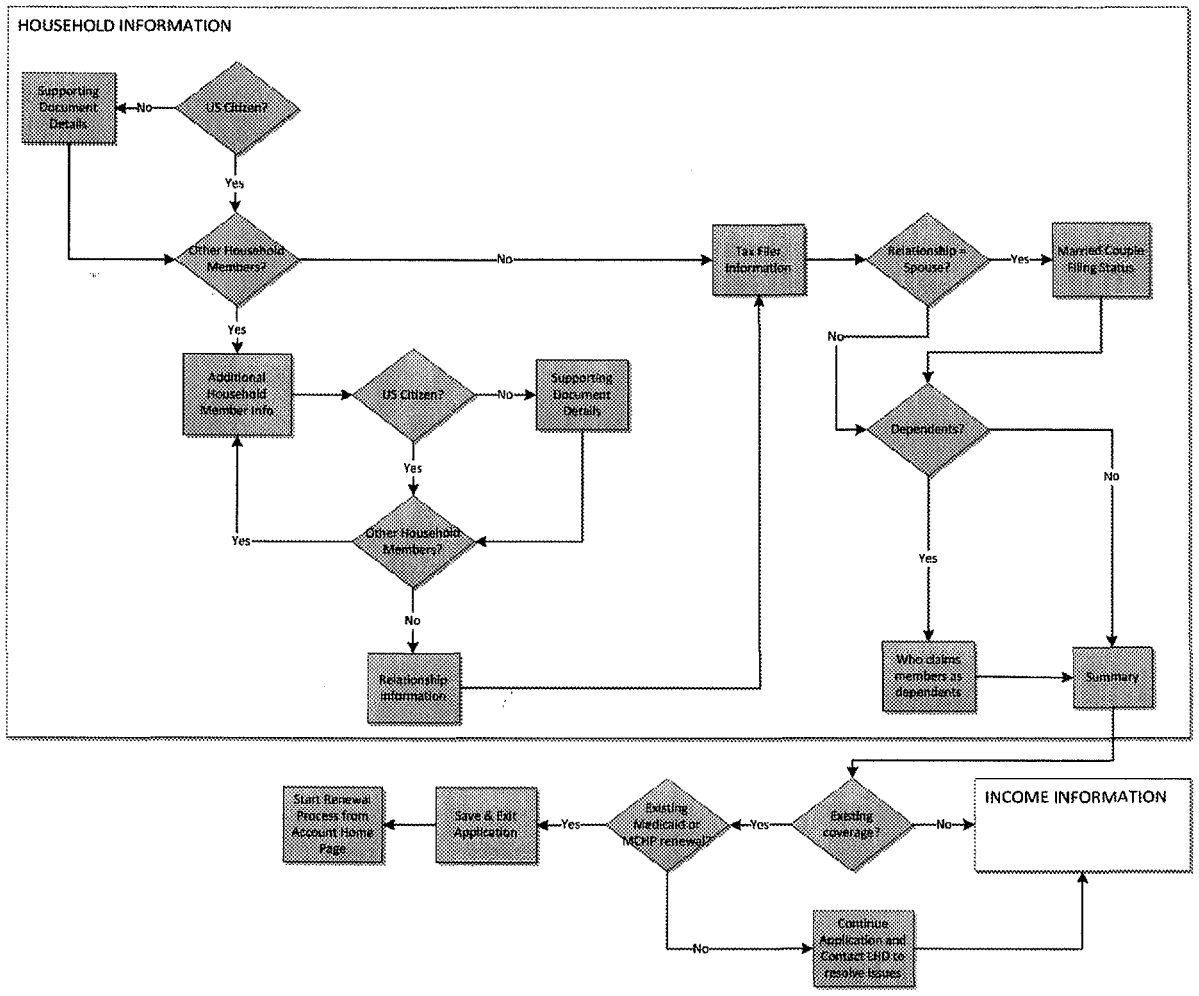
5.1.2 Tax Filer Information

Tax Filer Information
Banner
Please choose the tax filers in your household
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

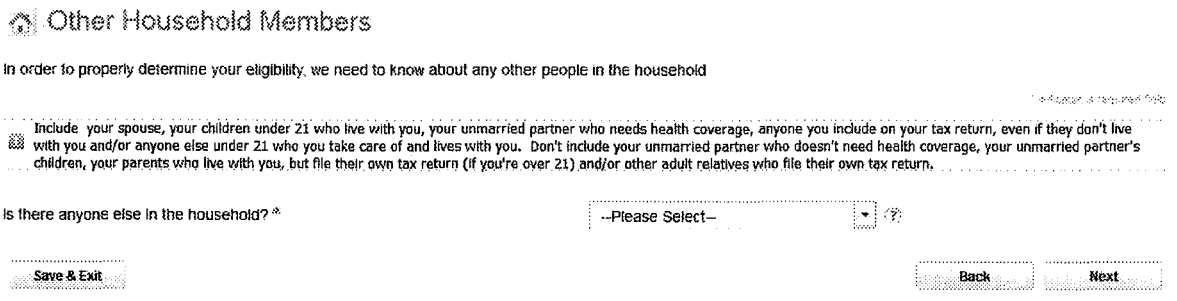


6 Section VI – Tell us how many people are applying for health coverage

6.1 Flow Chart



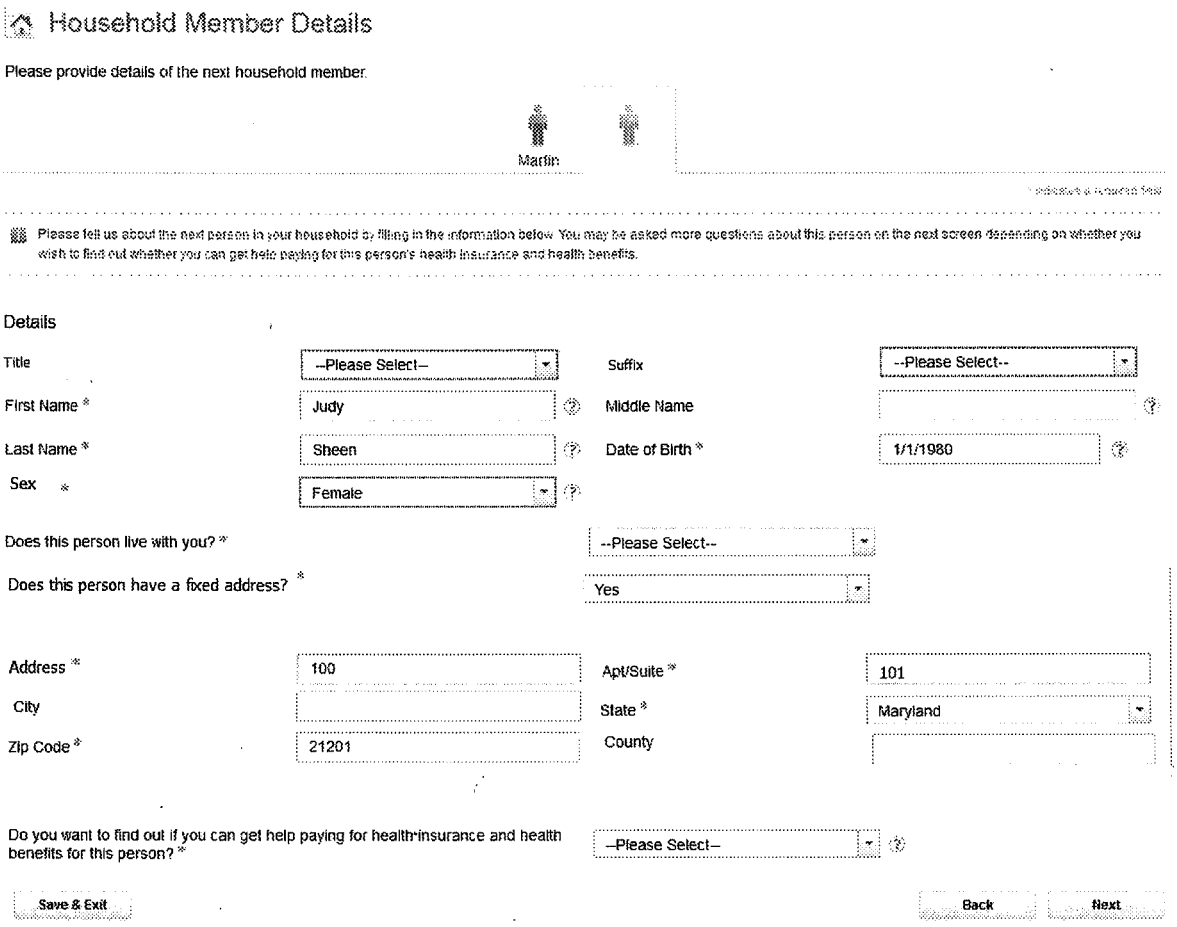
6.2 Other Household Members



6.3 Household Member Details

Household Member Details	Values (If applicable)
Banner	
Please provide details of the next household member	
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.	
Cluster: Details	
Title	Dr. Miss Mr. Mrs. Ms. Prof.
Suffix	Esquire Junior Senior First Second Third Fourth Fifth
First Name	
Middle Name	
Last Name	
Date of Birth	
Sex	Female Male
Does this person live with you?	No Yes
(If the dropdown value for the Live with you is 'NO', the following field(s) appear)	
Does this person have a fixed address?	No Yes
(If the dropdown value for the Fixed Address field is 'NO', the following field(s) appear)	
Is this person a Maryland resident?	No Yes

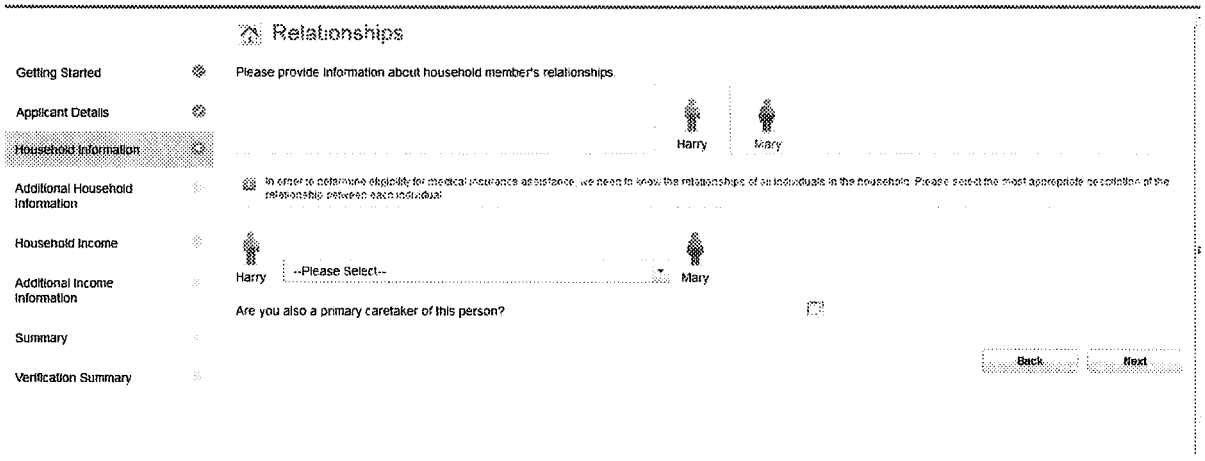
Household Member Details	Values (If applicable)
(If the dropdown value for the state resident is 'YES', the following field(s) appear)	
If this person does not have a fixed address, please choose a local health department based on the county this person spends the most time in.	
County	List of all the counties by state wise
Local Health Department/Organization	List of all the county Health Depts.
(If the dropdown value for the Fixed Address field is 'YES', the following field(s) appear)	
Apt/Suite	
Address	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties
If the State does not = Maryland then this displays.	
Cluster: Temporarily Absent from State?	
Is living outside the state temporarily and has intentions to return?	No Yes
Do you want to find out if you can get help paying for health insurance and health benefits for this person?	No Yes



