Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

June, 2012

v1.0

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Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of _____Maryland_____ requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is ___Medical Day Care Case Management_(MDC CM)___. (List each program name if the waiver authorizes more than one program.).

Type of request. This is:
__X_ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
___ a renewal request

Section A is:
___ replaced in full
___ carried over with no changes
___ changes noted in **BOLD**.

Section B is:
___ replaced in full
___ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of __5__ years beginning ____2/1/2026_____and ending _____06/30/2030_____.

State Contact: The State contact person for this waiver is ___Jamie Smith_____ and can be reached by telephone at (410) 767-1431, or fax at (---) _____---_____, or e-mail at jamie.smith1@maryland.gov. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

In accordance with Section 1902(a)(73) of the Social Security Act, Maryland Medicaid seeks advice on a regular, ongoing basis from designees including Maryland's Urban Indian Organization. Maryland's Tribal Government, the Urban Indian Organization (UIO), was consulted and provided notice and copies of the redline and clean waiver application via email on August 22, 2025. The UIO contact notified was kerry@nativelifelines.org.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

This waiver will provide authority for the State Medicaid Agency (SMA) to award a sufficient number of case management agencies (CMAs) to provide case management services to participants of the accompanying 1915(c) Medical Day Care Services Waiver (MDCSW).

The accompanying 1915(c) MDCSW provides eligible Medicaid participants who require a nursing facility level of care (LOC) a cost effective community-based alternative to institutional care. By offering the medical day care (MDC) service, the MDCSW is able to serve individuals ages 16 or older, affording them opportunities to stay connected to family and their communities. Each participant has a plan of care developed in collaboration with the adult medical day care provider they attend.

CMS identified a conflict of interest (COI) in the current MDCSW where service providers act as case managers. To cure this COI, CMS has mandated the SMA to put into place case management services to ensure participants a choice of CMA, and ensure those CMAs do not also provide other waiver services. The goal is to provide mandatory independent case management services to approximately 5,000 participants of the MDCSW.

Organizational Structure:
The Maryland Department of Health (MDH), Office of Long Term Services and Supports (OLTSS) will be the single SMA. OLTSS is responsible for ensuring compliance with federal and State laws and regulations related to the operation of the waiver. Additionally, OLTSS is responsible for policy development, authorizing and coordinating the participant and provider enrollment process, coordinating the fair hearing process, monitoring the performance of the MDC provider, overseeing the waiver and carrying out federal and State reporting functions.

The SMA monitors the CMAs who are responsible for coordinating an applicants' enrollment, offering/documenting applicants/participants' choice between institutional care and home and community-based services (HCBS) and choice among qualified providers, developing and monitoring the implementation of participants' plans of service (POS), and conducting site visits to monitor participant health, welfare, and satisfaction with services. In addition, the case managers initiate annual waiver eligibility redeterminations, ensure annual POS are completed and coordinate the denial and disenrollment processes as appropriate. The SMA or its designee are responsible for approving POS. In addition, the SMA directly monitors the activities of contracted CMAs.

Service Delivery Methods:
Medical day care services are rendered by MDC providers who must be licensed by the Office of Health Care Quality (OHCQ) and approved by the SMA according to provider standards developed by the OLTSS. Case management services are rendered by approved and enrolled

CMAs. All waiver services must be authorized and only those waiver services that comply with the participant's POS will be reimbursed by Medicaid.

The waiver requested is limited to the case management services.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

State Plan services are not included in this 1915(b)(4) waiver.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   __X_ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a.___ **Section 1902(a) (1) - Statewideness**
   b.___ **Section 1902(a) (10) (B) - Comparability of Services**
   c._X_ **Section 1902(a) (23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

___ the same as stipulated in the State Plan
_X_ is different than stipulated in the State Plan (please describe)

Reimbursement for waiver case management services in the proposed amendment to the MDCSW will be based on a rate set for a similar 1915(c) HCBS waiver - the Home and Community-based Options Waiver. Maryland will use the contracted MDCSW CMAs to provide case management services. The CMAs will enroll and be approved Medicaid providers, and bill for providing case management as a comprehensive waiver service in accordance with the 1915(c) Waiver authority and regulations. The providers will enter into the standard Medicaid Provider Agreement, but will meet additional quality standards and perform enhanced quality monitoring and remediation tasks as outlined in the competitive procurement.