6.4 Relationships

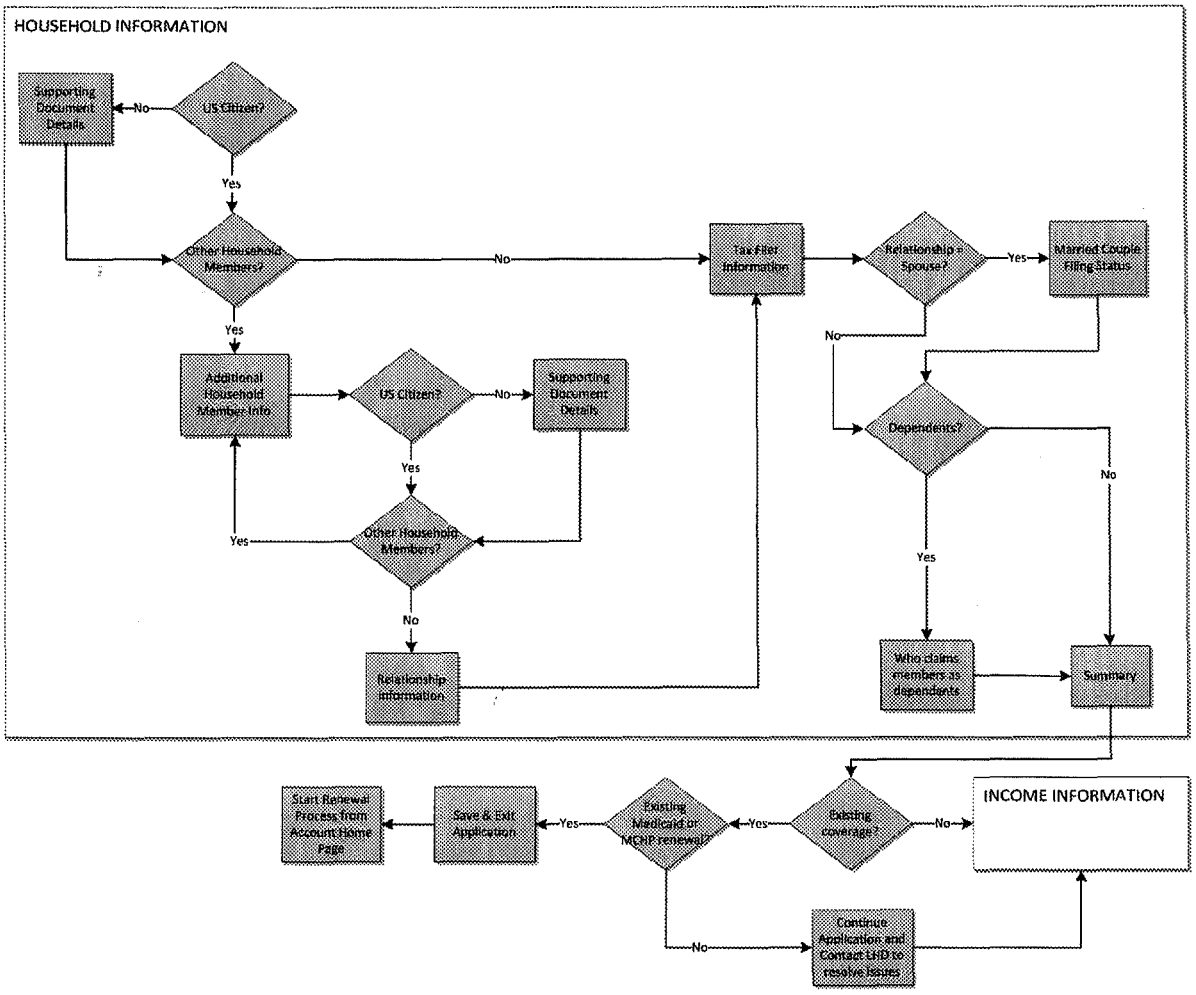
Relationships	Values (if applicable)
Banner	
Please provide information about household member's relationships	
In order to determine eligibility for medical insurance assistance, we need to know the relationships of all individuals in the household. Please select the most appropriate description of the relationship between each individual.	

Relationships	Values (If applicable)
Relationships	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
Are they also a non-parent caretaker of this person?	



7 Section VII – Tell us about each person

7.1 Flow Chart



7.2 Primary Applicant – Applying for Coverage

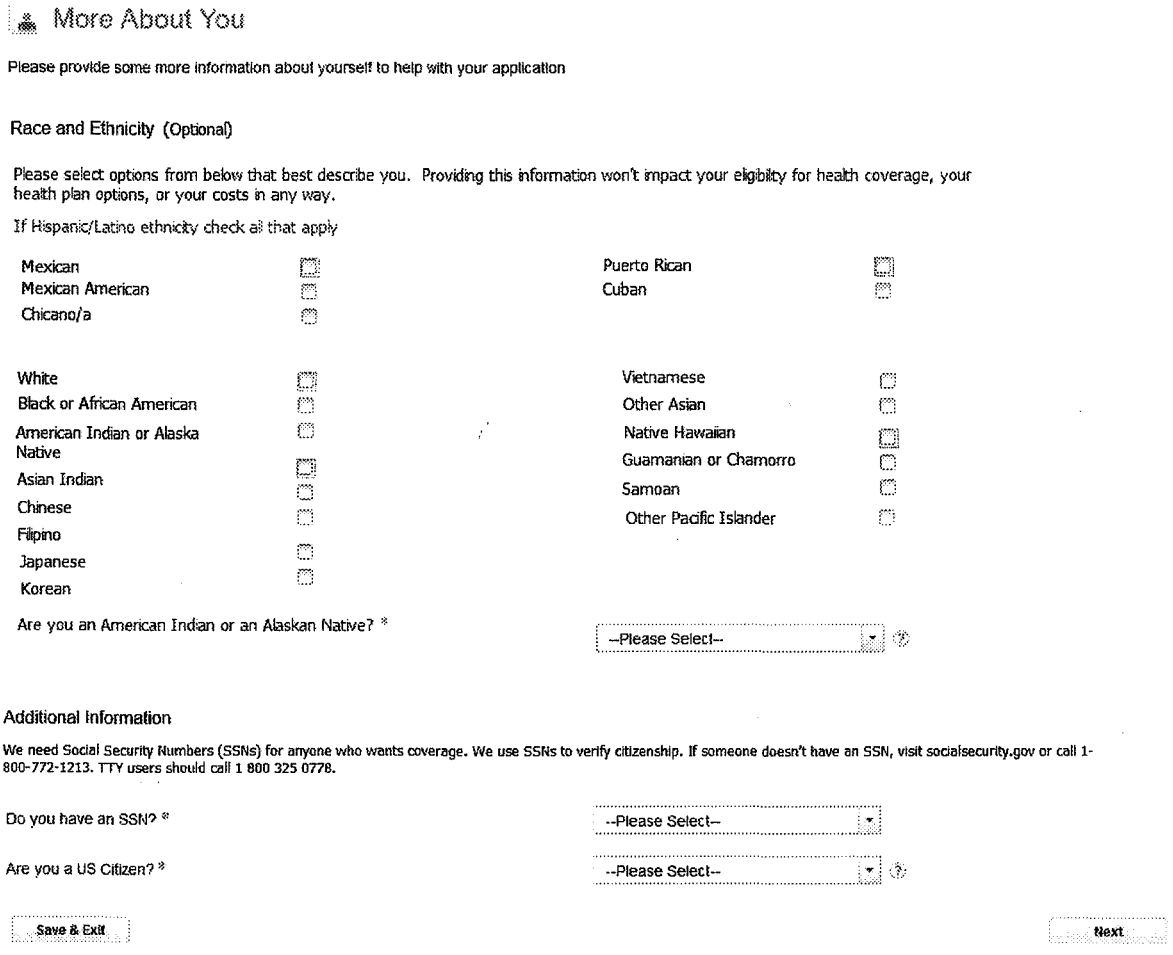
The information gathered in this screen is the same information that is gathered for all household members who are applying for coverage.

More About You	Values (If applicable)
Banner	
Please provide some more information about yourself to help with your application	
Cluster: 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	

More About You	Values (If applicable)
Mexican American	
Chicano/a	
Puerto Rican	
Cuban	
White	
Black or African American	
American Indian or Alaska Native	
Asian Indian	
Chinese	
Filipino	
Japanese	
Korean	
Vietnamese	
Other Asian	
Native Hawaiian	
Guamanian or Chamorro	
Samoan	
Other Pacific Islander	
Are you an American Indian or an Alaskan Native?	No Yes
(If the dropdown value for American Indian/Alaskan Native field is 'YES" the following field(s) appear)	
Tribal Identification Number	
Cluster: 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.	
Do you have an SSN?	No Yes
(If the dropdown value for Do you have an SSN? is 'No" the following field(s) appear)	
Have you applied for SSN?	No Yes
(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	Can be
Apply for Social Security Number	Links to ssa.gov
(If the dropdown value for the field SSN is 'YES' the following field(s) appear)	
SSN	

More About You	Values (If applicable)
Are you a US Citizen?	No Yes
(If the dropdown value for the field US Citizen is 'NO' the following field(s) appear)	
Are you a US National?	No Yes
(If the dropdown value for the field US National is 'NO' the following field(s) appear)	
Are you lawfully present in the United States?	No Yes
(If the dropdown value for the field Lawfully present is 'YES' the following field(s) appear)	
Date of Entry	
Supporting Document	See screenshot below
(If the dropdown value for the field US National is 'YES' the following field(s) appear)	
Supporting Document	Certificate of Citizenship I-551 (Permanent Resident Card) Naturalization Certificate Passport
If the household member is a female over the age of 13 regardless of whether they are an applicant or not the following questions appear.	
Is <name> currently pregnant or gave birth in the last 3 months?	No Yes
(If the dropdown value for the field pregnancy is 'YES' the following field(s) appear)	
Cluster: Pregnancy Information	
How many children is <name> expecting?	Numeric
If <name> is currently pregnant, please enter the due date.	
If <name> was currently pregnant, please enter the date the pregnancy ended.	
If the household member is a between the ages of 18 and 26 and is applying for health insurance the following questions appear.	
Was <name> ever in foster care?	No Yes
(If the dropdown value for the field foster care is 'YES' the following field(s) appear)	
Cluster: Foster Care	
Select the State in which <name> was in the foster care system.	Alabama ~ Wyoming
Was <name> in foster care on their 18th birthday?	No Yes
If the household member is a between the ages of 18 and 22 and is applying for health insurance the following questions appear.	

More About You	Values (If applicable)
Is <name> a full time student?	No Yes
(If the dropdown value for the field student is 'YES' the following field(s) appear)	
Cluster: Student Information	
What type of student is <name>?	
What type of school is <name> going to?	
What is the expected end date?	

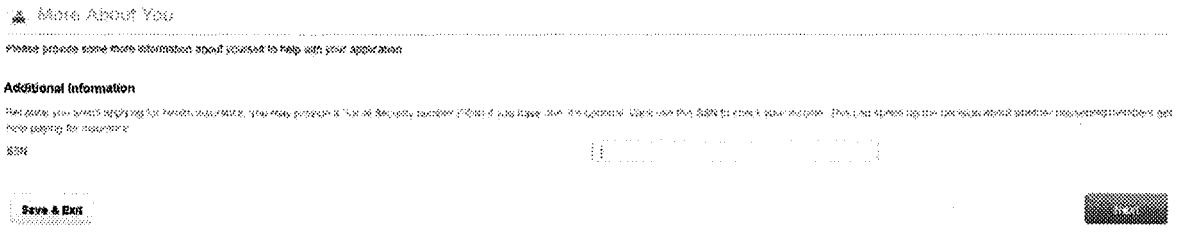


7.2.1 Document Types

--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
WT/WB Admission Stamp in Unexpired Foreign Passport
Other

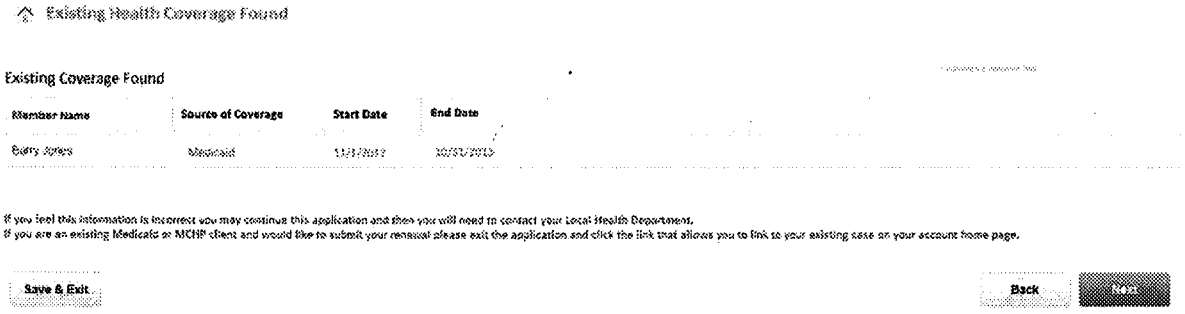
7.3 Primary Applicant – Not Applying for Coverage

More About You	Values (If applicable)
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	
Please provide some more information about yourself to help with your application	
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

Existing Health Coverage Found
Cluster: Existing Coverage Found
Member Name
Source of Coverage
Start Date
End Date
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 MCHP 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

Supporting Document Details	Comments
Banner	
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.	*(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?')*
Alien Number	Mandatory
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Cluster Name: Additional Information	
Text box	
Banner	

Supporting Document Details	Comments
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.	*(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?')*
I-94 Number	Mandatory
SEVIS ID	
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
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.	*(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?')*
Alien Number	Mandatory
Citizenship certification Number	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
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.	*(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?')*
I-94 Number	Mandatory
SEVIS ID	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	

Supporting Document Details	Comments
Banner	
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.	*(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?')*
I-94 Number	Mandatory
SEVIS ID	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
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	
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	

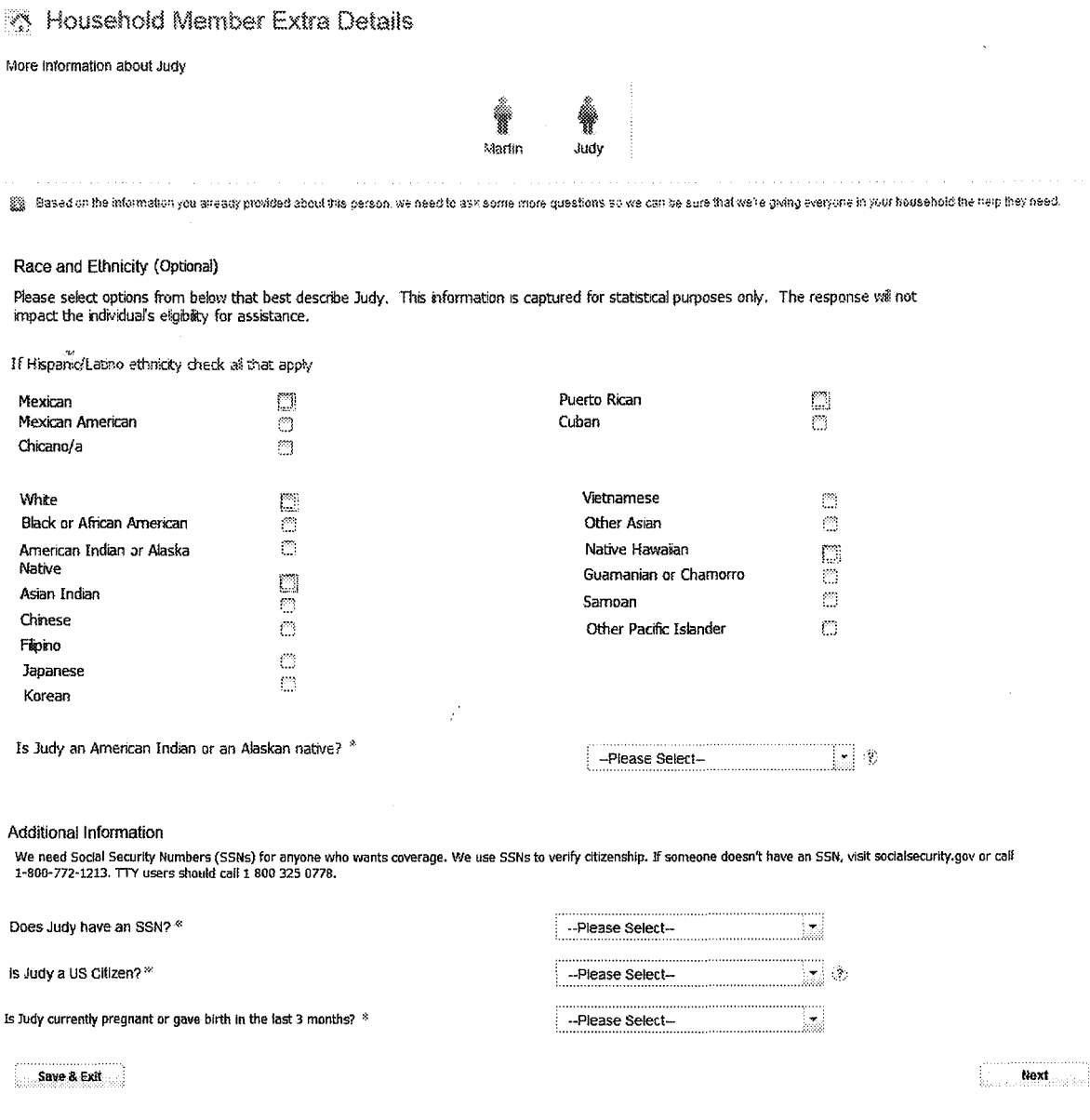
Supporting Document Details	Comments
Banner	
I-571 (Refugee Travel Document) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(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?')*
Alien Number	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
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	
Banner	
I-688A (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.	*(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?')*
Alien Number	Mandatory
Document Expiration Date	Mandatory + Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	

Supporting Document Details	Comments
I-688B (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.	*(This banner text and the related fields appear, when the user selects the option '**I-688B (Employment Authorization Document)**' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
I-688B (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.	
Alien Number	Mandatory
Document Expiration Date	Mandatory + Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
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.	*(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?')*
Alien Number	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
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.	*(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?')*
Alien Number	Mandatory
Passport Number	Mandatory
Visa Number	

Supporting Document Details	Comments
Document Expiration Date	Calendar Option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
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.	*(This banner text and the related fields appear, when the user selects the option **'Naturalization Number'** for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
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.	*(This banner text and the related fields appear, when the user selects the option **'Temporary I-551 Stamp'** 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	
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.	*(This banner text and the related fields appear, when the user selects the option **'Unexpired Foreign Passport' for the field** 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
I-94 Number	Mandatory
SEVIS ID	

Supporting Document Details	Comments
Passport Number	Mandatory
Visa Number	
Document Expiration Date	Mandatory + Calendar Option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
WT/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.	*(This banner text and the related fields appear, when the user selects the option **'WT/WB Admission Stamp'** 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
I-94 Number	Mandatory
Passport Number	Mandatory
Visa Number	
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.	*(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?')*
Identification Number	Mandatory
Other Document Description	Mandatory
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	

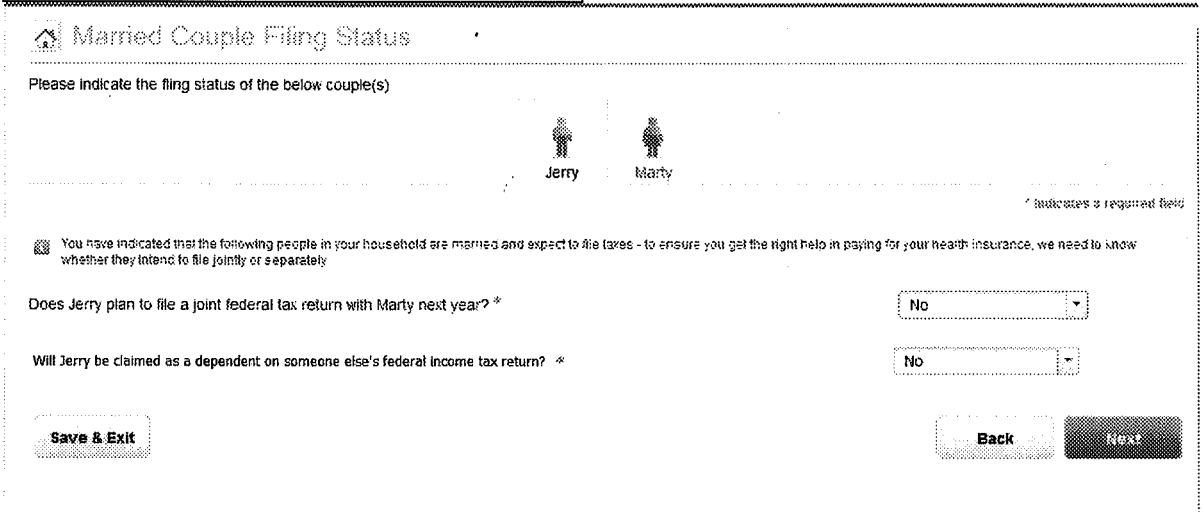
Type of Document	Naturalization Certificate (U.S. National)	Naturalization Certificate (Lawful Presence)	Certificate of Citizenship	I-94 DS2019 I-20	I-327 I-766	I-551	I-571 I-688 I-688A I-688B	Immigrant Visa	Temporary I0551 Stamp	Unexpired Foreign Passport	WT/WB Admission Stamp (foreign passport)
Alien Number	X*	X*	X*		X*	X*	X*	X*	X*		
Naturalization Number		X									
Passport Number								X*		X*	X*
Visa Number								X		X	X
Card Number						X*					
Citizenship Certification Number			X*								
I-94 Number				X*						X*	X*
SEVIS ID				X*						X	
Document Expiration Date			X	X	X	X	X	X	X	X	X
First Name	X	X	X	X	X	X	X	X	X	X	X
Middle Name	X	X	X	X	X	X	X	X	X	X	X
Last Name	X	X	X	X	X	X	X	X	X	X	X
Date of Birth	X	X	X	X	X	X	X	X	X	X	X



7.6 Married Couple Filing Jointly

Married Couple Filing Status
Banner
Please indicate the filing status of the below couple(s).

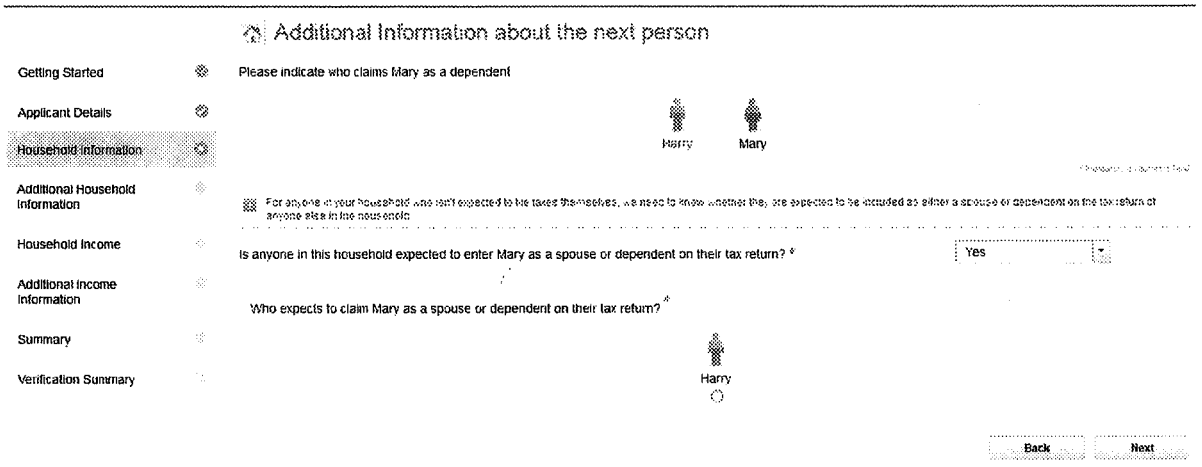
Married Couple Filing Status
You have indicated that the following people in your household are married and expected to file taxes - to ensure you get the right help in paying for your health insurance, we need to know whether they intend to file jointly or separately.
Does <primary> plan to file a joint 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?



7.7 Dependents

Additional information about the next person	Values (if applicable)
Banner	
Please indicate who claims [name] as a dependent	
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.	
Is anyone outside this household expected to enter [name] as a spouse or dependent on their tax return?	No Yes

Additional information about the next person	Values (If applicable)
(If the answer to the above field is 'NO', then the following fields appear)	
Is anyone outside this household expected to enter [name] as a spouse or dependent on their tax return?	No Yes
(If the answer to the above field is 'Yes', then the following fields appear)	
Who expects to claim [name] as a spouse or dependent on their tax return?	