2. **Procurement**. The State will select the contractor in the following manner:

_X_ **Competitive** procurement

___ **Open** cooperative procurement
___ **Sole source** procurement
___ **Other** (please describe)

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

___ Beneficiaries will be limited to a single provider in their service area.
_X_ Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

Selected CMAs will serve in one or more of Maryland's 23 counties and Baltimore City or Statewide. The SMA reviewed current and projected participant enrollment when selecting CMAs to ensure sufficient access to case management services across the State.

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

Individuals who are 16 years and older, eligible for traditional Medicaid State Plan services, and meet nursing facility level of care who do not participate in another HCBS waiver or PACE will be eligible for the MDCSW. An applicant is eligible to receive the case management services when it is determined through a comprehensive assessment (e.g.; interRAI) that an individual meets a nursing facility LOC. The interRAI differs in its evaluation of nursing facility LOC by asking additional questions related to the participant's formal and informal supports in order to develop a more refined plan of care. It assists participants, families and providers with identifying services, risks and other health-related issues.

The assessment was developed in 1994 based on CMS' Minimum Data Set (MDS) 2.0, is used worldwide and has shown to have robust inter-rater reliability. For more information and publications related to its testing and use, please see their website at http://interrai.org/home-care.html.

MDC case management also has additional requirements above those noted in the Medicaid State Plan such as incident reporting in the case of immediate jeopardy and other reportable events, and conflict of interest reporting to ensure separation between case managers and Medicaid providers as required by CMS standards.

MDC case management is billed at 15-minute increments at a rate of 23.2645 per unit. Billable units may only include services rendered under the direct scope of case management. In addition, CMAs must submit a monthly activities audit to OLTSS outlining the tasks

performed for billable services rendered. Rates are subject to the State's budget and are published via rate transmittal and in accordance with COMAR 10.09.07.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

_X_ Section 1931 Children and Related Populations
_X_ Section 1931 Adults and Related Populations
_X_ Blind/Disabled Adults and Related Populations
___ Blind/Disabled Children and Related Populations
___ Aged and Related Populations
_X_ Foster Care Children
___ Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
_X__Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
_X__Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
___ Other (Please define):

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.,* what constitutes timely access to the service?

Participants are required to select a CMA within 21 calendar days of being approved for the MDCSW. At the time applicants are determined to meet LOC eligibility they are provided information and marketing material of all available CMAs in their area to better make an informed decision. If the applicant does not choose a CMA within 21 calendar days, one is

automatically assigned. After being assigned, a case manager has 14 calendar days to make initial contact with the participant.

1. **How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?**

The CMAs will provide both initial and on-going waiver case management to the applicants and enrollees in their county/counties or statewide. The case management services can be effectively monitored by the SMA for timeliness through reports generated by a web-based tracking system (e.g.; LTSS*Maryland*) and off-site provider audits conducted by the SMA.

The SMA ensures that continuity and coordination of care are maintained under the MDCSW despite the use of selective contracting for CMAs.

The SMA has contracted with a sufficient number of CMAs distributed throughout the state to ensure participant choice and access. Participants may select any Medicaid-enrolled CMA awarded by the SMA, and CMAs are required to maintain policies that support participant transitions between agencies without service disruption.

2. **Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.**

If no CMA is selected in 21 calendar days, then a CMA will be assigned to the participant. Assignments are done "round robin" style if there is more than one CMA operating in the participant's county.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

The SMA solicited the Hilltop Institute to conduct an analysis and recommend the number of CMAs and case managers needed to sufficiently serve the current and projected number of unduplicated MDCSW participants. The Hilltop Institute took into consideration the comparable needs of this population and utilization data of case management services in the Home and Community-Based Options Waiver.

The SMA has contracted with a sufficient number of CMAs distributed throughout the state to ensure participant choice and access. Participants may select any Medicaid-enrolled CMA awarded by the SMA, and CMAs are required to maintain policies that support participant transitions between agencies without service disruption.