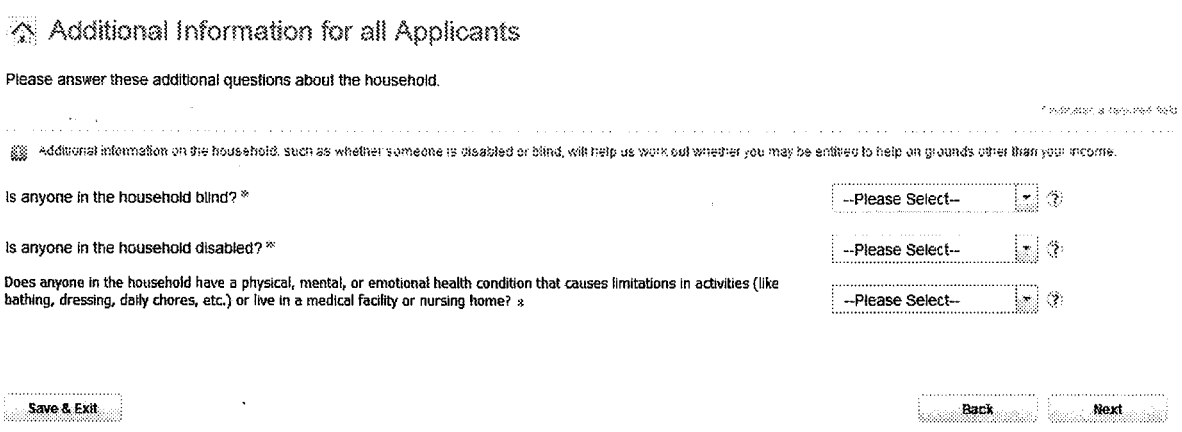


8 Section VIII – More about this household

8.1 Additional information for all Applicants

Additional information for all Applicants	Values (If applicable)
Please answer these additional questions about the household	
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.	
Is anyone in the household blind?	No Yes
Is anyone in the household disabled?	No Yes

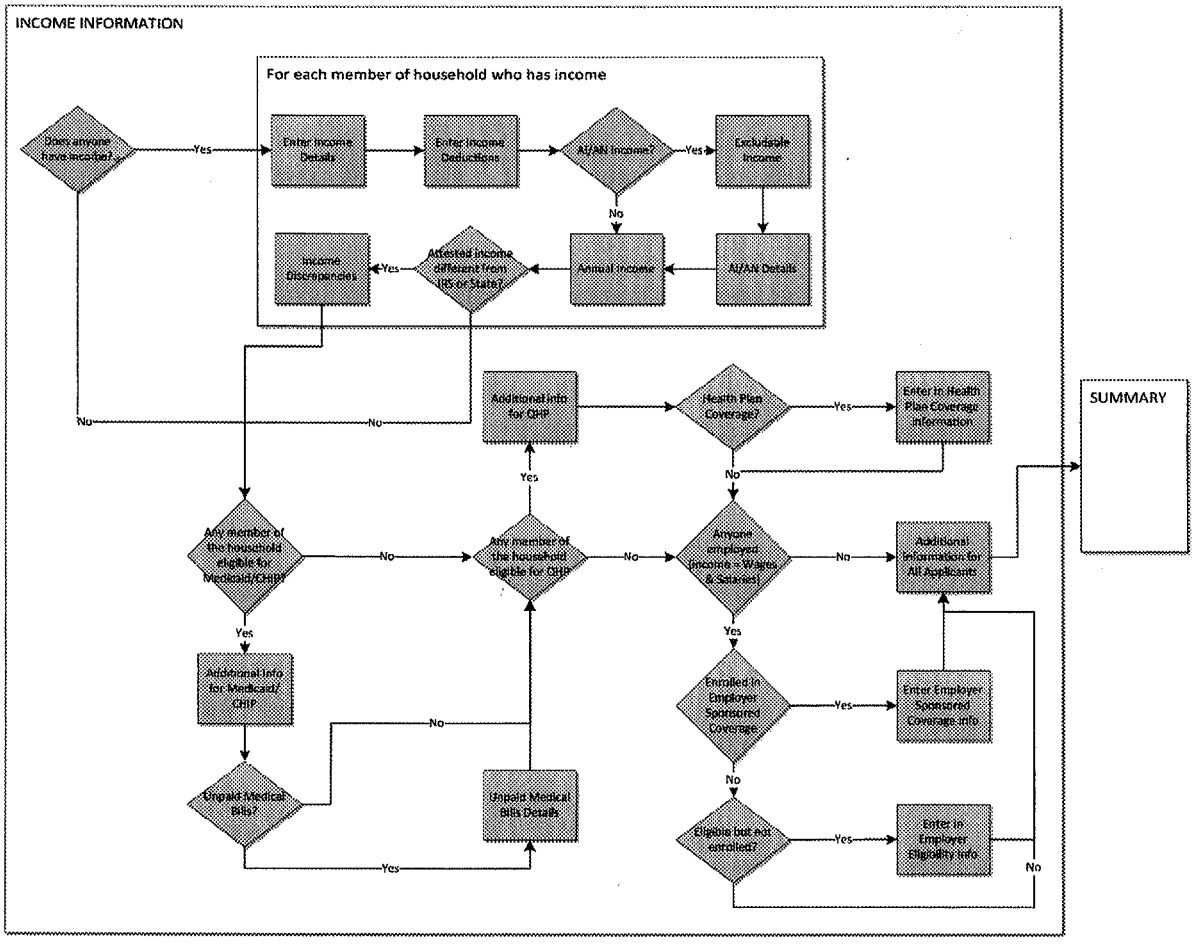
Additional Information for all Applicants	Values (if applicable)
Does anyone in the household have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?	No Yes



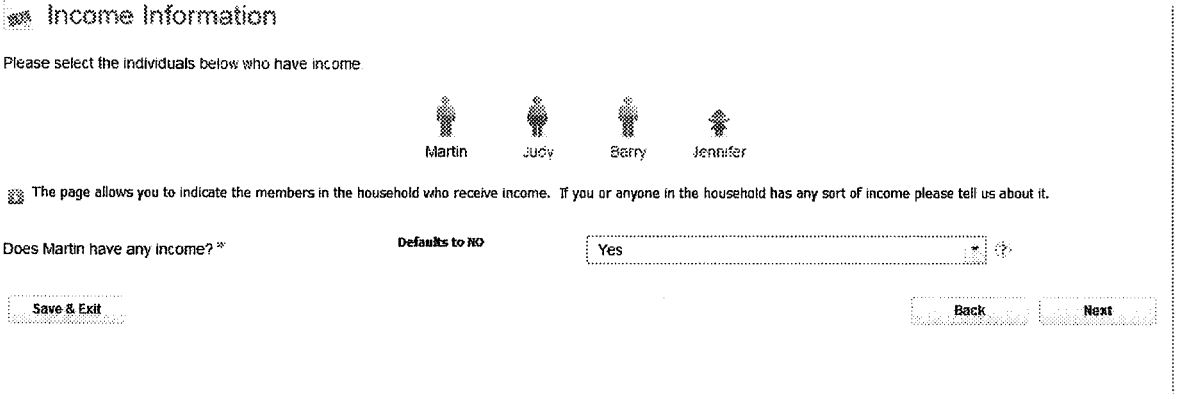
9 Section IX – Expedited Income

10 Section X - Current/monthly income

10.1 Flow Chart

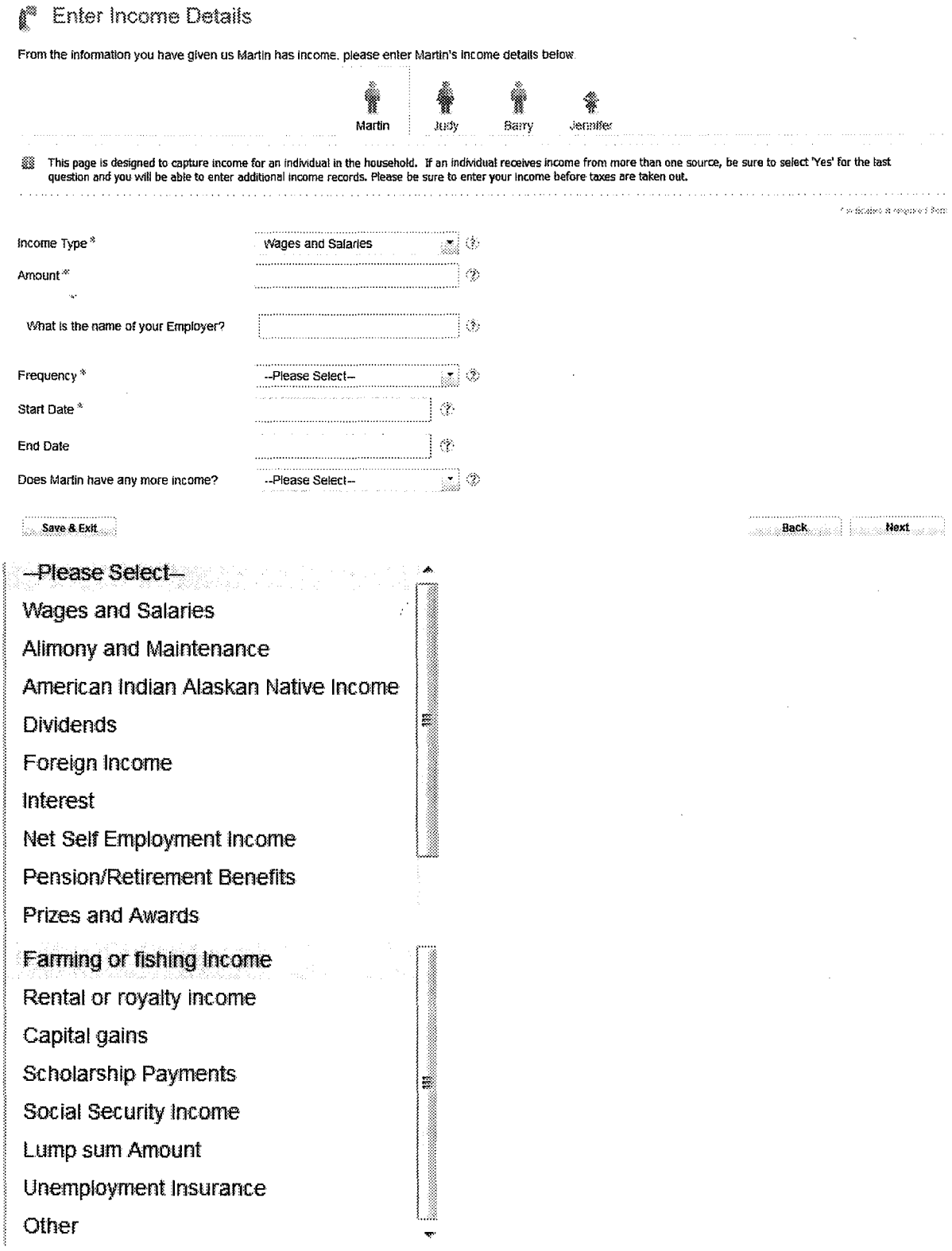


10.2 Income Information



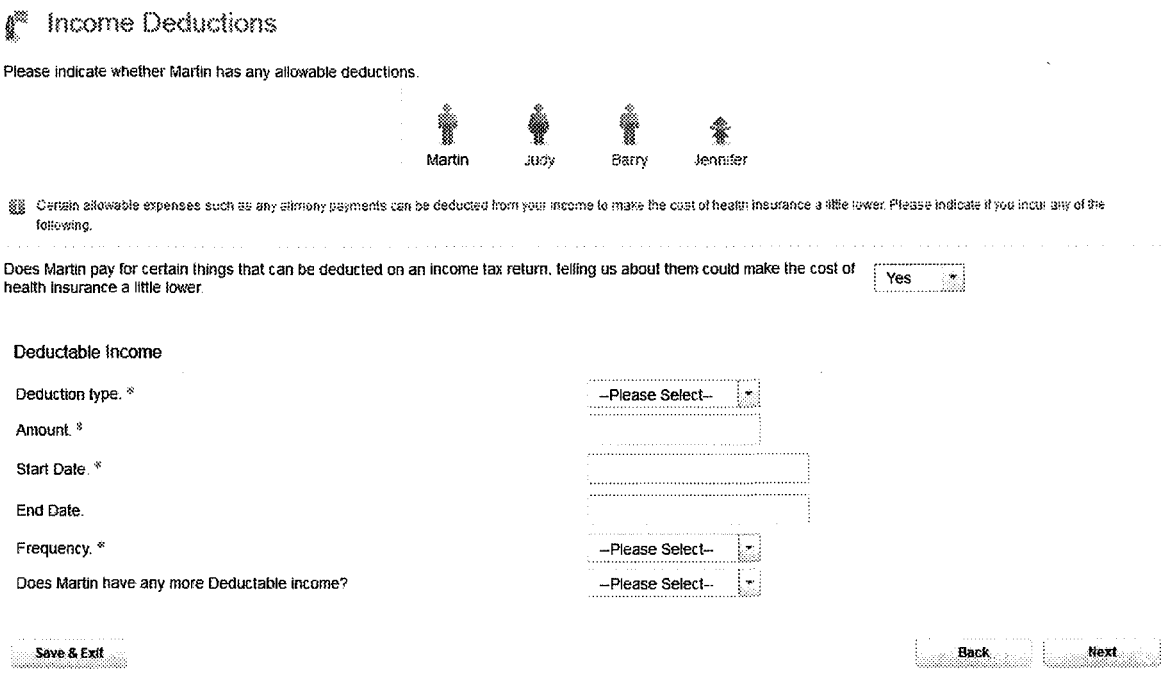
10.3 Enter Income Details

Enter Income Details	Values (If applicable)
From the information you have given us <name> has income, please enter <name's> income details below	
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	
Amount	Numeric
Frequency	Annually Bi-Weekly Monthly Quarterly Weekly
Start Date	
End Date	
Does [name] have any more income?	No Yes
If income type = 'Wages and Salaries' then the following is displayed	
What is the name of your employer?	
If income type = 'Foreign Income,' Interest' or 'Social Security income' then the following is displayed	
What portion of this amount is tax exempt?	

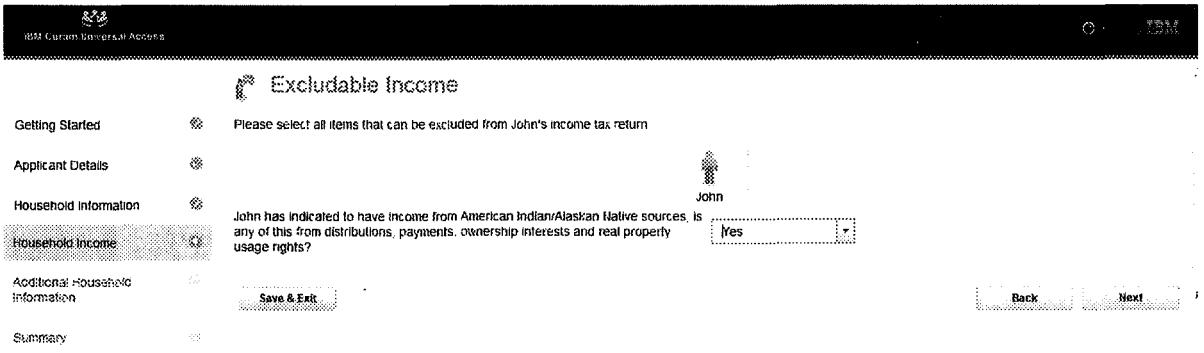

Enter Income Details
From the information you have given us Martin has income. please enter Martin's income details below
Martin
Judy
Barry
Jennifer
This page is designed to capture income for an individual in the household. If an individual receives income from more than one source, be sure to select '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
Amount *
What is the name of your Employer?
Frequency *
--Please Select--
Start Date *
End Date
Does Martin have any more income?
--Please Select--
Save & Exit
Back
Next
--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

10.4 Income Deductions

Income Deductions	Values (If applicable)
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:	
Does <name> 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.	No Yes
If the answer to the above field is 'YES', then the following displays	
Cluster: Deductible Income	
Deduction Type	Alimony paid Certain business expenses of reservists, performing artists, and fee-basis government officials Deductible part of self-employment tax Domestic production activates deduction Educator expenses Health savings account deduction Moving expenses Penalty on early withdrawal of savings Rent or Royalties Self-employed SEP, SIMPL, and qualified plans Self-employed health insurance deduction
Amount	Numeric
Start Date	
End Date	
Frequency	
Does <name> have any more Deductible income?	No Yes



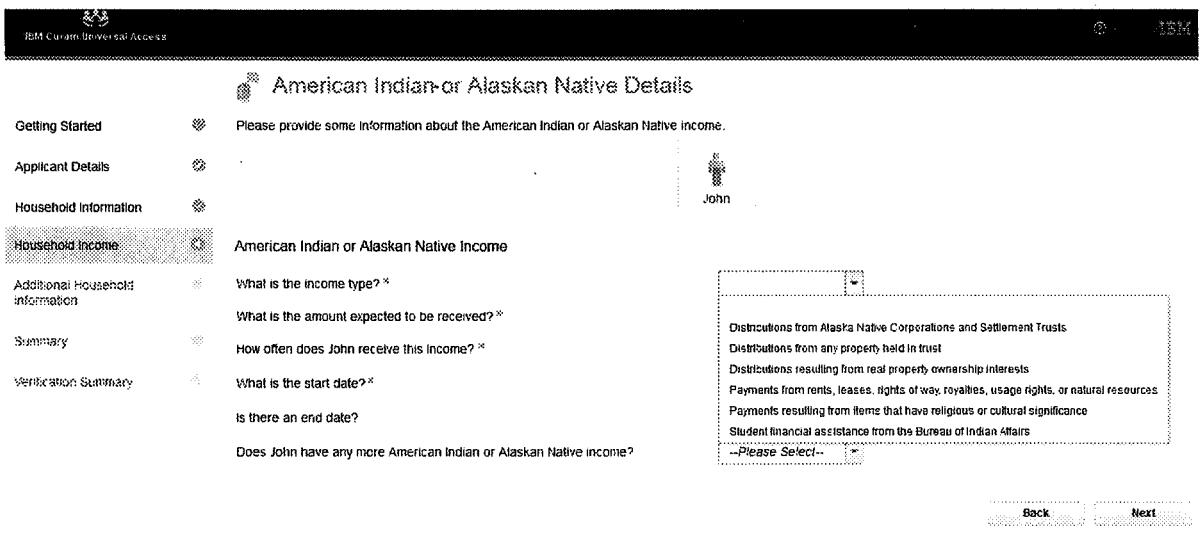
10.5 American Indian/Alaskan Native Excludable Income



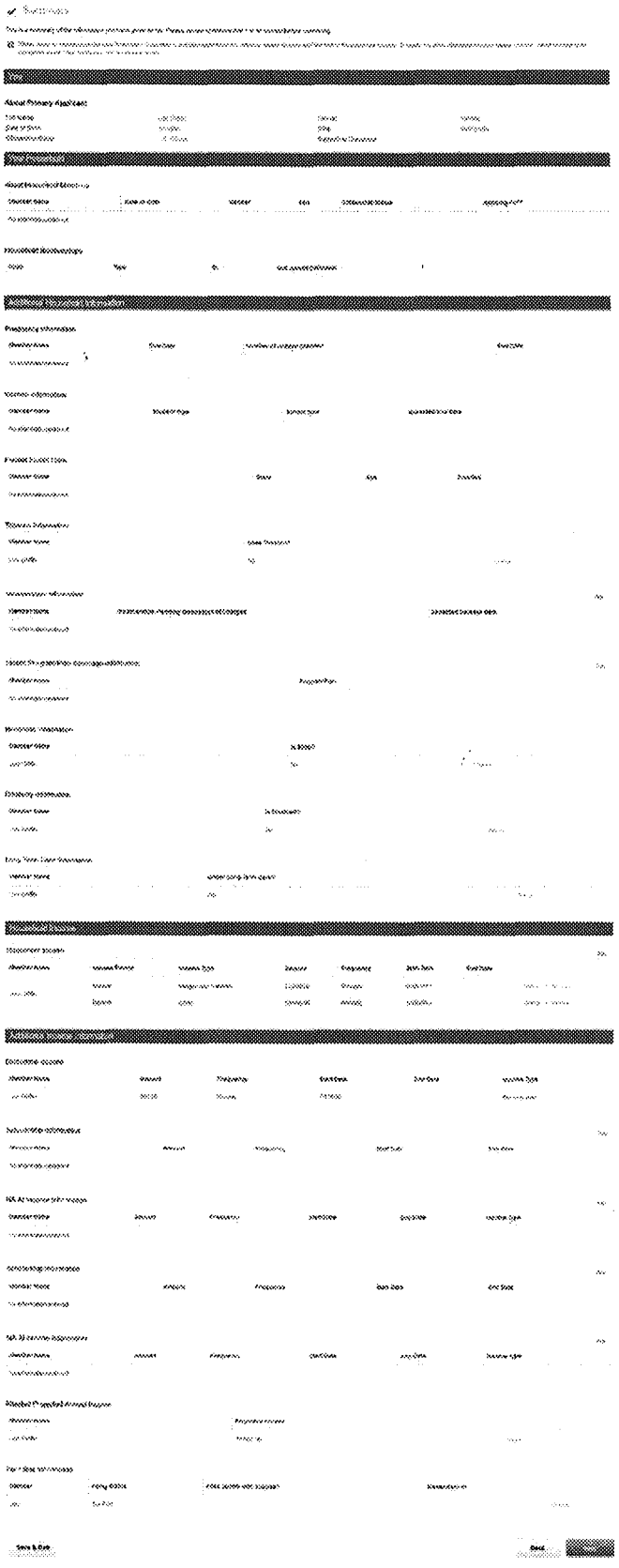
10.6 American Indian/Alaskan Native Income Details

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	

American Indian or Alaskan Native Details	Values (If applicable)
What is the income type?	Distributions from Alaska Native Corporations and Settlement Trusts Distributions from any property held in trust Distributions results from real property ownership interests Payments from rents, leases, rights of way, royalties, usage rights, or natural resources Payments resulting from items that have religious or culture significance Student financial assistance from the Bureau of Indian Affairs
What is the amount expected to be received?	
How often does <name> receive this income?	Frequency
What is the start date?	
Is there an end date?	
Does <name> have any more American Indian or Alaskan Native income?	No Yes

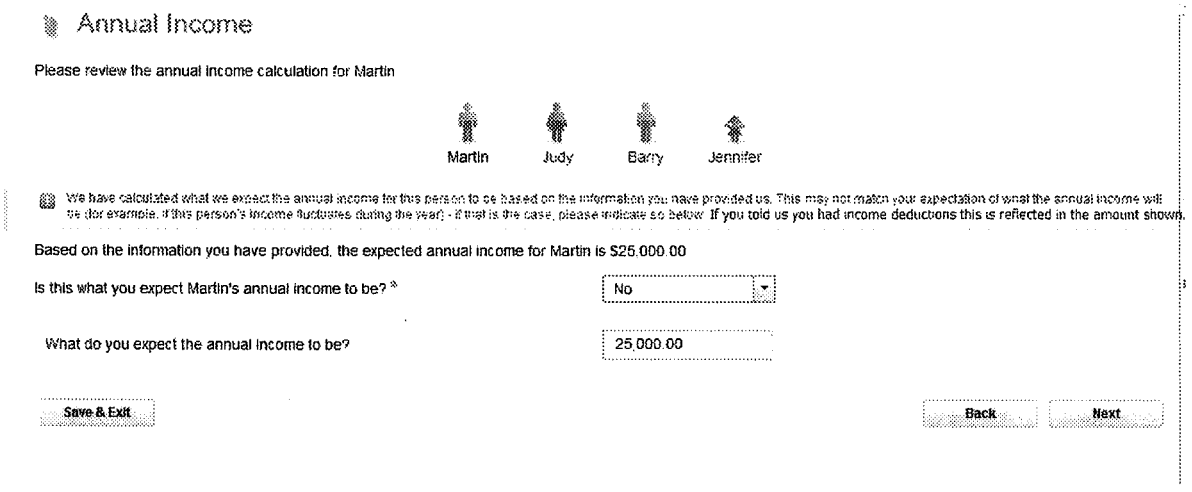


10.7 Summary



10.8 Annual Income

Annual Income	Values (If applicable)
Please review the annual income calculation for <name>	
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.	
Based on the information you have provided the expected annual income for <name> is <$amount>	
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