CMAs coordinate closely with MDC providers to ensure care planning. The SMA requires CMAs to document all referrals, service changes, and participant contacts in LTSS*Maryland,* allowing real-time tracking of care coordination activities. CMAs receive Chesapeake Regional Information System for our Patients (CRISP) notifications for participant hospitalizations or emergency department visits to support real-time care coordination.

All CMAs operate under uniform standards defined in the solicitation, ensuring consistency in assessment, care planning, service monitoring, and participant communication.

1. **Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.**

The SMA ensures provider capacity for MDC case management by maintaining a statewide network of Medicaid-enrolled CMAs with demonstrated capacity to meet program requirements.

The SMA requires CMAs to meet provider qualifications as outlined under the solicitation and monitors enrollment data to ensure geographic distribution of CMAs aligns with participant populations. CMAs are restricted to serving participants in a specific region and may accept referrals statewide.

Annual provider monitoring, including review of CMA staffing levels and caseloads, ensures adequate capacity is maintained even as enrollment or utilization increases. The SMA also requires CMAs to maintain staffing ratios consistent with the volume of participants served to prevent delays in care planning and monitoring.

The chart below shows the current projection of case managers needed by the county using the most recent participant count and the ability to meet caseload standards (minimum 1:20, maximum 1:55), per case manager.

County	**Case Managers Needed**
Montgomery	90-33
Baltimore City	55-20
Baltimore	34-13

Howard	23-9
Prince George	8-3
Anne Arundel	7-3
Allegany	4-2
Frederick	3-2
Harford	3-2
Washington	2-1
Dorchester	1
Charles	1
Carroll	1
St. Mary’s	1
Wicomico	1
Cecil	1
Calvert	1
Garrett	1
Worcester	1

Somerset	1
Talbot	1
Caroline	1
Kent	1
Queen Anne	0

1. **Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.**

   A real-time report will be utilized to identify individuals awaiting assignment to a case manager. This report is monitored daily to confirm adequate capacity. Should specific areas demonstrate insufficient case manager availability, direct collaboration with the relevant CMAs in those regions is initiated to increase capacity The SMA will assign the participant to the next closest available CMA approved for their jurisdiction using a "round robin" methodology.

   In addition to daily reports, the SMA will conduct provider network adequacy analyses (e.g., geomapping of providers, provider-to-beneficiary ratios), claims data analysis to identify access barriers, and grievance/complaint reviews related to access.

   When access issues are identified, CMA providers will develop corrective action plans, providers will be supported in recruitment initiatives for expanding case manager staffing to cover underserved areas; be supported in exploring service delivery models (e.g. telehealth); be supported in engaging in stakeholder support (e.g. advisory committees, local health departments, other state agencies, community organizations, serving individuals with complex needs).

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

The CMAs are responsible for ensuring applicants and participants choose HCBS as an alternative to institutionalization, have choice in providers, have their needs assessed, receive appropriate services, continuity of care, participate in person-centered planning including meeting with the participant and/or their representative, documenting service needs and wants, personal goals, and maximum service frequencies.

The CMAs are required to meet case management performance standards and are audited annually with regards to their performance. The CMAs are required to complete the following activities:

- Developing initial, annual, and revised POSs using a person-centered planning process
- Assist with eligibility, care coordination, and service maintenance and monitoring
- Conduct quality assurance and improvement activities to ensure services are delivered as outlined in the POS
- Assist with accessing and maintaining Medicaid coverage while coordinating community services and support from various providers and funding sources
- Adhere to SMA's Reportable Events/Immediate Jeopardy Policy
- Maintain contact with the participant to ensure their needs are met with the services and supports outlined in the POS and identify any unmet needs

1. **How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?**

Annual provider monitoring, including review of CMA staffing levels and caseloads, ensures adequate capacity is maintained even as enrollment or utilization increases. The SMA also requires CMAs to maintain staffing ratios consistent with the volume of participants served to prevent delays in care planning and monitoring.

Data is received, reviewed, and documented by the SMA staff. Sources of data include but are not limited to: providers' submission of enrollment documents; reportable events; continued stay reviews; UCA reports; and complaints made by participants and/ or their family/ caregivers, and service utilization and quality by case managers. Based on the nature of this information, data are disseminated to the appropriate staff to be reviewed, prioritized, and recorded.