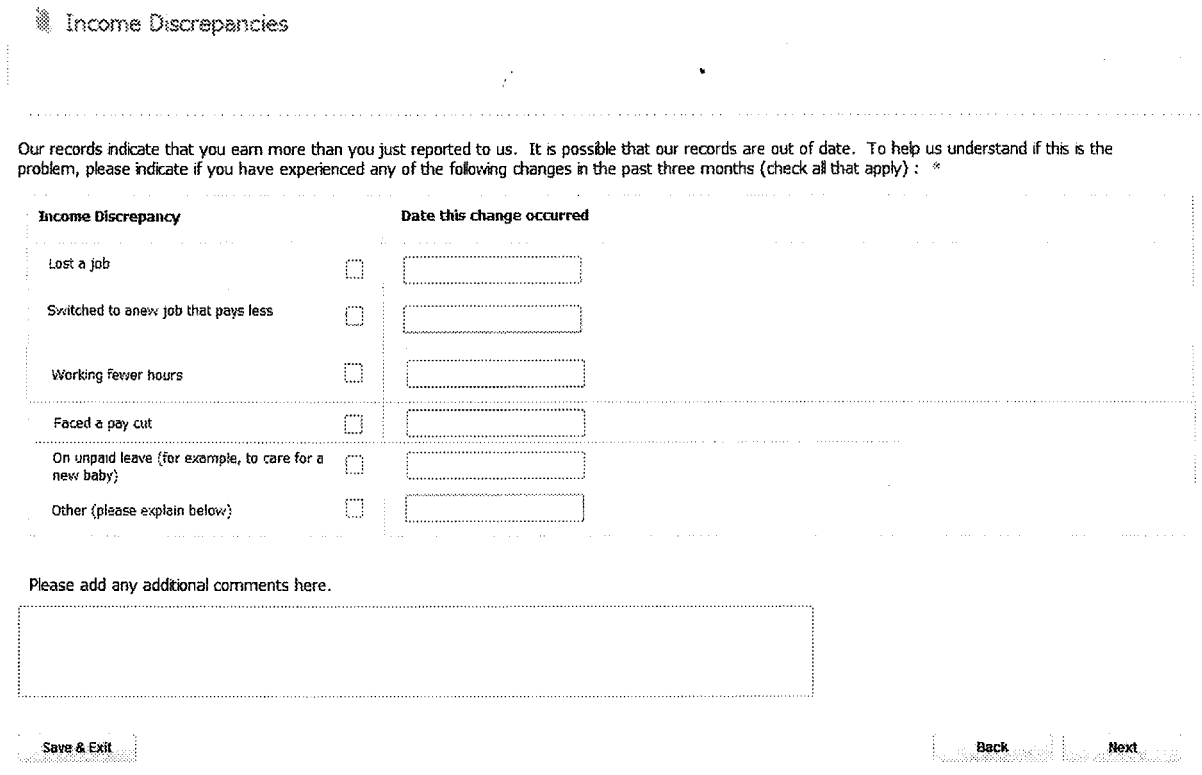


11 Section XI – Discrepancies

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

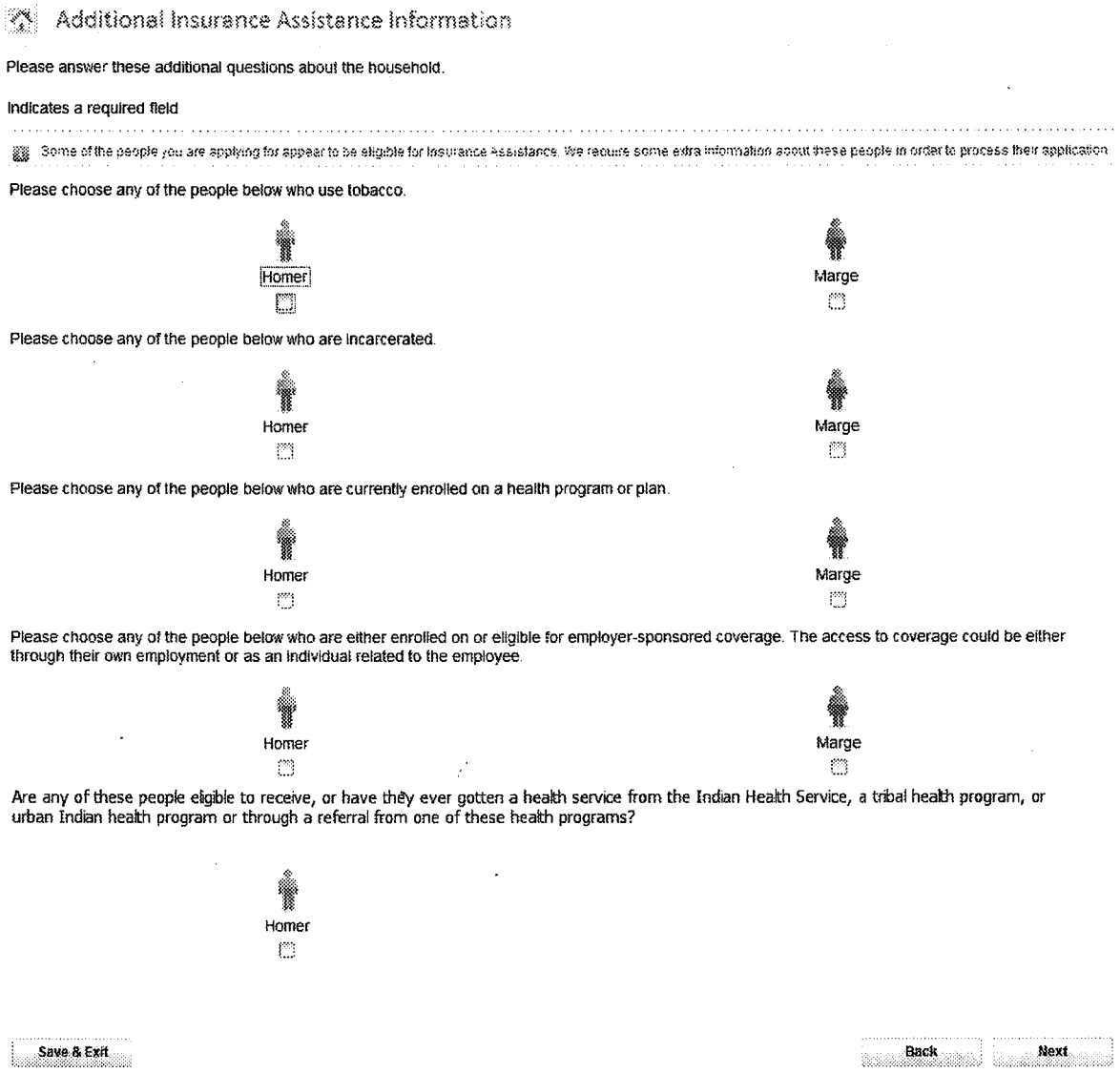
Income Discrepancies
You have indicated that your wages have decreased.
Our records indicate that you earn more than you just reported to us. It is possible that our records are out of date. To help us understand if this is the problem, please indicate if you have experience any of the following changes in the past three months (check all that apply):
Lost a job
Switched to a new job that pays less
Working fewer hours
Faced a pay cut
On unpaid leave (for example, to care for a new baby)
Other (please explain below)
Please add any additional comments here



12 Section XII – APTC program questions

12.1 Additional Insurance Assistance Information

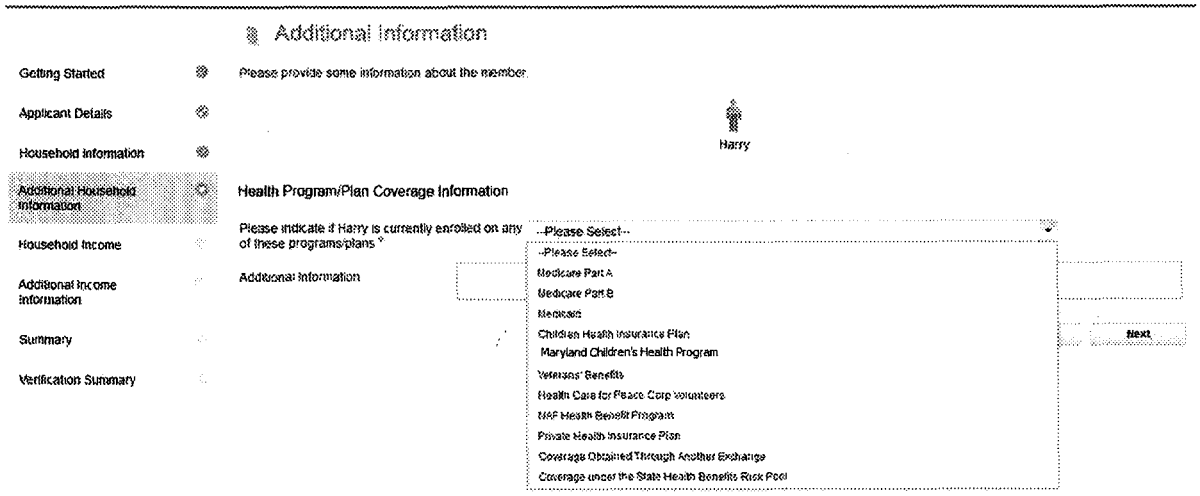
Additional Insurance Assistance Information
Banner
Please answer these questions about the household
Please choose any of the people below who use tobacco
Please choose any of the people below who are incarcerated
Participants
Please choose any of the people below who are enrolled in a health program or plan.
Participants
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.
Participants
Are any of these people eligible to receive, or heave 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?
Participants



12.2 Health Program/Plan Coverage Information

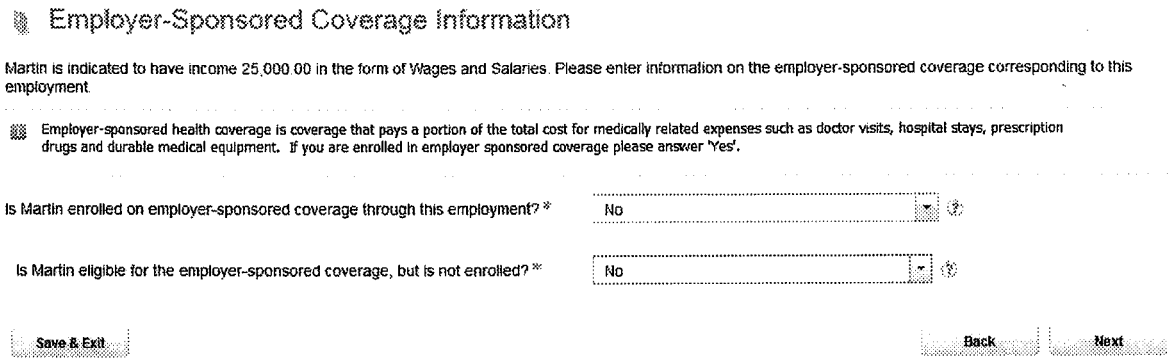
Health Program/Plan Coverage Information
Additional Information for Employer
(If the user selects the option 'YES' for the question 'Is anyone in your household currently enrolled on a Health Program or Plan?', then the following screen appears)
Cluster Name: Health Program/Plan coverage Information
Please indicate if [name] is currently enrolled on any of these programs/plans

Health Program/Plan Coverage Information
(If the user selects an option 'Private Health Insurance Plan' for the above question, then the following fields appear)
Plan Name
Provider Name
(If the user selects an option 'Coverage Obtained through another exchange' for the above question, then the following fields appear)
Exchange Name
State where the exchange is located
Additional Information