SMA staff monitor compliance with solicitation contract standards on an ongoing basis. Such standards include, but are not limited to, ensuring that an applicant has selected a CMA within twenty one calendar days of application, ensuring that a case manager is assigned by the CMA within three calendar days of selecting a CMA, ensuring that the case manager has initiated participant contact within fourteen days of referral, and has submitted a POS to LTSS*Maryland* within twenty days of acceptance of a new participant.

The SMA will receive reports from LTSS*Maryland*, Reportable Events Unit, Eligibility Versification System (EVS), and MMIS II, and may request ad hoc reports as needed. These reports are generated on a monthly basis for EVS and LTSS*Maryland*, and as needed for the Reportable Event Unit and MMIS II.

2. **Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.**

MDCSW applicants are required to choose a CMA or be assigned to a CMA. MDCSW applicants must work with their assigned CMA to develop and submit a person-centered plan of service in order to establish a service begin date and to maintain eligibility annually thereafter. Participants failing to work with their assigned CMA will have an opportunity to change CMAs if they choose and be educated on the requirement to do so to remain eligible for the waiver program.

CMAs not meeting utilization expectations will be monitored and provided technical assistance. CMAs not serving the minimum number of participants, not due to low enrollment in their service area, will be required to provide the SMA a corrective action plan detailing their remediation and action plan. The SMA will support the CMA in building up capacity through sharing marketing materials to interested applicants covered by the CMA's operating area.

CMAs are also expected to meet operational standards regarding the services provided. Such services include, but are not limited to, developing initial, annual, and revised POSs using a person-centered planning process working directly with applicants and participants to help them access Medicaid and non-Medicaid services. These POSs must be tailored to ensure the selected services and supports meet the unique needs of each individual. In addition to POS development, CMAs are expected to assist with eligibility, care coordination, and service maintenance and monitoring for their participants. Finally, it is the CMAs responsibility to conduct quality assurance and improvement activities to ensure services are delivered as outlined in the POS and the services meet or exceed established standards.

CMAs not meeting these standards will be required to submit a corrective action plan as detailed above.

Continued unsatisfactory levels of case management services being rendered may result in further sanctions. Sanction may be employed and escalated as outlined in the contract and as necessary.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. **Describe the State's quality measurement standards specific to the selective contracting program.**

The SMA assures the quality of case management services under the MDCSW through a structured selective contracting process that establishes rigorous standards for provider participation, ongoing monitoring, and performance improvement.

The SMA utilizes a competitive solicitation to select CMAs capable of delivering high-quality, conflict-free case management to waiver participants statewide. This solicitation outlines minimum and highly desirable provider qualifications, ensuring that only CMAs with relevant experience and demonstrated capacity are eligible for contract award. At minimum, CMAs must possess two years of experience providing community-based case management services for individuals with complex medical or behavioral health needs, older adults, and individuals aged 16 and older with disabilities. Highly desirable qualifications include additional years of experience, advanced staff credentials, and prior participation in Medicaid programs.

The provider selection process includes a comprehensive evaluation of each CMA's technical proposal and work plan, which must detail approaches to participant engagement, care coordination, timeliness of service delivery, and conflict-free practices in accordance with 42 CFR §441.301(c)(1)(vi). Proposals are reviewed and scored based on the following weighted criteria:

Quality of Proposed Work Plan (50%): This includes the provider's methodologies for performing initial assessments, annual plan updates, conflict resolution, staff training, and compliance with Medicaid requirements.

Organizational Qualifications and Experience (30%): Providers are assessed on their demonstrated experience, staffing qualifications, ability to meet caseload standards (minimum 1:20, maximum 1:55), and history of compliance with state and federal regulations.

Capacity and Coverage (10%): Evaluates the provider's capacity to serve one or more counties and maintain sufficient staffing to meet projected demand.

Cost-effectiveness (10%): Considers the provider's ability to deliver services efficiently without compromising quality.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

To maintain quality after contract award, the SMA requires CMAs to submit Quality Assurance and Quality Improvement (QA/QI) plans as part of their proposals. These plans must outline strategies for monitoring compliance with

contractual and regulatory requirements, evaluating participant outcomes, and implementing corrective action when deficiencies are identified. CMAs are also required to submit quarterly reports detailing conflicts of interest, participant access to interpretation and translation services, and compliance with reportable events policies under the solicitation.

Ongoing oversight includes:

Quarterly performance monitoring of case manager to participant ratios, timeliness of assessments, and service plan completions through LTSS*Maryland*.

Annual site visits and audits conducted by the SMA to verify documentation, participant records, and quality of service delivery.

Participant feedback surveys and analysis of grievance data to identify systemic issues.

Enforcement of corrective action plans or termination of contracts for CMAs failing to meet performance expectations.

This layered approach to provider selection and monitoring ensures that all contracted CMAs meet high standards of quality and performance, safeguarding access and continuity of care for waiver participants. The SMA's selective contracting methodology supports equitable service delivery statewide while aligning with federal requirements for case management under Medicaid HCBS waivers.

ii. Take(s) corrective action if there is a failure to comply.

OLTSS will require that all activities completed by the CMAs are entered into the LTSS*Maryland* data management system. The SMA monitors all CMAs through reports built into the system, and as the need arises, custom reporting. This includes an evaluation of all functions, including developing and submitting POS, submitting reportable events and the associated intervention and action plans. CMAs must submit activities for reimbursement in line with the solicitation.

Identified deficiencies require that the CMA submit an acceptable corrective action plan to the SMA. The CMA receives a letter indicating when the review has been successfully closed and the corrective action plan has been approved. The SMA maintains all documentation of the actions that were taken to remediate identified problems related to the required functions of the CMA.

2. Describe the State's contract monitoring process specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

The CMAs are required to meet certain case management performance standards and are monitored with regards to their performance in the matters of participant safeguards in the quality improvement-health and welfare section of the 1915(c) application. The following performance measures are evaluated annually:

- % of CMAs that meet the minimum qualifications for providing case management services per waiver year
- % of new CMAs completing orientation training
- % of participants' plans that address the assessed needs including health and safety risk factors
- % of participants' plans that address their personal goals
- % of participants' service plans updated/revised at least annually
- % of participants with services delivered in accordance with their service plan including the type, scope, amount, duration and frequency of services
- % of participants who received the list of medical day care providers when enrolled in the waiver
- % of participants' complaints resolved within the required time frame
- % of incidents for which prevention strategies were developed and implemented
- % of participants' incidents including abuse, neglect and exploitation resolved within required timeframe
- % of abuse, neglect, exploitation and unexplained death incidents reported within the required timeframe
- % of enrolled waiver participants (or families / legal guardians) who know how to report abuse, neglect, exploitation and unexplained death
- % of waiver participants who receive information on how to report abuse, neglect, and/or exploitation during the plan of service (POS) development process at least annually
- % of case mgmt agencies that received training provided by the State on identifying, addressing, and seeking to prevent abuse, neglect, and/or exploitation per waiver year (WY)
- % of reported abuse, neglect and exploitation incidents resolved by OLTSS

- % of unauthorized incidents of restrictive interventions that were appropriately reported
- % of unapproved restrictive interventions with a prevention plan developed as a result of the incident
- % of restrictive interventions performed that followed State policies and procedures, as specified in the approved waiver
- % of waiver participants who express satisfaction with the quality of services provided
- % of waiver participants receiving preventive health care
- % of claims that were paid in accordance with reimbursement methodology
- % of paid claims with proper documentation to support the services rendered
- % of targeted in-house utilization reviews that result in technical assistance or training for MDC provider
- % of targeted in-house utilization reviews that demonstrated the provider had appropriate internal fiscal integrity controls
- % of providers billing dates of service within the participant's authorized Service Plan
- % of targeted in-house utilization reviews resulting in recoupment of waiver funds
- % of claims paid according to the State's rate for services

ii. Take(s) corrective action if there is a failure to comply.