12.3 Employer Sponsored Coverage

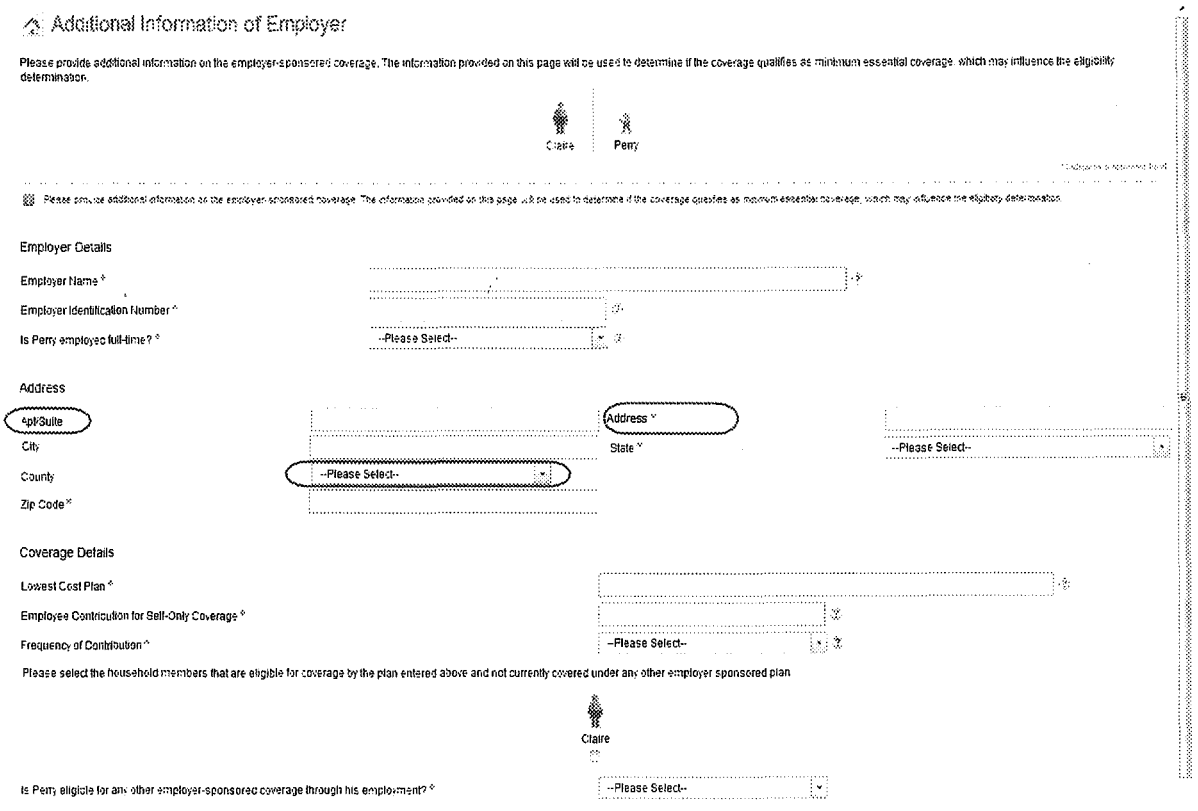
Employer Sponsored Coverage Information
<name> is indicated to have income <xxx>in the form of <income type>. Please enter information on the employer-sponsored coverage corresponding to this employment
Employer-sponsored health coverage is coverage that pays a portion of the total cost for medically 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?



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

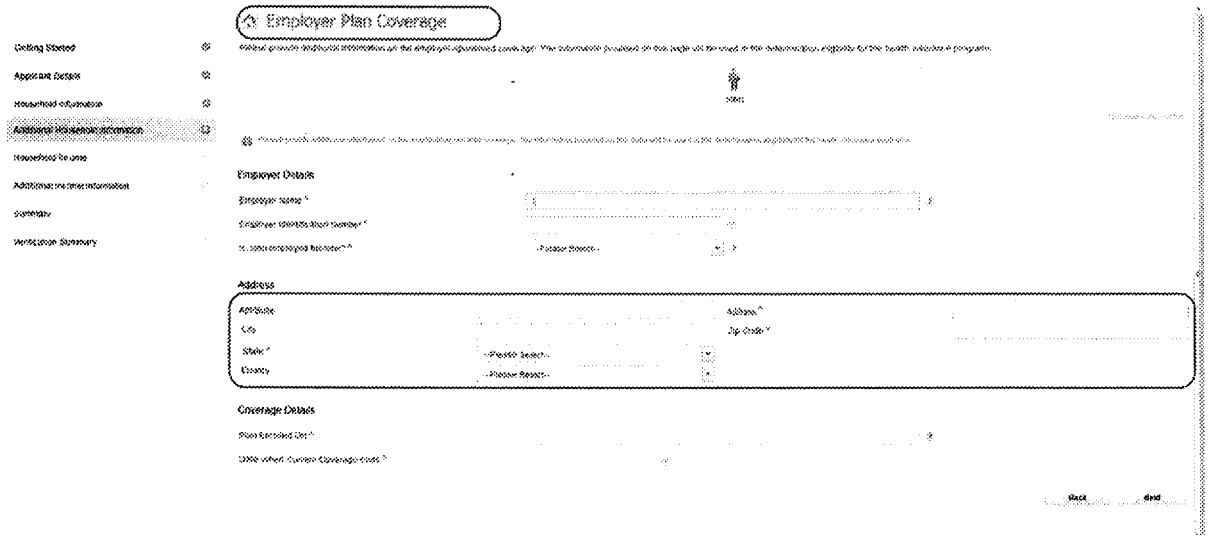
Additional Information of Employer
Frequency of Contribution
Please select the household member that are eligible for coverage by the plan entered above and not currently covered under any other employment sponsored plan
Is [name] eligible for any other employer sponsored coverage through his employment?



12.5 Employer Plan Coverage

Employer Plan Coverage

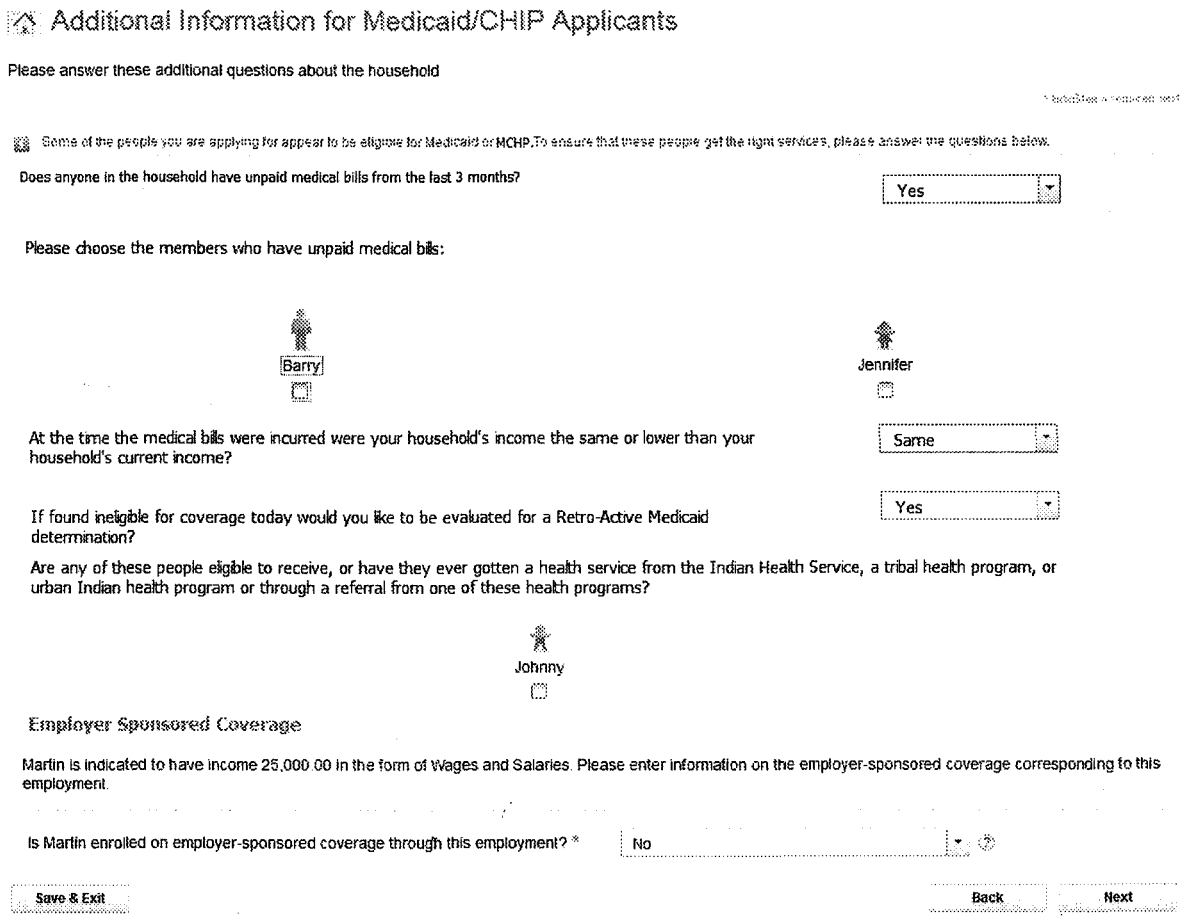
Employer Plan Coverage
(If the user selects the option 'YES' for the question 'Is enrolled for employer sponsored coverage information?', then the following screen appears)
Please provide additional information on the employer-sponsored coverage. The information provided on this page will be used in 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



13 Section VIII – Medicaid & CHIP specific questions

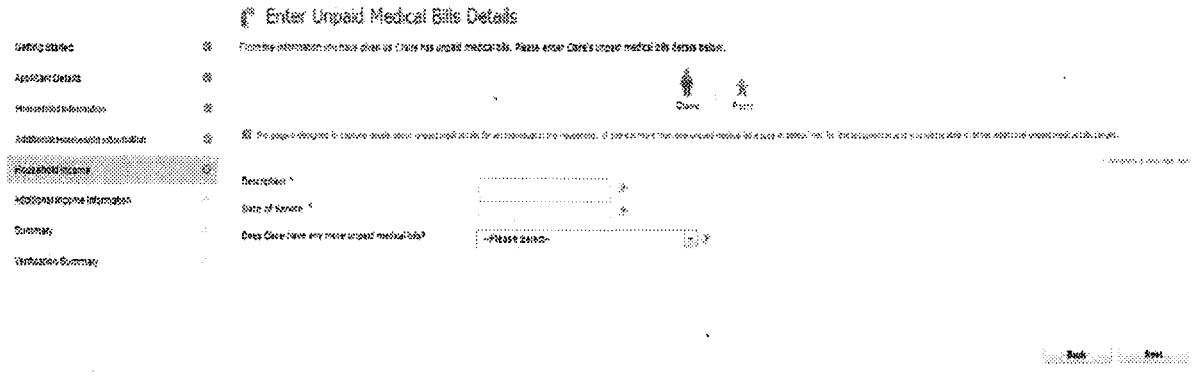
13.1 Additional Information for Medicaid/CHIP Applicants

Additional Information for Medicaid/CHIP Applicants	Values (If applicable)
Banner	
Please answer these additional questions about the household	
Some of these people you are applyfing for appear to be eligible for Medicaid or CHIP. To ensure that these people get the right services, please answer the questions below	
Does anyone in the household have unpaid medical bills from the last 3 months?	
Please choose the members who have unpaid medical bills	No Yes
If anyone selected 'Yes' to the above question then the following questions display	
At the time the medical bills were incurred were your household's income the same or lower than your household's current income?	Same Lower
If anyone selected 'Yes' to 'Are you an American Indian or Alaska Native' then this question displays	
Are any of these people eligible to receive, or heave 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?	
If found ineligible for coverage today would you like to be evaluted for a Retro-Active Medicaid determination?	No Yes
Cluster: Employer Sponsored Coverage	
<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	
Is <name> enrolled on employer-sponsored coverage through this employment?	No Yes

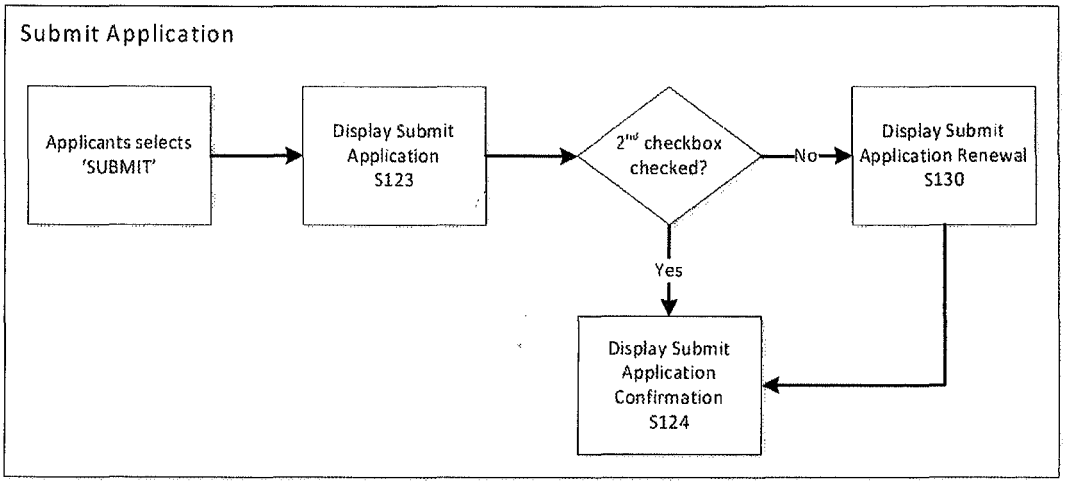


13.2 Unpaid Medical Bills Details

Enter Unpaid Medical Bills Details	Values (If applicable)
Banner	
From the information you have given us <name> has unpaid medical bills. Please enter <name's> unpaid medical bills details below.	
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.	
Description	
Date of Service	
Does <name> have any more unpaid medical bills?	No Yes



14 Section XV Review & Sign



14.1 Submit Application

Submit Application
Please read the following termas 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

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

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

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

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 **no**t 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.

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

Hospital Presumptive (Temporary) Eligibility Process

WHAT IS HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE)?

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

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

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

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.

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

When Does HPE Coverage Begin?

- HPE period begins with, and includes, the day on which the hospital makes the HPE determination

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

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.

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

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.

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

What does HPE cover?

- HPE offers full access to all benefits under Maryland Medicaid Fee-for-Service.

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

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)

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

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)

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

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.

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

Hospital Presumptive (Temporary) Eligibility Process

THE HOSPITAL'S ROLE IN HPE

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

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.

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

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.

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

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.

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

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.

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

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.

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

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.

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

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/.

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

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)

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

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

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

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.

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

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.

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

IV. Notify the applicant, continued

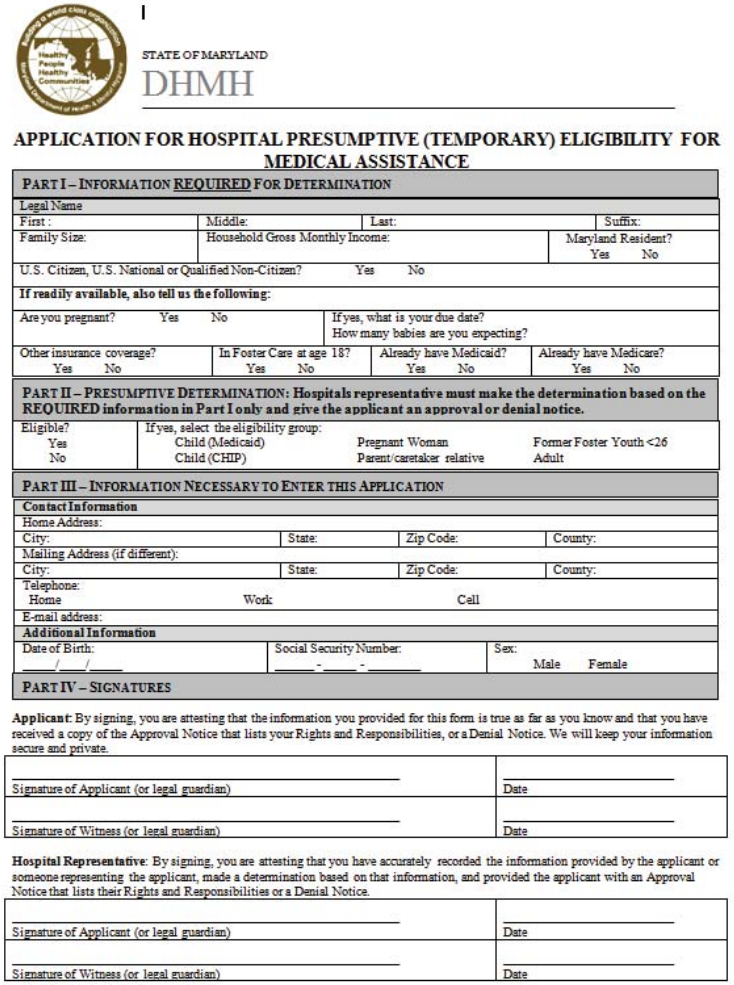
- Hospital provides the **ineligible** individual with:
  - A denial notice;
  - A copy of the completed HPE Application;
  - The full MA packet; and
  - Assistance with completing the MA application, or information on resources to help the individual complete and submit the MA application.

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

HPE Application

For all applicants, make sure all parts of the form are completed.



STATE OF MARYLAND
DHMH

APPLICATION FOR HOSPITAL PRESUMPTIVE (TEMPORARY) ELIGIBILITY FOR MEDICAL ASSISTANCE

PART I – INFORMATION REQUIRED FOR DETERMINATION

Legal Name			
First:	Middle:	Last:	Suffix:
Family Size:	Household Gross Monthly Income:		Maryland Resident? Yes No
U.S. Citizen, U.S. National or Qualified Non-Citizen? Yes No			
If readily available, also tell us the following:			
Are you pregnant? Yes No	If yes, what is your due date? How many babies are you expecting?		
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 – 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, select the eligibility group: Child (Medicaid)	Pregnant Woman	Former Foster Youth <26
	Child (CHIP)	Parent/caretaker relative	Adult

PART III – INFORMATION NECESSARY TO ENTER THIS APPLICATION

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:			
Additional Information			
Date of Birth: ___/___/____	Social Security Number: ___-___-____	Sex: Male Female	

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 Witness (or legal guardian)	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 Applicant (or legal guardian)	Date
Signature of Witness (or legal guardian)	Date

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

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

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

IV. Notify the applicant, continued

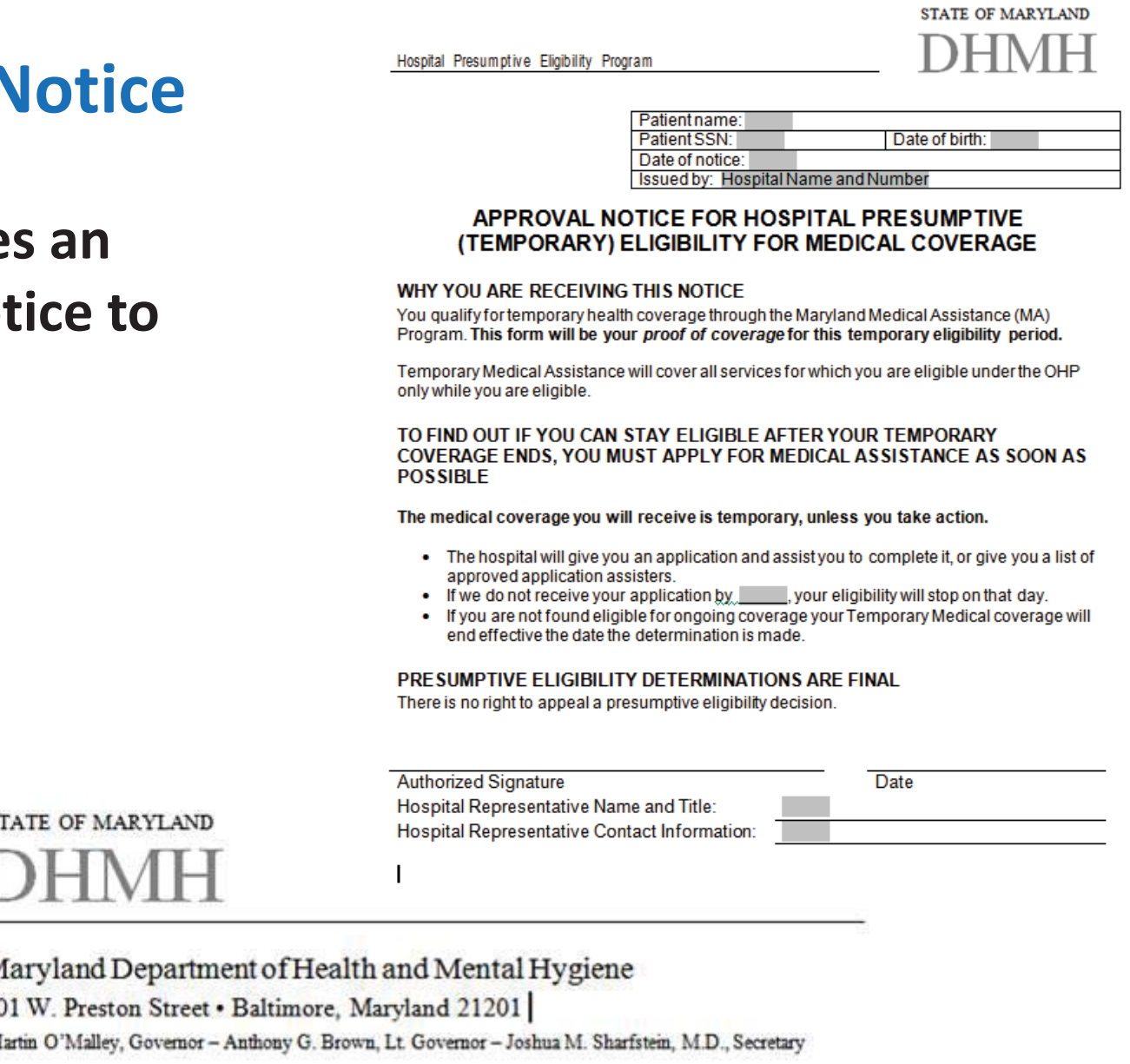
- The Approval Notice is proof of coverage.
  - If the applicant is eligible, the Notice of Approval will be the individual's proof of coverage until they receive their Maryland Medical Assistance Number and Coverage Letter.

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

Approval Notice

Hospital gives an Approval Notice to all eligible applicants.



STATE OF MARYLAND
DHMH

Hospital Presumptive Eligibility Program

Patient name:	
Patient SSN:	Date of birth:
Date of notice:	
Issued by: Hospital Name and Number	

APPROVAL NOTICE FOR HOSPITAL PRESUMPTIVE (TEMPORARY) ELIGIBILITY FOR MEDICAL COVERAGE

WHY YOU ARE RECEIVING THIS NOTICE

You qualify for temporary health coverage through the Maryland Medical Assistance (MA) Program. **This form will be your *proof of coverage* for this temporary eligibility period.**

Temporary Medical Assistance will cover all services for which you are eligible under the OHP only while you are eligible.

TO FIND OUT IF YOU CAN STAY ELIGIBLE AFTER YOUR TEMPORARY COVERAGE ENDS, YOU MUST APPLY FOR MEDICAL ASSISTANCE AS SOON AS POSSIBLE

The medical coverage you will receive is temporary, unless you take action.

- The hospital will give you an application and assist you to complete it, or give you a list of approved application assisters.
- If we do not receive your application by _____, your eligibility will stop on that day.
- If you are not found eligible for ongoing coverage your Temporary Medical coverage will end effective the date the determination is made.

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: _____

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

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

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

Denial Notice

Hospital gives a Denial Notice to all ineligible applicants.

Hospital Presumptive Eligibility Program

STATE OF MARYLAND
DHMH

Patient name:	
Patient SSN:	Date of birth:
Date of notice:	
Issued by: Hospital Name and Number	

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: _____

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

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.

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

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.

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

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.

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

Hospital Presumptive (Temporary) Eligibility Process

DHMH'S ROLE IN HPE

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

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.

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

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.

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

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.

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

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.

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

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).

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

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.

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

Hospital Presumptive (Temporary) Eligibility Process

THE APPLICANT'S RESPONSIBILITIES

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

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

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

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.

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

- 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

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

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.

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

Standards and Criteria

Proposed Quality Standard	Criteria
1. 90 percent of the time	The Hospital's determination that the applicants do not have current Medicaid/CHIP is correct
2. 90 percent of the time	The Hospital's determination that applicants did not receive temporary coverage within the past 12 months is correct.
3. 90 percent of all approved HPE applicants	Submit a full MA application no later than the last day of the month following the month during which the HPE determination is made.

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

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.

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

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.

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

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

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

Hospital Presumptive (Temporary) Eligibility Process

FEEDBACK AND Q & A

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