Identified deficiencies require that the CMA submit an acceptable corrective action plan to the SMA. The CMA receives a letter indicating when the review has been successfully closed and the corrective action plan has been approved. The SMA maintains all documentation of the actions that were taken to remediate identified problems related to the required functions of the CMA. Further failure by the CMA to meet performance expectations may result in financial sanctions and/or the termination of the contract by the SMA.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

The CMA will provide both initial and on-going waiver case management to the applicants and enrollees in their county/counties or statewide. The case management services can be

effectively monitored by the SMA for timeliness through reports generated by LTSS*Maryland*, and on and off-site provider audits.

The SMA ensures that continuity and coordination of care are maintained under the MDCSW despite the use of selective contracting for CMAs.

The SMA has contracted with a sufficient number of CMAs distributed throughout the state to ensure participant choice and access. Participants may select any Medicaid-enrolled CMA awarded by the SMA serving the jurisdiction in which they reside. CMAs are required to maintain policies that support participant transitions between agencies without service disruption.

CMAs coordinate closely with MDC providers to ensure care planning. The SMA requires CMAs to document all referrals, service changes, and participant contacts in LTSS*Maryland*, allowing real-time tracking of care coordination activities. CMAs receive CRISP notifications for participant hospitalizations or emergency department visits to support real-time care coordination.

All CMAs operate under uniform standards defined in the solicitation, ensuring consistency in assessment, care planning, service monitoring, and participant communication.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

The SMA permits CMAs to provide informational marketing materials to the SMA for distribution to waiver participants during the process of selecting a CMA. These materials are developed and produced independently by the CMAs and are not created, endorsed, or controlled by the SMA.

To ensure compliance with federal and state requirements, all CMA-submitted materials must adhere to the following standards:

Accuracy and Transparency: Materials must present factual, non-misleading information about the CMA's services, service area, and capacity.

Prohibition of Inducements: Marketing materials may not include offers of gifts, incentives, or other inducements to influence participant selection of a CMA, in accordance with 42 CFR § 438.104(a) and COMAR 10.09.07.

Accessibility: Materials must be made available in formats and languages appropriate to the waiver population, consistent with 42 CFR § 438.10(d) to ensure participants with limited English proficiency or disabilities have equitable access to information.

Approval Process: The SMA reviews all CMA-submitted marketing materials prior to distribution to ensure they meet program standards and do not create confusion or bias among participants. Materials that do not meet these standards are returned to the CMA with required revisions.

This process enables participants to make informed choices among qualified CMAs while safeguarding against coercive or deceptive marketing practices. The SMA retains the right to remove or withhold any materials deemed inconsistent with these requirements.

B. Individuals with Special Needs.

___ The State has special processes in place for persons with special needs (Please provide detail).

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. **Provide a description of the State's efficient and economic provision of covered care and services.**

The waiver requested is limited to the case management services in the proposed amendment for the MDCSW. The SMA assures it will comply with 42 CFR 431.55(f)

2. **Project the waiver expenditures for the upcoming waiver period.**

Year 1 from: _2_/_1_/_2026___ to _6_/_30_/_2026___

Trend rate from current expenditures (or historical figures): ____3.0____%

Projected pre-waiver cost __$1,349,942_____
Projected Waiver cost __ $510,138___
Difference: __ $839,907___

Year 2 from: _7_/_1_/_2026___ to _6_/_30_/_2027___

Trend rate from current expenditures (or historical figures): _____3.0___%

Projected pre-waiver cost ____$3,428,350____
Projected Waiver cost ___ $1,619,600_____
Difference: ___ $1,809,011_____

Year 3 (if applicable) from: _7_/_1_/_2027___ to _6_/_30_/_2028___
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)
Projected pre-waiver cost ____$3,625,232____
Projected Waiver cost ____$1,712,693____
Difference: ____$1,912,815___

Year 4 (if applicable) from: _7_/_1_/_2028___ to _6_/_30_/_2029___
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost ____$3,830,842____
Projected Waiver cost ____$1,809,831___
Difference: ____$2,021,303____

Year 5 (if applicable) from: _7_/_1_/_2029___ to _6_/_30_/_2030___
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost ____$4,045,525___
Projected Waiver cost ____$1,911,255____
Difference: ____$2,134,578____